Request Reference: FOI/028/23
Published: 28 August 2023

Information requested:

Please can I have access to The State Hospital Board Meeting Papers from 2019.

Response:

We have enclosed the Board meeting papers from 2019.

Advice and Guidance

Following your request, we have published the Board meeting papers from 2018/19 onwards. These are available from our website; https://www.tsh.scot.nhs.uk/about-us/the-board/board-meetings/

THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 25 APRIL 2019
9.45am

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

A G E N D A

1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 28 February 2019	For Approval	TSH(M)19/01  03 - Board Minute -Feb 19 - Public Sessi
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 19/24  04 - Actions List from Feb - Public Session.
5.	**Chair's Report**	For Noting	Verbal
	CLINICAL GOVERNANCE		
6.	**Patient, Carer & Volunteer Stories - Carer Story** Report by the Director of Nursing and AHPs	For Noting	Verbal
7.	**Review of Clinical Model - Update** Report by the Medical Director	For Noting	Paper No. 19/25  07 - Clinical Model review 06042019.doc
8.	**Clinical Governance Committee** Draft Minutes – 14 February 2019	For Noting	CG(M)19/01

08 - CG Minute - Feb meeting.docx

STAFF GOVERNANCE

9.	**Attendance Management Improvement Working Group** Report by the Interim Director of HR	For Noting	Verbal
10.	**Staff Governance Committee** Draft Minutes – 7 February 2019	For Noting	S(G)19/01 10 - Staff Governance Minute F

CORPORATE GOVERNANCE

11.	**Finance Report to 31 March 2019** Report by the Director of Finance & Performance Management	For Noting	Paper No. 19/26 11 - Finance Report.doc
12.	**Draft Annual Operational Plan** Report by the Director of Finance & Performance Management	For Approval	Paper No. 19/27 12a - Draft Operational Plan - cov 12b - TSH OPERATIONAL PLAN
13.	**Corporate Governance Blueprint** Report by the Board Secretary	For Approval	Paper No. 19/28 13a - Corporate Governance Blueprint 13b - CG Blueprint Report.doc 13c - Appendix A - Programme.docx 13d - CG Blueprint Improvement Plan.do
14.	**Annual Review of Standing Documentation** Report by the Director of Finance & Performance Management	For Approval	Paper No. 19/29

14a - SBAR Standing Doc.doc

14b - SFI Mar 18.doc

14c - SoD.doc

14d - Standing Orders Mar 18.doc

15. Audit Committee

Approved Minutes – 24 January 2019 — For Noting — A(M)19/01

15 - Audit Committee Minutes Jan 19.doc

Chair's Report - 28 March 2019 — Verbal

16. Chief Executive's Report — For Noting — Paper No. 19/30

16 - CEO Report - April 2019.docx

17. Any Other Business

18. Date and Time of next meeting

20 June 2019, 1pm in the Boardroom
At The State Hospital, Carstairs, ML11 8RP

19. EXCLUSION OF PUBLIC AND PRESS

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

THE STATE HOSPITALS BOARD FOR SCOTLAND ***TSH(M)19/01***

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 28 February 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

Chair:	Terry Currie
Present:	
Non Executive Director	Bill Brackenridge
Chief Executive	James Crichton
Non Executive Director	Nicholas Johnston
Non Executive Director	David McConnell
Finance and Performance Management Director	Robin McNaught
Director of Nursing and AHPs	Mark Richards
Medical Director	Lindsay Thomson
Non- Executive Director	Maire Whitehead
In attendance:	
Head of Social Work	Kathy Blessing
Chair of Clinical Forum	Aileen Burnett [Item 7]
Training and Professional Development Manager	Sandra Dunlop [Item 8]
Health Records	Louise Gray
Vice Chair of Clinical Forum	Sheila Howitt [Item 7]
Director of Regional Services, NHSGGC	Gary Jenkins
Head of Communications	Caroline McCarron
Patient Learning Manager	Julie McDonald [Item 8]
Head of Corporate Planning and Business Support	Monica Merson
Senior Project Manager	Angela Robertson [Item 19]
Senior IT Analyst	Paul Dobbin [Item 19]
Interim Human Resources Director	Kay Sandilands
Board Secretary	Margaret Smith
Director of Security, Estates and Facilities	David Walker
Lead Pharmacist	Morag Wright [Item 10]

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Currie welcomed everyone to the meeting, and noted apologies from Ms Anne Gillan. He welcomed Mr Gary Jenkins to the meeting noting that Mr Jenkins had been appointed to the role of Chief Executive to the Board with effect from 1 April 2019.

NOTED

2 CONFLICTS OF INTEREST

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

NOTED

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 13 December 2018 were noted to be an accurate record of the meeting.

APPROVED

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board noted progress on the action points from the last meeting, and received the following updates.

Mr Walker provided the Board with an update on the work progressed to date, focusing on improving the visitor experience at reception. A working group had been formed with Security, the Person Centred Improvement Lead as well as nursing staff. The group were reviewing a number of areas including the possibility of providing a single point of contact for visitors, scheduling of visits as well as the processes in place around the inspection of gifts. The working group would report through the Senior Management Team (SMT).

In response to a request from the Board, Ms Blessing provided further assurance that there were no concerns around the number of referrals to Adult Support and Protection (ASP) within the hospital as well as to the robust procedures in place for these referrals.

Mr McNaught provided the Board with an update in relation to Information Governance, on Board performance benchmarked against other health boards. There were no standardised metrics that provide for a direct comparison between Boards. However, The State Hospital's (TSH) size enabled an agile approach to Information Governance. Participation in national forums suggested that the Board's performance compared favourably with that of other Boards.

NOTED

5 CHAIR'S REPORT

Mr Currie provided Members with an update from the NHSScotland Board Chairs meeting which had taken place on 28 January 2019

The Cabinet Secretary, Ms Jeane Freeman, had asked Chairs to look at processes for responding to family members to ensure that these processes were robust and provided prompt responses.

Ms Freeman highlighted the lessons learned in infection control and cleanliness standards from recent issues found at the Queen Elizabeth University Hospital. She also emphasised the need to engage with the public through the media to place information in the public domain in such a way as to aim to increase public understanding. At the same it was acknowledged that this would be within the context of maintaining patient confidentiality.

The Chief Medical Officer, Dr Catherine Calderwood, had been in attendance at the meeting and outlined the recommendations from the Citizens Jury held in the autumn of 2018. The full list of recommendation would be available to Chairs following the launch event. Once available, Mr Currie would share these with the Medical Director and Director of Nursing and AHPs.

The Cabinet Secretary had advised Chairs that seven new Atlas Maps of Variation had been published on the ISD website on 29 January 2019, to ensure the Medical Directors were making use of these tools. Professor Thomson clarified the use of such tools and confirmed that to date there was no map available in the field of mental health.

Mr Currie advised that the Cabinet Secretary had expressed concern at the dip in waiting time

performance and the need to deliver on agreed trajectories by year end. The Cabinet Secretary emphasised the need to focus on implementing the actions emanating from the Health and Social care and Audit Scotland Report in the short term as well as to include the third and independent sectors within the overall process.

An update was received on EU Exit with a reminder to Chairs to gain assurances that Boards were making all necessary plans on the issues which will impact Board operations.

Chairs had received an update on the Corporate Governance Blueprint and that the Steering Group had prioritised determining the baseline position for Boards' current governance systems. The self assessment survey tool would be sent to all Boards at the beginning of February 2019 for completion during that month. Boards would then hold development sessions and produce an action plan for improvement by the end of March 2019. This should enable a report on the outcome of the self-assessment to be published and discussed by Boards at their meetings in April 2019.

NOTED

6 REVIEW OF CLINICAL MODEL

A report was received from the Medical Director to provide an update on the review of the clinical model, including the significant progress made in consultation activity since the last update to the Board at the December 2018 meeting. This was around three possible models and consultative workshops had taken place with staff and stakeholders. The intention was to continue this iterative process with staff to gain as wide a range of views as possible.

Professor Thomson highlighted the need to clinically manage the options appraisal process to ensure continuation of robust care for patients. Feedback had been received from the Patient Partnership Group (PPG) and overall message were that patients would be open to change. Mr Richards added that draft workforce modelling had been carried out recognising the different shift patterns and the feasibility of modelling. Further detailed work would be required in this area.

Members received this report warmly and were impressed at the level of engagement taking place which it was felt would give ownership of the model. Members who had participated in the stakeholder session had noted the breadth of stakeholders present which had led to an excellent session. A further update would be brought to the Board at their next meeting in April on the evaluation of options.

Action - Professor Thomson

NOTED

7 CLINICAL FORUM - 12 MONTHLY REPORT

A paper was received from the Chair of the Clinical Forum and Dr Burnett and Dr Howitt were in attendance to lead Members through their report, emphasising the future areas of focus of the forum as well as the importance of continuing to develop links with the Board.

Mr Crichton thanked Dr Burnett and Dr Howitt for taking on leadership of the Clinical Forum as an independent advisory committee to the Board, and for their work to date. This was an importance check and balance on the work of the Board. Members noted the connection of the Clinical Forum to front line staff and the opportunities presented to provide advice to the Board independently of the existing management structure.

Mr Currie thanked Dr Burnett and Dr Howitt for their report which was valued by the Board. He highlighted that the Board were keen to develop the link to the Clinical Forum and welcome their input.

NOTED

8 PATIENT LEARNING - 12 MONTHLY REPORT

A paper was received from the Interim Human Resources Director, to provide an update on patient learning services within the hospital, detailing service activity levels and key achievements during 2018. Ms Dunlop and Ms McDonald were in attendance to help provide further background.

Members noted the breadth of work undertaken and the positive nature of engagement with patients which was evidenced in events like the Patient Learning Awards which would take place on 13 March, and the art on display in the Skye Centre. The report was uplifting in providing a summary of the work undertaken.

There was discussion on how to increase uptake of activities from patients - with capacity uptake noted to be at 80%. This was a year on year improvement but Members sought assurance on the reasons that lay behind cancellation of sessions and how to improve uptake further. This was multi-factorial and could depend on patient preferences or well-being. A further factor was in a number of vacancies within the Skye Centre, as well as cancellation of sessions due to staff sickness absence. Mr Richards provided an update on the work ongoing to fill vacancies and referred to ongoing work undertaken to improve attendance across the organisation. .

The Board were content to note the content of the report.

NOTED

9 GLOBAL CITIZENSHIP: LINK WITH PAKISTANI PSYCHIATRIC ASSOCIATION

A paper was received from the Medical Director, outlining the work taken forward by Dr Khuram Khan, the organisation's Champion for Global Citizenship, to establish links between Scottish and Pakistani Psychiatric specialities.

The Board welcomed this report and commended the work to date.

NOTED

10 FALSIFIED MEDICINES DIRECTIVE

A report was received from the Medical Director, which outlined the plan of work taken forward within The State Hospital (TSH) with NHS Lothian Pharmacy Service (as TSH medicine supplier) towards implementation of the False Medicines Directive (FMD). Ms Wright was in attendance to provide a summary of the paper.

The Board noted the recommendations made to add FMD non-compliance to the Corporate Risk Register, noting that the regulator was supportive of a transition period past 9 February 2019 provided planning was in place; to continue to align with NHS Lothian FMD process and options appraisal for software, scanners rather than a TSH stand alone approach; the Health Centre to be used as the central location for verification and de-commissioning and to explore suitable personnel and procedures required for implementation.

NOTED

11 INTERNATIONAL TRAVEL REQUESTS

The Board received a paper from the Chief Executive, requesting international travel for the Head of Corporate Planning and Business Support to attend the International Association of Forensic Mental Health Services 2019 Conference (IAFMHS) in Montreal, Canada. The IAFMHS had accepted a presentation on "Staff and Patient Safety within The State Hospital". Learning would be shared with colleagues in the wider hospital through a Journal Club presentation. The Board received assurance that costs would be met through the 2019/20 training budget.

The Board also received a request for the Clinical Lead for Intellectual Disabilities to attend the Health Care in Secure Settings Conference in Sydney Australia - flights and accommodation would be booked by the conference organisers with no cost to TSH. Attendance at this conference would raise the profile of the work of TSH.

These two requests were approved by the Board.

APPROVED

12 CLINICAL GOVERNANCE COMMITTEE – CHAIR'S REPORT

The Board received the approved minutes of the meeting of the Clinical Governance Committee which took place on the 15 November 2018.

Mr Johnston provided an update on the key issues discussed at the Clinical Governance Committee meeting held on 14 February 2019 and confirmed that the minutes would be available at the next Board meeting. The Committee had focused in particular on the patient active day programme as well as risk reporting. There had been a discussion item on suicide prevention.

NOTED

13 CLINICAL WORKFORCE PLANNING

A report was received from the Interim Human Resources Director to provide the Board with an update in respect of workforce planning at TSH in line with the Workforce Plan for 2017/2022, and taking into account the review of the work progressed in the review of the clinical model and the Common Staffing Method defined by the Health and Care (Staffing) (Scotland) Bill.

Ms Sandilands summarised the report highlighting the interdependency of the Clinical Workforce Plan with the review of the clinical model as well as the Common Staffing Method. It would be the case that any delay in the timing of the either the clinical model or the Common Staffing method would impact on workforce planning.

Members asked for assurance that the new workforce tool would be effective and were assured that this would bring a robustness and rigour, and that it was important to note that it would not prescribe a minimum staffing level. There was an escalation process in place to ensure Board compliance. Support had been agreed through SMT for a new short term post to support implementation.

The Board noted the content of this report.

NOTED

14 ATTENDANCE MANAGEMENT IMPROVEMENT TASK GROUP

A report was received from the Interim Human Resources Director to update the Board on the work of the Attendance Management Task Group including an updated action plan. Ms Sandilands

advised the Board that the group were moving to focus upstream on preventative work to help reduce sickness absence.

The Board were supportive of this work and future focus for further improvement in an essential area of improvement for the Board. .

NOTED

15 INTERNATIONAL TRAINING - JANUARY 2019 - UPDATE

A paper was received from the Interim Human Resources Director to provide feedback in regard to PMVA instructor training delivered in the United Arab Emirates in January 2019.

Ms Sandilands summarised the report, advising that the delivery of the training had been successful. The report also assured the Board that releasing nursing staff for a two week period to assist in the delivery of the training had no adverse impact on care delivery within TSH.

Members welcomed this update especially the positive impacts in reputational and financial gains for the Board, and noted it as an area to be considered in future sustainability planning.

NOTED

16 STAFF GOVERNANCE COMMITTEE

The Board noted the approved minutes of the Staff Governance Committee meeting held on 29 November 2018. The Committee Chair, Mr Brackenridge, provided a verbal update on the meeting which had taken place on 7 February 2019 which had focussed on attendance management and policy compliance within Human Resources which had been subject to internal audit.

NOTED

17 FINANCE REPORT AS AT 31 JANUARY 2019

The Finance Report to 31 January 2019 was submitted to the Board by the Director of Finance and Performance Management, and Members were asked to note the content of this report. Mr McNaught led Members through the report highlighting the key areas of focus.

The Board reported an overspend position of £0.223m to 31 January 2019 with an in–month movement being an under spend of £0.054m. Mr McNaught advised the Board that actions were being identified to alleviate this pressure for the remainder of the year and this enabled the financial forecast to remain a breakeven position for year end. He provided further rationale in the continuation of the forecast of a breakeven position to year end, particularly around the reduction experienced in overspend in the Nursing and AHP budget.

The Board noted in particular the position in respect of the Board's contribution to the National Boards savings, and that it would not be able to contribute the second half of £0.220m during this financial year. Members also discussed the difficulties experienced in identifying recurring savings going into the new financial year.

The Board asked for a further update on the position to the end of month 11 as soon as it was available.

Action – Mr McNaught

NOTED

18 SERVICE SUSTAINABILITY

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

The report focussed on higher impact actions taken as well as the future focus for 2019/20. The key priorities would be associated workforce planning with the delivery of the clinical model, effective rostering and the expansion of the nursing pool. More widely there would be focus on the maximising efficiencies through Service Level Agreements and scoping opportunities for income generation and the rationalisation of the physical estate.

The Board noted progress made in the area and the future focus.

NOTED

19 BUSINESS INTELLIGENCE AND TABLEAU - PROJECT UPDATE

The Board received a report from the Director of Finance and Performance Management which outlined the progress made to date on this project. Ms Robertson and Mr Dobbin were in attendance to demonstrate Tableau dashboard developed using TSH data. A stakeholder workshop with senior stakeholders would take place on 21 March 2019 and the outcomes would be reported through SMT.

Ms Robertson advised that it was hoped that this system would help reduce the data burden for users and turn data into effective dashboards so that information could be used at the appropriate time thus helping effective decision making. This should create a self-service environment for users of the system which would be more efficient and engaging for users, producing more fluid and better quality reporting. Mr Dobbin provided a practical demonstration of the Tableau dashboards allowing Members to appreciate the practical applications of the system.

Members welcomed this update which had clearly demonstrated the benefits of the system. There was discussion around any need in IT hardware for users as well as training for staff at the point of implementation. The Board noted that this system was widely used by other NHSScotland Boards.

It was noted that further work was ongoing to identify the full scope of data required and the designing of dashboards. A further report would be routed through SMT following the workshop taking place in March with an update to the Board thereafter.

Action – Mr McNaught

NOTED

20 PERFORMANCE REPORT – QUARTER 2 - 2017/18

A report was submitted to the Board by the Director of Finance and Performance Management, which presented a high level summary of organisational performance for Quarter 3 – October to December 2018 and the Board noted the content of the report.

NOTED

21 ANNUAL REVIEW – UPDATE

A report was submitted to the Board from the Board Secretary to provide Members with feedback

on the Annual Review which took place in the hospital ion 14 January 2019.

This had been a Ministerial Visit and had provided an excellent opportunity to demonstrate the wide breadth of care experienced by patients at TSH. The Minister had met with the Clinical Forum and the Partnership Forum as well as meeting with patients, carers and volunteers in the Skye Centre. The Minister had also taken time to visit Lewis hub and to engage in a public question and answer session. There had been a high level of staff engagement in this session.

NOTED

22 AUDIT COMMITTEE

The Chair of the Committee, Mr McConnell provided a verbal update of the meeting which had taken place on 24 January 2019 and had focussed on resilience arrangements, internal audit of attendance management and a review of the Corporate Risk register.

NOTED

23 CHIEF EXECUTIVE'S REPORT

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

Mr Crichton provided an update in respect of preparedness for EU Withdrawal, advising that the Board was working closely with Scottish Government colleagues in this regard.

Members were content to note this report.

NOTED

24 REVISED MEETINGSCHEDULE - BOARD BUSINESS 2019

Members noted a minor change to the committee schedule for 2019.

NOTED

25 ANY OTHER BUSINESS

Mr Currie noted that this would be the final Board meeting for Mr Crichton as Chief Executive, as he would retire on 31 March 2019. On behalf of the Board, he thanked Mr Crichton for the major contribution he had made to the Board and wished him well for the future.

Mr Currie also noted that this would be the final Board meeting for Ms Blessing who would be leaving the Board to take up a new post with South Lanarkshire Council. He thanked her for her significant contribution to the hospital and wished her well in her new post.

NOTED

26 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 25 April 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

NOTED

25 EXCLUSION OF PUBLIC AND PRESS

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

AGREED

ADOPTED BY THE BOARD

CHAIR _____
(Signed Mr Terry Currie)

DATE 28 February 2019

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

ACTION NO	AGENDA ITEM NO	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	6	Review of Clinical Model	Further update to the nest meeting of the Board.	Lindsay Thomson	April 2019	**On Agenda**
2	17	Finance Report	A further update to Board Members on the position to the end of month 11.	Robin McNaught	March 2019	**Completed**
3	19	Business Intelligence and Tableau	Further update to SMT following March workshop. To be added to Board Workplan for further update.	Robin McNaught	April 2019	**Completed**

Board Paper 19/25

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2019
Agenda Reference:	Item No: 7
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Business Support
Title of Report:	Review of Clinical Model
Purpose of Report:	Update the Board on progress

1 SITUATION

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

2 BACKGROUND

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

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

The Board received an update in October on point 2. Review of the safety factors, and a further update in December on point 1. Review of the Clinical Model Principles and point 3. Review of the clinical service delivery model, which consisted of staff consultation activities via an online questionnaire and staff workshop.

3 ASSESSMENT

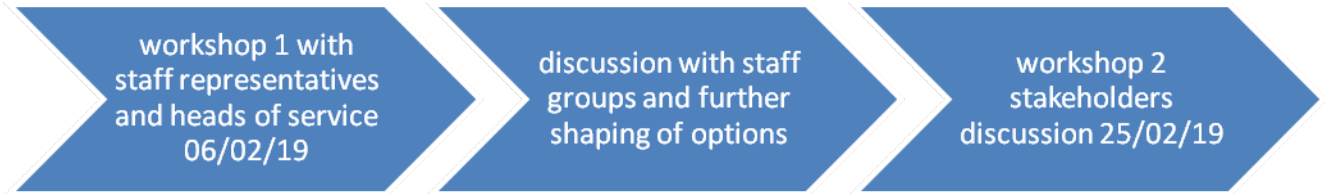
Staff Consultation
All staff were invited to respond to an online questionnaire which was live from 7th December 2018 until 14th January 2019, this questionnaire asked the following:

- What are the strengths with how we deliver our clinical care ?
- What are the current problems with how we deliver our clinical care ?

- What changes would you make to improve how we deliver our current clinical care?
- What would we need to think about to enable your proposed changes to improve how we deliver our clinical care model?
- What else do you need to support you to deliver high quality clinical care?
- Is there anything else you would like to say about how we deliver clinical care?.

Fifty seven responses were received to the above questions and analysis of the feedback was presented to staff via the workshop sessions below

Two workshop sessions were be delivered in February 2019 to develop, consult and test options for delivering clinical care with staff and stakeholders.



Staff Workshop 6th February

Thirty eight staff attended the staff workshop session on the 6th February.

Options form staff workshop
Emerging options form the staff workshop. Throughout the staff workshop session there emerged 2 areas of consensus:

1. Need for change in the TSH culture with a focus on clinical empowerment and strengthened clinical leadership to engage and develop staff

2. Two options for proposed structural change to the configuration of wards.

<u>Option 1</u> for structural change to ward configuration:
3 hubs operating a 3 ward system of progression
- Ward 1 - Admissions and acutely unwell patients
- Ward 2 - Continuing care
- Ward 3 - Rehabilitation and pre transfer

4th Hub -1 or 2 wards accommodating ID patients (if 2 wards then each ward with fewer numbers of patients)

<u>Option 2</u> for structural change to ward configuration:
2 admission wards (may be in 1 hub or spread across 2 hubs)
1 or 2 ID wards
5 (or 4) Continuing Care wards
2 Rehab wards with Skye Centre integration

Requirements for implementation

On further discussion and refinement the importance of culture and the conditions that would support change were more fully explained, these are detailed below;

- Consistency of approach in applying criteria of the admission (+acute care) wards and the rehab ward (e.g. rehab ward only for patients who are not on elevated observations).
- Co – production of the criteria for each ward so that there is clinical cross hub ownership and collaboration on this
- Once criteria and clinical model agreed then enable local governance and implementation so that Hub leadership teams have ownership for implementation – and responsibility for this.
- Create a culture of change and improvement with responsibility locally for implementation and management
- Create a culture of leadership based on competency and enable more effective MDT working
- Wider system leadership to ensure that staff are supported and developed
- Wider system enablement to let the model work with less committee reporting
- Progression for nursing staff and differentiation / specialist areas to operate in
- Potential to have a scheme of working across Forensic Network
- Allow / enable staff to choose their preference of where they work to get greater buy in and greater match of interests and skills to area of work.
- Best use of staff skills and provides opportunity for other disciplines to engage

Patient Workshop 18th February

The Options from the staff workshop were discussed with patients through a dedicated Patient Partnership Group workshop and ward outreach patient conversations. In total 45 patients gave their feedback on potential changes to the clinical model and also considered the status quo as an option.

From this process patients reviewed and discussed the 3 options and for each identified benefits (boats), challenges (pebbles) and obstacles (boulders). From this process it emerged that patients who were engaged in this process were keen for change and that the status quo option was least preferred. There were difference of opinion around the benefits and drawbacks of continuity of RMO and whilst there seemed to be agreement that progression through the hospital was a good thing, that care would need to be taken if patients health deteriorated and they were moved back into a higher dependency ward, that this was not seen as a punitive measure but protective for the mental health.

Stakeholder views on emerging options

The Stakeholder Workshop was attended by 12 stakeholder including the Scottish Prison Service, Mental Welfare Commission, Scottish Government, Scottish Health Council, Volunteers and Careers. Participants were asked to reflect on what they had heard from staff and patients feedback and the emerging options. Feedback from this session included that Stakeholders liked the graduated approach to care, both option 1 and 2 offered this. There were no strong opinions about a favoured option however general agreement on the following:

1. Need for the Clinical Model to be able to flex to the changes in patient numbers
2. Increased engagement for both patients and staff - need further staff engagement in this process
3. Cultural change will be essential to match any structural change in the hospital
4. Opportunity for development of staff skills to specialise in particular areas of care
5. Expansion of opportunities for patients to engage in wider activities

6. Opportunity of development of peer to peer support for patients
7. Opportunity for flexible workforce to ensure the right staff are in the right place at the right time
8. A clear pathway and progression through the hospital would benefit patients
9. Benchmark against other high secure environments to ensure that we learn and share practice.
10. Work towards least restrictive option
11. Good leadership is key to the delivery of any option to ensure that it is implemented and staff and patients are supported through any change process

Emerging Principles

From the staff, patient and stakeholder engagement there are emerging principles that have resonated with all, these are;

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

Staff Engagement Process

Following the Staff Workshop on the 6th February, Stakeholder Workshop on the 25th February and Patient Workshop on the 18th February, there has been an invitation for staff to feedback comments and also a programme of planned engagement with staff groups. To date 97 clinical staff have attended the engagement meetings and 12 individuals have submitted written responses representing Nursing, Social Work, Pharmacy and Psychology.

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

The programme of planned engagement is outlined below:

- Meeting with AHP staff – 10 staff attended discussion and feedback
- Meeting with Practice Development Staff – 4 staff attended
- Meeting of RMO's at the MAC – 10 staff attended
- Three meetings arranged with Nursing Staff through Participatory Learning Group
  23/03 – 38 staff attended with all Hubs and wards represented
  06/04 – 31 staff attended with all Hubs and wards represneted
  20/04 – meeting to be held
- Security Staff team meeting - 4 staff attended
- Psychology Staff team meeting – planned for 29/04
- Meeting with Partnership Forum 19/03/19

Reactions from staff groups to the Clinical Model Review

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

- More tailored security based on patients needs, least restrictive where appropriate
- Sense of progression for patients
- Integration between rehab wards and the Skye Centre
- ID patient's needs to continue to be meet in a specialized ID service, possibly with 2 wards

- Patient mix more tailored with admissions and clinical acuity accommodated in specific areas

In addition other key messages from Staff Engagement are noted below:

Leadership, culture and team working

- Overall strong leadership needed to take forward and deliver any change, reflection that the current model has not been implemented as was planned e.g. 9-5 shifts and as a result has not worked well and as promised.
- Key focus to remain on addressing cultural change and not focusing all our energy on reorganizing the wards, although this will be helpful
- A consistent approach to communication across the site would be helpful to ensure that all staff have access to the same information
- Affordability of each option is key to ensure that whatever steps are taken next, they can be implemented as planned.
- Concern that we plan on paper an ideal model then cannot implement to specification because we don't have the staff to do it
- Multidisciplinary team working – wider clinical staff teams could be used more effectively to support patient experience. Wider team members could be involved in delivering care beyond 9-5 Mon – Fri and be more engaged in the life of the ward.
- Team working and team culture – there is a need to develop team culture and support staff, feeling that staff 'good will' is depleted and causing difficulties. Need to focus on developing a more supportive culture for nursing staff.
- Clarity on next steps, timeline and plan for implementation would be helpful

Additional structural options to consider

- Change is welcomed – patient mix is a key issue – welcome progression of care pathway and ability to specialise in specific areas of care e.g. admission, rehab, continuity of care, ID.
- Consideration given to reconfiguring one of the wards to accommodate a very small number of patients, possibly maximum 4, major mental illness with higher staffing levels to provide an individualized caring arrangement to patients with higher levels of clinical acuity and aggression/ violence
- Flexible option to open a High Dependency Unit as and when required
- Consideration be given to matching groups of patients in terms of their needs. For example, there are a number of older relatively stable patients who are being cared for in wards with high levels of clinical activity arising from much younger patients who are experiencing active symptoms
- Option 2 – bigger change, continuity need not be lost if all RMO follows patients through to rehab Hub (somehow)
- 2 ID wards would enable that group to have more space. It would require a flexible/revolving door type of approach to enable patients to move between spaces as and when required. Having the right staff in the right place at the right time would allow a consistent staff group of people who have developed their expertise in working with this group over the years. It would allow the hub to be a dedicated ID space with the adaptations/modifications required. It would also allow our patients with ID that are hosed in Iona 1,3 and mull 2 to return to the one hub

- Ward and Hub environment – the current ward lay out is difficult to nurse acute and ID patients as not enough space and limited number of quiet rooms
- Support for admissions ward however we will need to review the ward environment and structure of the ward areas. Is there a possibility to reopen Harris as a clinical area and use this for admission
- Need to demonstrate that TSH operates a recovery model – protect Rehabilitation time, need to consider how we can incorporate recovery language into describing what we do and how we do it.
- There currently are not enough Hub based activities and some patients recognise that if they are on Level 3 observations they have more opportunity for individualised care and are better off – this can operate as a disincentive for patients to have decreased observation levels which impacts on staffing levels
- Transitions – patients experiencing transitions whilst in TSH may be better for them. On transfer/ discharge out of TSH patients experience a transition, therefore moving words and or clinical teams in the hospital can help prepare for discharge

Safety and security

- Safety and Security are key concerns, connection to Police and ensuring we are using latest evidence base on equipment and sharing what works with others

Systemic issues and forensic mental health system

- Nursing staff would like to have better networks across the Forensic Estate to share practical information and experience of delivering care
- Staff shortages are an issue – this will need to be considered in the review of the Clinical Model and any new structure will need to be appropriately staffed and financed.
- Clarity on whether the National Review of Forensic Services will affect the review of the Clinical Model
- Opportunity to share practice across the Forensic Estate and work more closely with medium secure to support patient transitions
- Legislative changes that have impacted on the ID service – the Adult Support and Protection legislation has had an impact on how and where we nurse patients the number of disassociations has increased. This has an impact on the ID service and how it can be configured.
- Nurse recruitment and retention – the crisis of recruitment and retention in mental health nursing was recognised and concern that TSH isn't making enough progress in recruitment. Suggested solutions around increasing the number of health care assistants having opportunity to complete their RMN training through reintroduction of secondment with tie in clause to ensure staff return and are committed to the hospital for a number of years. Also increase the numbers progressing through Open University. Newly qualified RMN's shared experiences of having to be firm with universities about wanting to come to TSH for student experience. Is there more can be done with universities to build relationship and ensure students have opportunity to come as a matter of course. Current pool contracts of 22.5 hours seen as a disincentive as many staff are looking for full time hours. Ensure we recruitment to permanent posts as well as pool posts.

Next Steps

Initial high level financial and workforce planning information for each option will be developed. An options appraisal workshop will be held on 14th May with the staff group who originally developed the options. Feedback will be presented on the engagement process and appraisal criteria will be outlined. Staff will be invited to score each option against the appraisal criteria. Analysis of this will provide an indication of the preferred option for further consideration by the Executive Team and the Board.

A draft timeline is attached as appendix 1

4 RECOMMENDATION

The Board is invited to note progress on the review of the Clinical Model

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Corporate objectives of high quality clinical care and staff experience
Workforce Implications	Workforce implications that may arise from the review of the Clinical Model will be formally assessed at options appraisal stage
Financial Implications	Financial implications that may arise from the review of the Clinical Model will be formally assessed at options appraisal stage
Route To Board Which groups were involved in contributing to the paper and recommendations.	Clinical Governance Committee / SMT
Risk Assessment (Outline any significant risks and associated mitigation)	Risks that may arise from the review of the Clinical Model will be formally assessed at options appraisal stage
Assessment of Impact on Stakeholder Experience	Through stakeholder workshop
Equality Impact Assessment	Not formally assessed

Appendix 1

Timeline for Consultation on Clinical Model

Timescale	04/02	11/02	18/02	25/02	04/03	11/03	18/03	25/03	01/04	08/04	15/04	22/04	May	June	July	August
Consultation on the clinical model	***Workshop with staff***	***Feedback to staff on output from workshop***		***Workshop with stakeholder***	***Engagement with staff***											
Development and appraisal of options		***Work up options and criteria***			***Options appraisal – initial high level implications for workforce and financial planning.***								***Workshop with staff to appraise options and score against criteria***			
Board meeting				***28/02 Update Board on consultation process***								***25/04 Update Board on engagement process and plans for options appraisal***		***20/06 Update on evaluation of options against criteria and identification of preferred option***		***22/08***
Partnership discussion							***19/03 Feedback Partnership Forum***				***16/04 Feedback Partnership Forum***		***14/05 Feedback Partnership Forum***			
SMT			***20/02 Update on consultation process***				***20/03 Update on options appraisal and consider any emerging option***				***17/04 Update on staff engagement***		***15/05 Update SMT on options appraisal workshop***			

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the Clinical Governance Committee Meeting held on Thursday 14 February 2019 at 9.45am in the boardroom, The State Hospital, Carstairs.

CHAIR:	
Non Executive Director	Nicholas Johnston
PRESENT:	
Non Executive Director	Maire Whitehead
IN ATTENDANCE:	
Chief Executive	Jim Crichton
Board Chair	Terry Currie
Chair of Medical Advisory Committee	Khuram Khan
Head of Corporate Planning and Business Support	Monica Merson
Clinical Operations Manager	Brian Paterson [Item 14]
Director of Nursing and AHP	Mark Richards
Board Secretary	Margaret Smith
Clinical Effectiveness Team Leader	Sheila Smith
Chair of MHPSG	Gordon Skilling [Item 7]
Medical Director	Lindsay Thomson
Senior Nurse, Practice Development	Mhairi Ward [item 16]

1 APOLOGIES AND INTRODUCTORY REMARKS

Mr Johnston welcomed everyone to the meeting. Apologies were received from Mr David McConnell, Mr John Marshall and Mr Robin McNaught.

NOTED

2 CONFLICTS OF INTEREST

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

NOTED

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 15 November 2018 were approved as an accurate record.

APPROVED

4 PROGRESS ON ACTION NOTES

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

NOTED

5 MATTERS ARISING

There were no further matters arising.

NOTED

6 PSYCHOLOGICAL SERVICE REPORT

This paper was deferred until the May meeting to allow the Head of Psychological Services to present the report.

NOTED

7 MENTAL HEALTH PRACTICE STEERING GROUP

A paper was submitted by the Director of Finance and Performance Management, which provided a summary of the work of the Mental Health Practice Steering Group (MHPSG). The Co-Chair of the group, Dr Gordon Skilling was in attendance to highlight the key points of the report. The report was received warmly by the Committee.

Dr Skilling acknowledged some difficulty experienced in the monitoring of clinical outcomes, particularly in realising the potential of data application by clinical teams - a wider move within the hospital towards more flexible business intelligence would support this. The direction of travel should be towards practical application of data analysis.

The wide remit of the group was noted, which could become involved in many areas of functioning within the hospital - the focus on realistic medicine was welcomed.

The Committee was asked to approve a change to the sponsoring Director of the group to the Medical Director, and this was agreed along with the recommended activities of work and intended focus of the group over the coming year.

APPROVED

8 FORENSIC NETWORK CQIF ACTION PLAN

An update report was submitted to the Committee by the Medical Director to provide an update on the action plan leading out of the peer review visit which took place on 27 April 2018.

The Committee discussed the deeper nature of this review and reviewed the action plan in detail. A suggested amendment was made in relation to page 1 around staffing levels for accuracy.

Action - Mark Richards

A further suggestion was made in bringing forward the timescale for review of the visitor experience at reception.

Action - Sheila Smith

The Committee was content to note the updated action plan, subject to these amendments.

NOTED

9 CLINIAL GOVERNANCE GROUP REPORT

A report was submitted to the Committee by the Medical Director as a summary of the work of this group during 2018. Professor Thomson led Members through the report highlighting areas of good practice as well as proposed areas of work.

The Committee noted the very comprehensive nature of the report. There was discussion around

observation practice within the hospital and the new national guidelines in this area, as well as how this related to nursing staffing levels. It was noted that this was an area under review with exploration of the data to ensure effective monitoring of this.

The Committee noted the report, and that the group was functioning well within its remit. It was noted that this would be recorded as an area of good practice on this Committee's log.

Action - Sheila Smith

NOTED

10 DUTY OF CANDOUR

A report was submitted by the Head of Corporate Planning and Business Support, and Ms Merson led Members through a summary of the report. This provided an update to the Committee on the implementation of the procedure within the hospital during October to December 2018.

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

NOTED

11 LEARNING FROM COMPLAINTS AND FEEDBACK - QUARTER 3 REPORT

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

Professor Thomson summarised the key points for the Committee, and Members noted the content of the report.

NOTED

12 INCIDENTS AND PATIENT RESTRICTIONS

A report was submitted to the Committee, on behalf of the Medical Director, which provided an overview of activity of incidents and patient restrictions within the third quarter of the current financial year.

It was noted that incidents of self harming should be included in the trend reporting around health and safety incidents going forward.

The Committee remained concerned about reporting timescales for Category 1 and Category 2 Reviews and discussed the difficulties experienced. These included access to staff for interview during the investigation stage, as well as capacity within the Risk Department for these types of reviews. There was agreement that it was important to include witnesses to ensure thorough investigation even though this may slow down the process.

The Committee also considered the process itself for approval of the reviews, and how this compared to other Health Boards. It was agreed that a paper would be brought back to the next meeting of the committee to consider these issues further as well as benchmarking this against practice in other Health Boards.

Action - Monica Merson

NOTED

13 STAFF AND PATIENT SAFETY REPORT ACTION PLAN

A report was received from the Medical Director, to provide the Committee with an update in respect of progress in the implementation of the action plan. Professor Thomson summarised this for Members and also placed this update within the context of the ongoing work on the review of the Clinical Model.

NOTED

14 UPDATE OF PATIENT DAY PROJECT

A report was received from the Director of Nursing and AHPs to provide an update on this project, and Mr Brain Paterson was in attendance to summarise the key points for the Committee. He highlighted the key challenged in implementation as well as progress made to date.

Mr Paterson outlined the key aim of the project was to get to the position where patients were involved in activities for 5 to 7 days a week both within and outside of the Skye Centre. Work was progressing well to ensure that patient timetables could be stored within the RiO system as this would help facilitate patient activity. There was discussion around the importance of clinical staff being involved to help commit patients to participating in activity opportunities.

This work would also be closely linked to the review of the Clinical Model in developing opportunities for patients as well as helping to manage staffing across hub areas.

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

NOTED

15 CATEGORY 1 REVIEW – 18.01

The Committee reviewed and considered this report. Mr Crichton provided an overview of the report as well as the background to this being conducted as an independent review.

The Committee requested a further update in respect to the action plan being taken forward within the hospital in response to the report.

Action - Monica Merson

NOTED

16 DISCUSSION: SUICIDE PREVENTION

Ms Mhairi Ward was in attendance to present an overview to the Committee on action taken at the hospital in relation to the National Suicide Prevention Leadership Group Delivery Plan. The focus has been on a local prevention plan with the policy and practice plans updated in 2018. It was planned to have an online resource available by May 2019, and further bespoke training initiatives were being planned for this year.

There was discussion around the low rate experienced within the hospital over time, and this was compared with self harming incidents. Ms Ward explained that training on self harm would be included in this programme given its importance as a risk factor.

Members asked about training for staff generally, and Ms Ward confirmed that this was being considered to ensure that all staff had awareness in this area. This would also be in line with public health policy ambition.

The Committee thanked Ms Ward for her attendance and this very helpful update.

NOTED

17 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

The Committee asked that further paper be prepared for the May meeting in relation to the CIR process.

The functioning of the Clinical Governance Group was noted as an area of good practice.

18 WORKPLAN

The Committee agreed with the changes that had been made to the Clinical Governance Committee workplan in relation to the main clinical reports being allocated to separate meetings instead of all coming to the same meeting. It was also agreed that, due to the number of papers that will be submitted to the May meeting, there would be no discussion item.

19 ANY OTHER BUSINESS

The Medical Director led discussion around recent media report and autism within the hospital.

This provided Members with assurance in respect of the governance arrangements at the State Hospital for the well being of patients and to ensure patients are detained within the hospital appropriately.

The Medical Director also highlighted the work of the Patient Advocacy Service in terms of its independence from the organisation, as well as role of the Mental Welfare Commission.

Members were assured in respect of this review of governance within the hospital in view of this recent media interest. They were also in agreement that it would be appropriate to respond to media reports through See Me.

Members asked that a wider scope be taken in terms of update to the Board around media interest and that this should include any enquiries around staff dismissal as recently reported. This would be reported to the next private session of the Board.

Action - Margaret Smith

It was noted that there were no items from this meeting to be shared with the Staff Governance Committee.

20 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 9 May 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

The meeting concluded at 12.15pm

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the meeting of the Staff Governance Committee held on Thursday 7 February 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

Present:

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

In attendance:

Organisational Development Lead	Jean Byrne [Item 11]
Chief Executive	Jim Crichton
Board Chair	Terry Currie
Training and Professional Development Manager	Sandra Dunlop [Item 9]
Unison Representative	Tom Hair
Occupational Therapist	Sarah Innes [Item 6]
Education & Learning Officer	Donne McBride [Item 5]
Occupational Therapist	Triona O'Sullivan [Item 6]
Deputy HR Director	Kay Sandilands
Board Secretary	Margaret Smith

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

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

NOTED

2 CONFLICTS OF INTEREST

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

NOTED

3 MINUTES OF THE PREVIOUS MEETING HELD ON 17 AUGUST 2017

The Committee approved the Minutes of the previous meeting held on 29 November 2018 as an accurate record.

AGREED

4 ACTION POINTS AND MATTERS ARISING FROM THE PREVIOUS MEETING

Members noted progress made to date and received a further updates:

Action [1] Training session for line managers/ HR advisors on the Occupational Health (OH) referral process scheduled to be completed by June 2019. Members asked if an earlier date for this could be arranged if possible given the importance of improving attendance management

within the organisation.

Action [3] Ms Sandilands confirmed that the EASY service was an added value to the contract providing OH support and was not paid for by The State Hospital (TSH) on a case by case basis. A wider review of the value this service brings was underway and an update would be brought to the next Staff Governance Committee meeting.

NOTED

5 ATTENDANCE MANAGEMENT STRATEGY

Mr Crichton explained that this item related to the work of the Attendance Management Improvement Task Group, and that Ms McBride had been one of a number of staff members who had engaged with the group to provide feedback. Her presentation had been valuable and for this reason she had been invited to share it with this Committee.

Ms McBride led Members through her presentation which encompassed patterns of absence as well as cultural factors within TSH, and how to drive change within the organisation. She made some suggestions around incentivising good attendance at work, as well as the importance of team work thus helping to create a supportive working atmosphere. She focused on the importance of recognition for staff on a number of levels including long service recognition within the NHS, and individual recognition of staff members who had made particular achievements within the organisation. Ms McBride also made some practical suggestions around re-organising the model of support to staff following an absence, widening contact made from the direct line manager.

Members received the presentation warmly and there was discussion on how consideration of sickness absence when offers of employment were made including for existing members of staff seeking promotion. Ms Sandilands provided assurance that this was the case. The Committee were very supportive of the organisation finding means to support recognition of staff achievements.

The Committee discussed the importance of training for line managers in conducting return to work interviews as these can be difficult especially with colleagues that you know and work with closely.

Mr Brackenridge thanked Ms McBride for her presentation and noted the positive engagement of staff in tackling attendance management across the organisation.

NOTED

6 i MATTER STORYBOARD

Ms Innes and Ms O'Sullivan were in attendance to present their iMatter Storyboard to the Committee as an example of the positive impact of action planning within iMatter. As an introduction they outlined recent development within the AHP cohort and the way that the service was coming together to work as one team, following the recent appointment of the new AHP Lead.

The team had undertaken an Appreciative Inquiry under a 4D model; Discovery, Dream, Design, Desired Outcome. This had enabled the team to focus more clearly on taking positive action rather than on fixating on a problem. Ms Innes and Ms O'Sullivan spoke enthusiastically about the outcomes of this journey for their team and these encompassed improvements to morale and working practices within a more cohesive team.

Members were impressed by this presentation and the demonstration of change carried out successfully within the department. They noted the possibility of transferring these benefits through

shared learning throughout TSH. Members also asked about the benefits for patients in terms of care delivery, and were reassured to learn that joint working had led to more consistency for patients in the delivery of therapy activity.

Mr Brackenridge thanked Ms Innes and MS O'Sullivan for their attendance and presentation which had been of value to the Committee.

NOTED

7 ATTENDANCE MANAGEMENT REPORT

The Committee received the Attendance Management Report for November 2018 and Ms Sandilands was in attendance to summarise the key issues. The absence rate was noted to have been 8.93%, although the reported figure for December 2018 should be confirmed at 7.3% representing a further reduction overall. It was noted that long term absence continued to be of particular concern.

Members requested further information in regard to the numbers of staff on each level of absence i.e. through the stages of the Attendance Management Policy. It was agreed that MS Sandilands would review this data and report this back to the next meeting of this committee in May 2019.

Action – Ms Sandilands

NOTED

8 ATTENDANCE MANAGEMENT IMPROVEMENT WORKING GROUP

Ms Sandilands provided the Committee with an update on the work of this task group since the date of the last Staff Governance Committee meeting and summarising the key priorities of the group.

The Committee discussed the importance of the application of policy through the line manager with support from HR colleagues. This was an area in which it was recognised that there had been specific focus through TSH in terms of strengthening application of the policy. There should be consistency of approach, and it was noted that national 'Once for Scotland' policies would be taken forward within NHSScotland shortly. Members asked for a report on the national policies to be brought to the Committee focusing in particular on what any change to policy would mean for TSH.

Action – Ms Sandilands

NOTED

9 PERSONAL DEVELOPMENT PLANS

A paper was submitted to the Committee to provide a progress update in relation to personal development planning and review staff governance standard and associated compliance. Ms Sandra Dunlop was in attendance to provide an overview to Members. She explained that progress was continuing well and that TSH compliance rate compared favourably against the national position.

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

NOTED

10 HR PERFORMANCE – EMPLOYEE RELATIONS ACTIVITY

The Committee received a report which provided an update on employee relations activity up to and including 31 December 2018. Ms Sandilands updated Members on the data in the report to note that the number of suspensions had reduced from four to two.

Ms Sandilands described the work progressing to reduce timeframes around process, as well as bringing more focus to preventative measures e.g. mediation.

The Committee noted the content of the report.

NOTED

11 EVERYONE MATTERS: 2020 WORKFORCE VISION STAFF GOVERNANCE ACTION PLAN

The Committee received a report from the Interim Human Resources Director by way of an update on the 2018/20 action plan. Ms Byrne was in attendance to help summarise this for the Committee.

Members discussed the drop in completion of action plan through the iMatter process noting that whilst the national picture was similar, they would like further detail to be brought back in relation to the areas/ departments within the hospital with low completion rates.

Action – Ms Sandilands

NOTED

12 SICKNESS ABSENCE AUDIT REPORT

The Committee received an update from the Interim Human Resources Director which provided an update on the outstanding actions from the recent internal audit report.

A review by internal auditors was scheduled to commence 25 February 2019. And the Committee were content to note progress made in this area.

NOTED

13 HEALTH, SAFETY AND WELFARE COMMITTEE, DRAFT MINUTES - 4 DECEMBER 2018

Members received and noted the draft minutes of the Health, Safety and Welfare Committee which had taken place on 4 December 2018.

NOTED

14 PARTNERSHIP FORUM – MINUTES OF MEETINGS HELD IN NOVEMBER AND DECEMBER 2018

Members received and noted the minutes from each meeting.

NOTED

15 HEALTH AND SOCIAL CARE STAFF EXPERIENCE REPORT 2018

The Committee received this report and Ms Sandilands summarised the content. Members agreed that there were many positives to be taken from the report as well as recognising the need for continue improvement.

NOTED

16 ANY OTHER BUSINESS

Mr Brackenridge noted that this would be the final attendance at the Committee by Mr Crichton, Ms Gillan and Mr Currie and thanked them for their contributions over the years.

17 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 30 May 2019 at **9.45am** in the boardroom, The State Hospital, Carstairs.

The meeting concluded at 11.40am

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2019
Agenda Reference:	Item No 11
Sponsoring Director:	Director of Finance and Performance Management
Author(s):	Head of Management Accounts
Title of Report:	Financial Position as at 31 March 2019
Purpose of Report:	Update on current financial position

1 SITUATION

1.1 The Senior Team and the Board consider the Revenue and Capital plans, and financial monitoring. This report provides information on the financial performance to 31 March 2019, which is also included in the Partnership Forum agenda.

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

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

2 BACKGROUND

2.1 Revenue Resource Limit Outturn

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

The Board is reporting an under spend position of £0.025m to 31 March 2019, with the in-month movement an under spend of £0.210m, primarily due to:-

- Further review of centrally held monies and benefit of delays in projects
- RHI income for the last quarter 'accrued' in to March (due to be paid April)
- Year-end accruals scrutiny giving benefit in month
- Income from overseas training
- Pharmacy SLA benefit year-end invoice (staff saving)
- Anticipated income for exceptional circumstance patients
- Estates backlog maintenance spend held back at year-end
- Pressure in Social Work year-end invoice (pay awards)
- Increase in Nursing overtime

2.2 **Forecast Outturn**

The forecast outturn trajectory for the year-end was breakeven, however the year-end position is £0.025m underspent, therefore a favourable movement of £0.025m.

We have had late notification that HMRC has settled in our favour to reduce VAT on utilities to 5% from 20%, this windfall will benefit TSH in 2019/2020, but noted in the table at 2.3.

As reflected and noted in the November return, we will not be in a position to contribute the second £0.220m to the National Boards savings, as that would adversely have affected our ability to achieve breakeven for 2018/19.

Previous Year to Mth 12	**33,396,081.27**	**33,396,081.27**	**33,391,252.22**	**4,829.05**
Spent Type	Annual Budget £'s	Year to Date Budget £'s	Year to date Actuals £'s	YTD Variance (budget less actuals) for period 12
Other Operating Income	(589,051.00)	(589,051.00)	(944,363.83)	355,312.83
Pay	28,572,676.14	28,572,676.14	29,311,580.69	(738,904.55)
Savings	27,174.83	27,174.83	0.00	27,174.83
Purchase Of Healthcare	820,585.00	820,585.00	796,424.31	24,160.69
Non Pay	4,907,518.00	4,907,518.00	4,621,846.70	285,671.30
Hch Income	(790,537.00)	(790,537.00)	(882,919.82)	92,382.82
Capital Charges	2,760,123.00	2,760,123.00	2,778,183.35	(18,060.35)
Sale Of Assets	0.00	0.00	2,988.18	(2,988.18)
	35,708,488.97	**35,708,488.97**	**35,683,739.58**	**24,749.39**

The table below notes areas that should be brought to the attention of the Board – although at this stage they are unquantified.

2.3

PRESSURES
National Pay Deal (only AFC funded)
Increase in sup'ers 19/20 (clarification on funding pending)
Holiday Pay (and possible retrospection) - Locke v British Gas
Rebandings (HR to advise)
Perimeter Fence - FBC - Additional Staff
Double Running costs for senior managers resilience
DOCAS (SLA for Union dues)
POSSIBLE BENEFITS
VAT element on Utilities in our favour (v HMRC)

3 ASSESSMENT

YEAR TO DATE POSITION – BOARD FUNCTIONS

Directorates	Annual Budget 1819 £'k	YTD Budget Mar 19 £'k	YTD Actuals Mar 19 £'k	YTD Variance (budget - actual) (adverse) / favourable Mar 19 £'k	Budget wte	Actual WTE
Cap Charges	2,760	2,760	2,781	(21)	0.00	0.00
Central Reserves	381	381	219	162	-4.80	0.00
Chief Exec	1,887	1,887	1,885	2	23.67	23.61
Finance	2,830	2,830	2,772	58	37.33	36.74
Human Resources Directorate	787	787	749	38	13.33	12.76
Medical	3,452	3,452	3,209	243	34.63	35.52
Misc Income	(130)	(130)	(154)	24	0.00	0.00
Nursing And Ahp's	18,154	18,154	18,725	(571)	378.82	389.50
Security And Facilities	5,586	5,586	5,498	89	123.63	117.71
Under / (over) spend	**35,708**	**35,708**	**35,684**	**25**	**606.61**	**615.84**

3.1 **Capital Charges** pressure.

3.2 **Central Reserves / unidentified savings** – Sit centrally (phased to Month 12) until released to match appropriate spend, however an element of this (the benefit arising from delays in planned projects) has been phased to January and February from Month 12. Spend for apprenticeship levy; carry forward annual leave for Nursing is coded here.

Chief Executive –

3.3 HR Director secondment only being filled 0.50wte.
2/5ths of Finance Director recharged to Golden Jubilee (this ceased at the end of December 2018).

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

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

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

3.6 **Medical Services**
Medical - Recharges to other Boards are higher than was planned in base budgets, also benefits from earlier vacancies.
Psychology – vacancies (due to continued closure of two wards).
Pharmacy – currently reflects an under spend on drugs, and a saving on the SLA due to staff movement.

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

3.8 **Nursing and AHPs**

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

Nursing & AHP's	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for	Budget WTE	Actual WTE
Advocacy	147	147	147	0	0.00	0.00
AHP's & Dietetics & SLA'S	607	607	465	142	13.38	10.52
Hub & Cluster Admin & Clinical Operations	762	762	785	(23)	23.17	21.24
PCI & Pastoral	193	193	162	31	3.40	2.45
NPD & Infection Control & Clin Gov	386	386	371	15	5.80	4.66
Skye Centre	1,518	1,518	1,391	127	38.33	32.63
Ward Nursing	14,541	14,541	15,404	(863)	294.74	318.00
Total Nursing and AHP's	**18,154**	**18,154**	**18,725**	**(571)**	**378.82**	**389.50**

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

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

Hub & Cluster Admin & Clinical Ops – overtime and earlier double running.

PCI & Pastoral - beneficial effect of vacancies, and underspend in patients visitors travel.

NPD etc. – Seconded posts from Nursing, offsetting vacancies.

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

Ward Nursing Overtime, detailed in following table, and under achieved savings.

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

The £'s includes NI'ers @ 11%

2018/19 Ward Nursing Hours		
Period	Overtime Hours	Excess Hours
APR	1,645	503
MAY	3,900	485
JUN	5,310	531
JUL	5,027	536
AUG	6,330	765
SEPT	6,781	665
OCT	4,838	479
NOV	4,347	322
DEC	3,101	756
JAN	3,540	712
FEB	4,039	661
MAR	4,188	816
TOTAL	**53,046**	**7,231**

The £'s includes NI'ers @ 11%

2017/18 Ward Nursing Hours		
Period	Overtime Hours	Excess Hours
APR	3,732	734
MAY	3,010	707
JUN	4,046	464
JUL	5,144	568
AUG	6,822	848
SEPT	6,885	496
OCT	6,694	552
NOV	6,587	377
DEC	5,433	472
JAN	6,628	366
FEB	6,532	431
MAR	2,181	209
TOTAL	**63,694**	**6,224**

2018/19 Ward Nursing £s		
Period	Overtime £	Excess £
APR	41,056	7,981
MAY	100,150	7,945
JUN	136,449	8,164
JUL	131,193	8,683
AUG	165,734	12,590
SEP	178,136	10,905
OCT	129,588	7,794
NOV	113,828	5,059
DEC	78,946	11,066
JAN	90,787	9,419
FEB	105,243	9,034
MAR	107,425	11,373
TOTAL	**1,378,535**	**110,013**

2017/18 Ward Nursing £s		
Period	Overtime £	Excess £
APR	93,077	11,283
MAY	75,198	10,553
JUN	100,626	7,136
JUL	130,226	8,526
AUG	174,100	12,473
SEPT	177,335	7,781
OCT	177,187	8,072
NOV	168,648	6,058
DEC	137,775	7,646
JAN	175,417	5,768
FEB	172,113	7,046
MAR	56,952	3,446
TOTAL	**1,638,654**	**95,788**

YTD Mar '19 - cumulatively £63k overtime is charged to Nursing from Skye Centre this is not reflected in the above table (table is Ward staff only)

3.9 Security and Facilities

Security & Facilities	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for	Budget WTE	Actual WTE
Facilities	4,065	4,065	3,910	155	83.86	74.80
Security	1,521	1,521	1,588	(67)	39.77	42.91
Total Security & Facilities	**5,586**	**5,586**	**5,498**	**89**	**123.63**	**117.71**

Facilities – Mainly under spends in catering and housekeeping, which are due to ward closures and the effect of vacancies. Utilities significantly under spent due to the mild winter.

Security – Sickness cover, acting posts, staff for perimeter fence project.

4 EFFICIENCY SAVINGS TARGET

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

4.2 The following table shows the annual savings, achieved to date, and balance for year-end.

Vacancies contribution has far surpassed the projection.

Savings Annual Target LDP	Savings Annual Target LDP			Savings (Achieved) YTD, as at Mar 19			Savings still to be achieved by year end (n/a Mar)		
	2018-19			2018-19			2018-19		
	Rec £'k	Non-Rec £'k	Total £'k	Rec £'k	Non-Rec £'k	Total £'k	Rec £'k	Non-Rec £'k	Total £'k
Efficiency & Productivity Workstreams:									
Service redesign (Clinical)	5	0	5	0	0	0	5	0	5
Drugs & Prescribing	20	20	40	0	10	10	20	10	30
Workforce	244	588	832	270	902	1,172	(26)	(314)	(340)
Procurement	0	0	0	0	0	0	0	0	0
Financial management / corporate initiatives (Non Clinical)	29	47	76	19	6	25	10	41	51
Financial management / corp init (Non Clinical) - Estates	133	65	198	82	20	102	51	45	96
Other	0	100	100	0	0	0	0	100	100
Unidentified Savings	0	515	515	0	483	483	0	31	31
Total In-Year Efficiency Savings	**431**	**1,334**	**1,765**	**371**	**1,421**	**1,792**	**60**	**(87)**	**(27)**
£280k already achieved in base	Trajectory (1/12ths of LDP)			**431**	**1,334**	**1,765**			
	(under) / over achieved			**(60)**	**87**	**27**			

5 CAPITAL RESOURCE LIMIT

Capital allocations anticipated from Scottish Government amount to £0.303m, spend now matches.

This does not recognise any specific funding yet for the Perimeter Security Project, there has been a slight delay to the start of this.

	Annual Plan £'k	YTD Plan £'k	YTD Actual £'k	YTD Variance £'k
Estates	30	30	30	-
IM&T	212	212	212	-
Vehicles	-	-	-	-
Other equipment	27	27	27	-
Security Fence Dvpt	34	34	34	-
TOTAL	**303**	**303**	**303**	**-**

6 RECOMMENDATION

6.1 **Revenue: Under spend of £0.025m.**

Assumed Tranche 2 savings is not returned. Vacancies continue to contribute to over achieved savings, albeit non recurrently. Overtime in Nursing is still considerably higher than budget.

Quarterly Financial Review meetings, over and above the monthly Management Accounts meetings, help eliminate any surprises in the accounts and aids forecasting the year-end outturn. Savings are realised monthly and are slightly higher than planned.

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

6.2 **Capital: Breakeven.**

Data Centre Replacement spend go through March 2019.

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

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2019
Agenda Reference:	Item No: 12
Sponsoring Director:	Director of Finance and Performance Management
Author(s):	Director of Finance and Performance Management
Title of Report:	Annual Operational Plan
Purpose of Report:	For approval

1 SITUATION

Until 2018/19, the Local Delivery Plan ("LDP") was a high level strategic plan submitted by each NHSScotland Board to SG covering a 3 or 5-year period. In February 2018, instruction was received from SG that these individual board LDPs were to be replaced by draft Annual Operational Plans ("AOP"), to support Boards in their delivery of safe and accessible treatment and care, and this has continued for 2019/20.

2 BACKGROUND

The instruction received in late February 2019 confirmed the continuation of the submission of a draft AOP for 2019-20 (where relevant shared and aligned with the strategic plans of IJBs). This was to focus primarily on operational performance to provide the foundations for delivering the Cabinet Secretary's priorities on waiting times improvement; investment in mental health; and greater progress and pace in the integration of Health and Social Care

3 ASSESSMENT

A first draft AOP was submitted on schedule to the Scottish Government in March 2019, with the final submission due by the end of April with the support of the Board. It is anticipated that the Chief Executive and the Finance and Performance Management Director will then be engaged for feedback as part of SG's programme to discuss the key aspects of all Operational Plans with each individual board.

4 RECOMMENDATION

The Board is asked to note the draft Annual Operational Plan, to highlight any comments or revisions, and to approve its submission to SG Health Performance and Delivery Directorate.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Draft Operational Plan has replaced the LDP document to communicate the Board's strategy to SG.
Workforce Implications	Noted in the draft Plan.
Financial Implications	No direct financial implications from the draft Plan – the draft Plan is however supported by the 2019/20 budget.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Directors; Senior Management Team Members; Clinical and Risk Governance representatives; Finance representatives.
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified.
Assessment of Impact On Patient Experience	None identified.
Equality Impact Assessment	No identified implications.

The State Hospitals Board for Scotland

Annual Operational Plan

2019 – 2020

(Final Draft 18 April 2019)

1. Introduction

The State Hospitals Board for Scotland (TSH) is a forward-thinking collaborative national board providing clinical care for the population of Scotland and Northern Ireland. We provide specialist individualised assessment, treatment and care in conditions of high security for male patients with mental disorders. The patients, because of their dangerous, violent or criminal propensities, cannot be cared for in any other setting.

TSH has a reputation for delivering world class forensic mental health care. Visitors and stakeholders both from home and abroad have been hugely positive about the patient centred approach and focus on recovery. Working with partners in our Forensic Network, we have established a reputation for high standards of care and treatment, innovative research and education and wish to build on this in 2019/20 and beyond.

The vision of TSH is to:

- excel in the provision of high secure forensic mental health services;
- promote collaboration across social care, health and justice services;
- strive to be an exemplar employer;
- achieve positive patient outcomes;
- ensure the safety of our staff, patients and the public

Our service has embraced the ambitions of the Scottish Patient Safety Programme and have been a key contributor to improvements in patient safety both locally and on the national stage. Work undertaken through this programme has led, for example, to a reduction in incidents of violence or aggression (check this is statistically accurate). We will further develop our programme of patient safety work over the next year focusing on the safety principles of communication, risk management, least restrictive practice, leadership and culture, and physical health.

TSH is fully committed to the principles, values and objectives articulated in *Everyone Matters: 2020 Workforce Vision*. We continue to set out our commitment to our staff in implementing this vision and making real improvements to the health of our organisation as a whole, and to the health of the people who work within it. We recognise that it is the people in our organisation who deliver the service and that the support, engagement and contribution of our employees is paramount in delivering the objectives in this plan. We are committed to working in partnership and place significant emphasis on maintaining and improving staff health and wellbeing and ensuring that our NHS values and behaviours are clearly visible to everyone who is part of our service. We will continue to invest in our staff's access to training in improvement methodology, building capacity and expertise. The introduction of the EASY service (Early Access to Support for You, an absence support tool) is helping us direct staff who are unwell to sources of help support rapidly and effectively.

Given the unique nature of the service TSH provides, we are committed to working in partnership with the Justice Service, Police Scotland and Integration Authorities. We aim to explore areas of collaboration that enable the specialist expertise of TSH to be shared with partnership agencies for the overall betterment of seamless patient care in mental health.

Despite the successes of TSH, there is much still to do. As a no-smoking facility and illicit drug and alcohol free area, the twin challenges of smoking and substance misuse are areas of existing success. However, addressing health and social inequalities for our patient group is a major challenge.

Our primary challenge is patient obesity and its related physical health problems. TSH is building on existing measures to promote healthier choices for patients and will be delivering an agreed programme of initiatives over the coming year aimed at improving the physical wellbeing and health of patients in our care. People with life-long mental illness are likely to die 15- 20 years prematurely because of physical ill-health related issues. We are aligned to the Mental Health Strategy; there should be parity of esteem between physical and mental health and we wish to realise this aim. We recognise our patients as equal partners in their own healthcare and their expectation of good physical health.

Many of our patients have limited educational attainment linked to a range of factors in their lives prior to admission. This can lead to social exclusion and difficulty attaining employment in future years. Patients benefit from access to recreational and educational facilities on site and are supported to develop their skills and educational attainment during their stay.

We are strongly committed to maintaining and improving opportunities for our patients to access both physical and educational activities as part of their care programme.

Our plan for 2019/20 builds on a shared vision with our staff around our key priorities and how we wish to achieve these now and in the future.

We aim to realise our ambitions of continuous improvement through working effectively not just as a local team, but across NHS Scotland and our wider stakeholder partners. We are committed to that aim and ensuring that we are deploying our resources as effectively as we can to meet our patients' needs, driving out inefficiencies and improving the quality and standards of the care and treatment we deliver.

2. Vision, Service and Clinical Strategy

2.1 Vision

The vision of TSH is to:

- excel in the provision of high secure forensic mental health services;
- promote collaboration across social care, health and justice services;
- strive to be an exemplar employer;
- achieve positive patient outcomes;
- ensure the safety of our staff, patients and the public

2.2 Values and Aims

The State Hospital shares the same core values of NHS Scotland which are:

- Care and compassion;
- Dignity and respect;
- Openness, honesty and responsibility;
- Quality and teamwork

Our primary twin aims are:

- Maintenance of a safe and secure environment that protects patients, staff and the public;
- Provision of high quality, person centred, safe and effective care and treatment

2.3 Service Strategy

TSH is committed to fostering a forward-looking positive "can do" organisational culture. We will ensure that a focus on continuous improvement underpins all of our activities and that our working environment is rich in educational and staff development opportunities. We are committed being a progressive organisation that values and develops collaborative leadership and strategic capacity.

Quality care will be underpinned by person centred values and placing a high value on research and audit. We aim to attract and develop a highly skilled and resilient workforce; where the role of the multi-disciplinary team is central to delivery of high quality care, and the experience and feedback of our patients, visitors and staff actively shapes our service.

There are a number of challenges that TSH are addressing:

Health Inequalities

- Physical health inequalities for our patient group is significant; reducing obesity and increasing physical activity are key outcomes in addressing this issue.

Workforce

- Higher than average levels of sickness absence, particularly in nursing, can risk impacting on staff morale, have a detrimental effect on staff training and development and create unnecessary financial pressures. This challenge could also divert resources away from direct patient care and service development opportunities.

- A large proportion of staff are approaching retirement age which presents risks to the sustainability of our workforce and service if not proactively addressed.

Efficient Use of Our Resources

- We need to deploy our workforce more effectively if we are to continue to meet patients' needs and drive out unnecessary waste.

- We must ensure that we are working collaboratively and efficiently with other National and Territorial Boards to optimise opportunities for improved quality, reduced costs and enhanced resilience and shared knowledge.

- We will assess and refresh our alignment with the Health and Social Care health and wellbeing outcomes and indicators.

- We welcome the opportunity to participate with partners in shaping the future model for Forensic Mental Health Services in Scotland, in line with terms of reference of the national review process.

- We will work in collaboration with the Mental Health and Justice Directorates on the review process of the Mental Health (Care and Treatment) (Scotland) Act 2003, where the specialist expertise of TSH can be utilised.

In order to ensure that we fulfil our vision for the service, it is essential that everyone at TSH has a clear understanding of our mission, our values and our organisational priorities. TSH will aim to ensure that front line managers are empowered to communicate and lead change, keep their teams well informed and engaged and display exemplar partnership approaches.

2.4 Productivity and Benchmarking

TSH is committed to supporting the drive for efficiency and productivity. Savings targets have been met in each of the recent years.

The Hospital's strategy, which us under review currently, will incorporate the essential elements of the Sustainability & Value Programme, 2020 Vision, the Mental Health Strategy and the Health and Social Care Delivery Plan.

In future years, it is very likely that the Hospital will have increasing challenges generating the same level of cash releasing savings. In order to ensure that service delivery can continue to improve and develop, our focus will need to move to improvements in operational productivity. This will require new approaches to driving and monitoring efficiency and productivity.

In 2019/20, review work will be undertaken with regard to costs in order to benchmark how the tariff based commissioning system works in the high secure hospitals in NHS England. It is important for TSH to benchmark how these organisations manage their efficiency and cost variation models and brings any potential learning or development opportunities forward for consideration.

3. A Person Centred, Safe and Effective Organisation

Performance targets have been aligned with the three quality ambitions in the NHS Scotland Healthcare Quality Strategy; person centred, safe and effective. Outcomes will be measured against agreed targets, and achieved through an incremental continuous improvement approach by way of the existing governance structure, e.g. the Board and associated committee structures.

3.1 Safe

Security

The Hospital's secure environment is provided by three domains of Security:

- Physical security
- Procedural security
- Relational security

Physical security is provided through high quality physical barriers and sophisticated electronic detection and observation systems.

Procedural security is provided through Policies, Procedures and working practice.

Relational security is provided by clinical staff working closely with patients to deal with risk, illness and offending behaviours. The Clinical Model sets out how the hospital delivers safe and effective relational security as an integral part of its clinical work. The Security Department has Clinical Security Liaison Managers working as an integral part of Clinical Team.

The Hospital has its own Security Standards, which are aligned to the national High Secure Care Standards produced by the Forensic Network and adopted as national policy.

Compliance with Security Standards was audited by the Forensic Network in April 2018 and an external advisor review which was completed in June 2018. At the time of these audits a small

percentage of non-compliant areas were identified, for which actions have been taken to address; at the time these did not present any significant risk to the security or safety of TSH.

3.2 Person Centred

The ultimate aim is to meet patients' mental health needs, enabling, when appropriate, the patient to move onto another setting. Patients often have very significant physical health needs (related to risk taking behaviours such as substance misuse; or consequences of treatment over a prolonged time in institutional care); or are living with the effect of long term conditions. There are many contributory factors involved such as: lack of exercise, obesity, complications of psychotropic medication, and the consequences of a self-selected poor diet. For some years now, the Hospital has been a smoke free environment. The hospital has an 8 item outcome report which can be used on an individual, ward, hub or hospital wide basis to chart improvements.

Mental Health

The Hospital uses a variety of measures to indicate the effective management of mental health at an individual patient level:

- The ability to agree discharge or transfer safely to another setting.
- Patterns and trends of historic risk information such as violent and aggressive behaviour.
- Improvement in the PANSS (Positive and Negative Syndrome Scale for psychotic symptoms), BEST (Behavioural Status) nursing index score, and in the PECC (Psychosis Evaluation tool for Common use by Caregivers).
- Improvement in the formulation and management of risk profile of patients. Reduction in dynamic risk factors can be demonstrated on the clinical and risk items of the regularly updated HCR-20 assessments. (HCR-20 is a tool to manage risk of violence assessment and planning (Historical Clinical Risk -20)).
- The use of DASA (Dynamic Appraisal of Situational Aggression) scores on a regular to inform the approach to care delivery.
- For intellectual disability patients a more dynamic measurement of progress in relation to the management of risks is evidenced through the DRAMS (Dynamic Risk Assessment and Management System) tool. This assessment should be reviewed at minimum, monthly, by the key worker.
- The psychological therapy service is utilising the CORE (Clinical Outcomes for Routine Evaluation) system which is a short self-report measure of mental health and wellbeing outcomes that will be used nationally to evaluate psychological therapies.
- Reduction in frequency and intensity of levels of observation.
- Individual patients being assessed fit for grounds access whether full or partial.
- Activity levels – all forms
- Social interaction with external visitors
- Treatment engagement
- Monitoring of agreed mental health outcome measures.

Physical Health

The Hospital remains committed to ensuring that patients are encouraged and supported to adopt a healthy lifestyle particularly in relation to smoking, activity, and nutrition. Proactive assessment of significant risk factors can lead to improved outcomes for long term conditions. An approach which supports self-management is crucial to a better long term outcome, which means that education plays an important part in improving health. The hospital uses the following measures routinely – BMI and physical activity – reporting on these on a quarterly basis with the Hospital's Key Performance Indicators.

Safe use of medicines is an important focus as it relates to physical health, with monitoring and continuous improvement driven through the Scottish Patient Safety Programme.

An Effective Clinical Strategy

Diagnosis is through assessment and formulation of patient risks and needs (psychological, physical, functional, social and spiritual). Each member of the multidisciplinary clinical team contributes. The aim is to address identified treatment needs to support recovery from mental disorder and reduce the risk of future offending. When appropriate, the aim will be for the patient to move on, whether that is return to prison, transfer to a lower security hospital, or, in rare cases, discharge into the community. This takes on board best practice recovery models and approaches. Risk assessment and management is integral.

Services for patients with an intellectual disability tend to be more intensive, at a slower pace, and have a greater need for consistency, communication and engagement.

A significant number of patients have one or more risk factors for cognitive impairment, secondary to longstanding severe schizophrenic illness, substance misuse (including alcohol) and acquired brain injury. Such impairment may impact on patients' understanding of, and compliance with, treatment. Assessments are carried out on admission and include specialist assessments for areas of specific identified difficulties. This should lead to care and treatment being completely tailored to meet individual need.

The need for processes to be in place to support early detection of dementia is addressed through cognitive screening as part of the psychology assessment undertaken on admission; and by clinical teams being alert to patients who present a reasonably high index of suspicion (certain patient groups are more susceptible). When required, a specialist neuro-psychology assessment is conducted.

Treatments and activities are provided within high secure conditions, and are tailored to meet the requirements of individual patient risk assessment and management plans.

The following 7 goals ensure the organisation remains focussed on delivering our quality vision:

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

A strategic quality improvement and assurance work plan will be developed and published setting out the key actions for the delivery of the seven goals. In addition to this, each clinical area will publish a work plan that will be owned by them, drawing on specialist support where required. The delivery of the work plans will engage staff, patients, carers and volunteers. The State Hospital will build commitment to this agenda and create a culture of accountability for continuous quality improvement. During 2019, the Hospital's Clinical Service Delivery Model will be under review, with the aim of ensuring the most efficient, effective and person centred option is taken forward. This process is now underway including engagement with staff, stakeholders, patient groups at all levels throughout the organisation.

Over the course of this strategy, a quality improvement education and learning framework will be further developed and implemented to improve knowledge and skills across all staff groups within the Hospital.

Through this, the Board will aim maximise the use of quality improvement methodologies, using data for improvement as well as assurance, and will strive to learn from experience. It will instil ownership for delivery of safe, effective, person centred care, encouraging staff to manage local responses to feedback, raising issues and concerns, learning from adverse events and sharing learning with others.

Assurance that clinical service delivery is safe, effective and person centred will be enhanced in 2019/20 through the introduction of Excellence in Care. Core and mental health specific nursing quality measures will be introduced as part of a national assurance framework, focusing on areas such as culture, leadership, safety, effectiveness, person centredness and quality improvement.

4. Strategic Objectives

TSH has established a set of Strategic Objectives:

- Reduce obesity and increase physical activity.
- Implementation of the "Patients' Day" project.
- Reduce the use of additional hours.
- Optimise efficiency in clinical practice and clinical service delivery.
- Transform services to optimise efficiency whilst maintaining quality.
- Identify ways of generating more income.
- Promote attendance and reduce sickness absence.
- Support a forward looking culture.
- Create conditions for supporting quality assurance, quality improvement and change.
- Look at ways of better utilising technology to support the national digital agenda.
- Explore more cost effective stewardship of assets and resources.
- Develop effective workforce and succession planning strategies and measures that will address identified rapid turnover in the future.
- Explore options for effective shared services and resilience building through enhanced collaborative working both internally and externally.
- Ensure opportunities to develop the whole workforce are maximised; focussing on leadership development and the review of workforce models to ensure a sustainable, skilled and competent workforce.

These are detailed in the Hospital's Service Strategy, along with detail of delivery, lead responsibility and alignment to our quality ambition. A strategy session will take place annually to review and re-confirm or amend the long-term direction of the Hospital. In 2018/19, the State Hospital developed its Strategy Map for 2018-2020, which is attached as Appendix 1.

Monitoring systems are in place to review progress with these objectives through our governance framework.

5. Operational Delivery

Improvements in the quality of clinical care are best led by multi-disciplinary teams providing front line services. By providing accessible information relating to the quality of care (on a close to real

time basis) we can support clinicians to focus their improvement activity in response to 'live' challenges and monitor the impact of changes made.

During 2019/20, the Board will introduce the tableau platform to staff in front line roles, ensuring real time data for high quality service delivery and to drive service improvement.

Whilst the clinical workforce is key to the provision of safe, effective and person-centred patient care, their role and contributions are only enabled with the support of the wider workforce. There is an absolute recognition that safety, quality and person centeredness is everyone's responsibility, and therefore every member of The State Hospital staff has a role to play.

Leaders and managers in all areas have particular responsibility as role models and enablers in the promotion of safety, quality and person centeredness and must demonstrate this through their everyday actions and behaviours. Investment in our leaders is important, and we will focus on providing development opportunities for our staff ranging from promoting Project Lift through to delivery of local programmes aimed at staff moving into their first leadership role.

Internal links and partnership working to support clinical quality are extensive. A number of specialist groups and committees have been set up to share and develop good practice and deliver elements of clinical quality. These committees and specialist groups have a dual reporting line: an operational management route to the Clinical Governance Group, and a governance route to either the Staff Governance Committee, Clinical Governance Committee, or Audit Committee.

Evidencing that we have workforce capacity matched to clinical need will be supported through work we will progress in 2019/20 in response to safe staffing legislation. Working collaboratively with workforce leads at National Services Scotland, we will deliver on activities related to the common staffing method, as well as a focus on excellence in rostering practice.

Although service leads for quality assurance and improvement are in place, all individuals and teams are responsible for applying quality assurance and improvement into practice. This responsibility is demonstrated through:

- Professional Codes of Practice;
- Continuous professional development;
- Performance and appraisal review process;
- Revalidation;
- Improvement activity and measurement;
- Audit;
- Evidence Based Practice;
- Personal Reflection;
- Learning from adverse events, complaints and feedback.

6. Collaborative Working

National Health Boards have again been tasked by the Scottish Government Health and Social Care Directorate (SGHSCD) to work together to identify ways to collectively standardise and share services with a target to reduce the operating costs of National Boards by £15m in 2019/20, the aim being that this revenue can be reinvested in frontline NHS Scotland priorities.

The National Boards have agreed that:

- There is an absolute commitment to deliver the target on a sustainable basis

- There is scope to do this by continuing to develop collaborative working to create improved quality and efficiency
- There is further scope to develop the 'Once for Scotland' approach and our work could be shared wider within the other Boards
- Rather than delivering this saving through a pro-rata share of the £15m apportioned in terms of the RRLs of each Board (or other arbitrary allocations), which was enacted in 2017/18; the plan is to deliver it through targeting real change in the way we deliver support services and providing a true and measurable once for Scotland basis

The work in delivering the target has therefore focused on four key work streams: HR, Procurement, Finance and Estates.

In 2019/20, TSH will assess the opportunities to work with the West of Scotland territorial Boards and National Board Collaborative to assess all opportunities for TSH in the regional and national planning agenda.

Collaboration for the provision of a number of administrative services is being taken forward with local authorities and other NHS boards including South Lanarkshire Council (Social Services, HR services); NHS Greater Glasgow and Clyde (payroll); NHS NSS (finance, procurement); and NHS Lothian (prescribing).

TSH is also an active participant in the NHS Scotland Global Citizenship programme, with direct involvement included at a senior level with the medical directorate.

7. Responsibility and Accountability

Individual directors have lead responsibility for specific elements relating to the Health and Social Care Standards and the Mental Health Strategy, including the development of strategies, policies and plans for their delivery.

Each lead Director is responsible for progress reports to the Board within their area of responsibility, including principle risks to achieving their objectives, their impact on the Board's objectives and plans for the year ahead. This is performance-managed through the Directors' objectives by the Chief Executive, followed by the Remuneration Committee.

The Clinical Governance Group, chaired by the Medical Director, has a standing agenda section devoted to action plans in order to ensure that continuous quality improvement is embedded within the organisation.

The Medical Director has Executive responsibility for Clinical Quality. The Medical Director attends and provides assurance to the Clinical Governance Committee, which monitors this Strategy, through regular reports including an annual Clinical Governance Report to the Board.

The Clinical Governance Committee ensures actions arising from clinical quality activities are implemented. The Committee has a comprehensive, rolling plan of work which ensures that all aspects of clinical governance are scrutinised by this group, and the Chair of the Clinical Governance Committee provides a progress report to the Board.

We have established a Clinical Forum; this is an independent advisory committee that reports directly to the Board.

Elements of practice relating to staff professional development and support are reported to the Staff Governance Committee. However, arrangements are in place to ensure that issues impacting on

patient care and treatment arising from staff governance arrangements are reported and managed through the clinical governance structure. These arrangements are reviewed annually.

The Board is responsible for ensuring that adequate resources are committed to deliver the strategic goals for clinical quality.

8. Financial Plan

Financial Planning is an integral part of the Operational Planning process. As part of this process each Board is required to submit an Operational Plan to Scottish Government by 30th April 2019.

TSH is forecast to meet their statutory financial targets as set out for March 2019 financial year end with no significant risks highlighted. These include the following limits which must not be exceeded:

1. Revenue Resource Limit (RRL) – resource funding for net revenue expenditure allocated by the Scottish Government for ongoing operations
2. Capital Resource Limit (CRL) – resource funding for net capital expenditure allocated by the Scottish Government for investment in fixed assets
3. Cash Requirement – cash required to fund the net payments for all ongoing operations and capital investment

In addition to this there is a requirement to generate efficiency savings year on year both in terms of cash releasing savings to match the increased costs and productivity savings to deliver against the increased demands of patient care including complexity, activity increases and the requirement to continually invest in technology and quality improvements.

Year on year the Board has successfully achieved or delivered in excess on its challenging Efficiency targets and for 2018/19 Efficiency savings delivered were £1.792m against an Operational Plan target of £1.765m.

8.1 2019/20 Scottish Government Budget

The financial plan incorporates the Scottish Government Pay Policy which recommends a 9% pay increase for public sector workers across 2018/19-2020/21. There will be a cap on pay applied for highest paid (those earning above £80,000). The final pay settlement for NHS staff will of course be subject to the NHS pay reviews process as in previous years.

The Scottish Government Budget reflects the commitment that more than half of frontline spending will be in community health services by the end of this parliament. The 2019-20 funding is designed to support a further shift in the share of the frontline NHS budget dedicated to mental health and to primary, community and social care. It is expected that NHS Boards and Integration Authorities contribute to this Programme for Government commitment and it will be essential that this is clearly evidenced as part of plans for 2019-20. Whilst this is not directly relevant to this Board any opportunity to support this will be included within the Board financial and local delivery plans.

The key points from the Scottish budget announced that are reflected within the Board financial plans for 2019/20 are:

- The State Hospitals Board for Scotland will receive an uplift of 1%, similar to the other national ‘patient facing’ Boards

- The National Board savings requirement of £15 million in 2018-19 will be made recurring in 2019-20, together with any under-achieved carry-forward from 2018-19; the allocation of this to be agreed in new financial year.

8.2 Financial Planning 2019/20

The financial plan sets out the resources available to the Hospital and how these will be used, and includes regular funding planning assumptions as follows;

- Scottish Government RRL baseline budget as described within RRL allocation letter and 2019-20 Scottish Budget
- Scottish Government RRL budget includes the baseline funding uplift of 1%
- Reflects proposed change to Scottish Government Outcomes Framework funding with the continuation of the e-health associated element through a revised funding model with separate in-year allocation
- Planning assumption that central funding support will be provided above the first 1% of pay award for Agenda for Change grades only
- Savings contribution towards National Boards' £15m requirement continuing at a level to be confirmed
- Continued support towards eHealth leads and eHealth allocation from former Outcomes Framework allocation
- Consultant Distinction award funding reflecting submission to the Scottish Advisory Committee on Distinction Awards (SACDA)
- Funding to support Implementation of Excellence in Care, MH (Mental Health) Secondment and Disabled Graduate scheme

The table below contains an extract of the three year financial plan – and the main assumptions, pressures and risks behind the plan are in the following section.

Operational Plan	**2019/20**	**2020/21**	**2021/22**
Income	**£'k**	**£'k**	**£'k**
Core RRL	33,972	35,070	36,058
Non-core RRL - Capital Charges	2,857	2,857	2,857
Non-core RRL AME*	112	112	112
Total Income	**36,941**	**38,039**	**39,027**
Expenditure			
Pay			
Capital Charges	2,857	2,857	2,857
AME* Provisions	112	112	112
Non-Pay	5,858	5,933	6,033
Income	(1,142)	(1,176)	(1,205)
Savings	(2,103)	(1,972)	(1,861)
Total Expenditure	**36,941**	**38,039**	**39,027**

*Annually Managed Expenditure

8.2.1 Overall position

The financial plan is balanced and delivery of a breakeven position during 2019/20 remains dependent upon realisation of the savings plan. Financial risks remain very high around the workforce plan skill mix and staff rostering, with significant risk also around the currently high level of 2019/20 savings unidentified, which contributes to a high risk of financial shortfall should these be unachieved.

The plan is based on the indicative budgets set by the Scottish Government.

Savings targets continue to be extremely challenging – both for the Board individually, and collaboratively along with the other seven National Boards.

8.2.2 Funding

As the public sector as a whole face funding cuts, the NHS has had some protection. This year the recurring increase in funding equates to 1%, with an additional contribution from UK consequential to an element of the proposed pay uplift. With planned payroll increases, incremental drift, and previous unfunded increases in NI (National Insurance) contributions, continued close budgetary scrutiny is required in order to cover the inflationary increases in costs and the required savings.

On the basis of informal guidance received, it is assumed for 2019/20 that any increased level of Employer's Superannuation contribution – currently noted as a 6% uplift – will be fully funded.

8.2.3 Savings

At this draft stage the savings have not yet been split by detail, only by total and Recurring or Non Recurring, as meetings with individual directorates to negotiate savings are currently being held.

Planned Savings	**2019/20**			**Risk Rating**		
	Rec	Non-rec	**Total**	**High**	**Med**	**Low**
	£000s	£000s	**£000s**	**£000s**	**£000s**	**£000s**
Service redesign	22	95	117			117
Drugs and prescribing		20	20			20
Workforce	57	480	537			537
Procurement		0	0			0
Infrastructure	56	306	362			362
Other		100	100		100	
Total Efficiency Savings workstreams	135	1,001	1,136		100	1,036
Financial management / corporate initiatives						
Unidentified savings assumed delivered by y/e		967	967	967		
Total Core NHS Board Savings	135	1,968	2,103	967	100	1,036
Savings delegated to Integration Authorities	*0*	*0*	*0*	*0*	*0*	*0*

There are continued efficiency and productivity improvements sought which will be identified, managed and implemented through this period. Savings targets for 2019/20 are particularly challenging as the Hospital manages the pressures noted in the next section.

8.2.4 Pressures

There are a number of pressures facing the Hospital over the coming year:

- Increased Employer's Superannuation costs – 6% uplift from 14.9% to 20.9%
- Payroll impact from the expected outcome of the legal case "Locke vs British Gas" and the potential liability for additional shift payments required.
- 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 and clinical service delivery model are currently under review, and may also be influenced by the safe staffing legislation.
- Pressure from any unfunded element of increased payroll costs, e.g. executive pay.
- Potential increases in rates.

- Utility costs continuing to rise, giving both a price and usage pressure in 2019/20.
- Associated costs related to the Perimeter Security and Enhanced Internal Security Systems Project – e.g. cost of staff escorting contractors. Recent advice has indicated that these may be included in the capital project funding, which is to be confirmed in 2019/20.
- A number of costs associated with the upkeep of the Hospital estate, which are monitored closely and outturns adjusted accordingly. Ongoing evaluation of this impact over the coming years is assessed in order that budgetary pressures can be controlled.

There are also a number of specific risks associated with the plan:

- As noted above, the requirement for the National Boards to provide additional savings of £15m (plus any unachieved savings carried forward from 2018/19) on a recurring basis in 2019/20.

- Savings plans – as stated above the operational running costs of the site are more than planned. A savings plan around the workforce, capital charges and supplies is followed; however additional savings may need to be made if the on-going costs are more than forecast. Also year on year it gets harder to identify workforce savings without impacting on patient care or security. If plans fall behind the financial balance could be at risk unless other non pay savings can be found, and currently a high proportion of the savings for 2019/20 is still to be identified.

- The lack of any increase in capital funding potentially leaves equipment replacement at risk, as the formulae allocation will require close control and review to be able to cover any major equipment replacement programmes.

8.2.5 Capital – Property and Assets

The performance of assets is seen as critical by the Hospital. In order for the Hospital to meet its strategic objectives it is essential that existing and planned investment is targeted and effectively utilised. The Property and Asset Management Strategy (PAMS) reflects the following aims:

- To maintain and develop a high quality, sustainable site and assets that support the provision of high quality forensic mental health care in appropriate and secure facilities.
- To ensure that the operational performance of assets is appropriately recorded, monitored, reported and reviewed and, where appropriate improved.
- To ensure an effective asset management approach to risk management and service continuity.

The significant capital item forthcoming is the Perimeter Security and Enhanced Internal Security Systems Project in 2019/20-2021/22 – estimated at £8.6m. This is currently at the tendering stage – with submissions received in April 2019 and an anticipated tender award in May 2019 – and the associated projected level of available revenue resource required for contractor escorting and project management will continue to present a major challenge for implementation of the Property and Asset Management Strategy, together with regular estates and security work, and IM&T (Information Management & Technology) equipment replacement programmes. Further work has taken place internally to re-examine security threats to the hospital and additional work commissioned to establish how those threats may be mitigated, including review of CCTV requirements, which will be reflected in the business case. The split of the funding across the three years is currently subject to the outcome of the tender process, with an estimate noted below.

	2019-20 £000s	2020-21 £000s	2021-22 £000s	2022-23 £000s	2023-24 £000s
Capital Resource Limit (CRL)	269	269	269	269	269
Other centrally provided capital funding	4,313	2,965	1,302	-	-
Total Capital Resource Limit	4,582	3,234	1,571	269	269

9. Governance

The governance and management landscape is increasingly complex both nationally and locally. One of the Hospital's local quality commitments is to improve meeting effectiveness but this is only a small part of what is required. The national Outcomes Framework and the national Quality Strategy are twin drivers towards more outcome based approaches rather than process based approaches.

9.1 Governance and Management Arrangements:

There are three statutory governance strands for Boards and the governance structure is set up to deal with these through the Clinical Governance, Staff Governance and Audit Committees. Management is based around the clinical teams, reporting to the senior management team.

Leadership walkrounds will continue in 2019/20 – involving the Executive Directors, the Senior Management Team, the Patient Safety Steering Group, and the non-executive Directors by invitation. Actions arising are followed up, and reviewed at later walkrounds and at SMT (Senior Management Team).

Corporate document standards are in place to help streamline the flow of documentation, and the group and committee structures within the Hospital are regularly reviewed to streamline, rationalise and simplify meeting arrangements so that these are fit for purpose.

The corporate risk register is reviewed annually by the Board and quarterly by the Audit Committee. A full review of the Risk Register was undertaken in 2018/19, in consultation with executive directors and senior management staff. In addition, local departmental risk registers are now in place and are being evaluated in 2019/20, from which any identified high risk item is given consideration for the requirement to be reflected in the corporate register.

The establishment of the Risk, Finance and Performance Group has provided the Hospital with an improved focus on risk monitoring and appraisal, with all corporate risks fully reviewed now on an annual rolling basis, including monthly updates on any assessed as high risk.

9.1.2 Staff Governance

The Staff Governance Standard provides the organisation with a platform to drive improvements in the management of staff. Our staff governance action plan identifies important actions we plan to take to ensure that the five objectives of the standard are met.

The staff governance action plan includes plans to achieve national targets such as:

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

In addition to working towards the achievement of these standards, there are a number of local priorities which are important for 2019/20.

The Board developed a workforce plan for 2017/2022 however it is anticipated that this will be updated in September 2019. The revised workforce plan will take into account the Board revised clinical model and the outcomes from the Common Staffing Method.

The development of the TSH revised clinical model is expected to be complete in May 2019. This is based on:

- Consultation on the clinical care delivery model (February / March 2019)
- Development, appraisal and testing of options (March / April 2019)
- Identification of preferred option (May 2019).

With reference to workforce planning activities, the planned stages are:

- Development of draft headline multi professional staffing model and projected costs based on clinical service delivery model options (May 2019).
- Ensuring the common staffing method is embedded in practice. This includes development and co-ordination and implementation of an annual plan to run WFP tools for nursing across all of our areas (July 2019)
- Ensuring a consistent approach to analysis of workload and workforce info, quality measures and high secure context to inform nursing staffing requirements on site (July 2019).

The outputs from the application of the Common Staffing Methods is proposed to be available from July 2019. This work will be conducted in collaboration with the National Workforce Advisors hosted through Healthcare Improvement Scotland. We will also take an improvement based approach to ensure that the availability of the nursing workforce is responsive to the needs of our patients.

The interdependency of these three work streams; Clinical Service Delivery Model Review, Common Staffing Method and Workforce Plan, should be noted. Time delays in either the Clinical Service Delivery Model Review or the Common Staffing Method will have a knock on effect and ultimately delay production of the Workforce Plan.

9.1.3 Staff Experience and Engagement

<u>iMatter</u>

The Board continues to fully implement the iMatter Staff Engagement Tool achieving a participation rate of 77% and an aggregated Board EEI (Employee Engagement Index) score of 77% in 2018/19. 12 weeks post completion, a fall in the number of action plans (23%) completed was acknowledged and local support provided to increase this to 60%. On-going support will be provided during 2019/20 to encourage participation, action plan completion and Directorate stories.

The Board will continue in 2019/20 to embed the NHS values through an established Values and Behaviours group. There is a key organisational objective to focus on staff recognition; introducing both staff awards and service recognition schemes in 2019.

There is ongoing work to support a healthy work-life balance (Healthy Organisational Culture), care delivery and staff rostering/shift arrangements (Sustainable Workforce). In addition there has been a focus on working across boundaries, sharing learning and good practice. This has been achieved in 2018/19 through the annual learning plan underpinned by OD, investment in our PDP process and Turas appraisal system as well as encouraging a collegiate approach to learning through initiatives like Greatix and TSH 30:30.

National work around more effective collaboration between national and regional NHS Boards is fully supported by The State Hospital. Collaborative working with the other national boards to develop joined-up approaches continues in a number of key areas e.g. leadership development, OD

plan, HR, procurement. The organisation already works closely with other boards to deliver some essential services e.g. primary care and social work.

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

Partnership Working

The Board continues to support effective Partnership arrangements, which have been developed over many years, and are embedded throughout the organisation to overcome workforce issues and deliver key outcomes. Partnership working is supported through the State Hospital's Partnership Forum and a range of partnership groups including Attendance Management Task Group, Values and Behaviours programme, WF Transitions.

APPENDIX 1

The State Hospital Strategy Map 2019 – 2020

NHS Scotland aims to:

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

The State Hospital mission:

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

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

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

The State Hospital Strategic objectives:

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

Outcomes, by 2020 The State Hospital will have:

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

Board Paper 19/28

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2019
Agenda Reference:	Item No: 13
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Corporate Governance Blueprint
Purpose of Report:	For Discussion and approval

1 SITUATION

Following development of the Corporate Governance Blueprint, the Board took part in a self-assessment survey between 15 February and 1 March 2019. A Board Development Session took place on 28 March to review the results.

2 BACKGROUND

The Board Development Session allowed consideration of the results of the self- assessment against the five functions described in the Corporate Governance Blueprint, as well as identifying the key factors driving the results.

3 ASSESSMENT

This process has clarified the key corporate governance priorities for the Board in the coming year and an improvement plan has been developed to support this work in the five key areas outlined.

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

The Board is required to submit its report and improvement plan to Scottish Government by 30 April 2019.

4 RECOMMENDATION

The Board is asked to:

- Discuss and approve each point outlined in the improvement plan.
- Reach consensus on any suggested additions to the improvement plan.
- Discuss the implementation and monitoring framework for the improvement plan.

A revised document will be circulated to the Board on noon on Friday 26 April 2019 for agreement.

Any further suggested revisions should be submitted by noon on Monday 29 April 2019.

The final agreed document will be submitted to Scottish Government on 30 April 2019.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To implement the Corporate Governance Blueprint
Workforce Implications	None identified
Financial Implications	None identified
Route To Board Which groups were involved in contributing to the paper and recommendations.	In compliance with Scottish Government directive, and in response to Board request.
Risk Assessment (Outline any significant risks and associated mitigation)	None Identified
Assessment of Impact on Stakeholder Experience	As outlined within the report
Equality Impact Assessment	None Identified
Fairer Scotland Duty	None identified

THE STATE HOSPITALS BOARD FOR SCOTLAND

CORPORATE GOVERNANCE BLUEPRINT SELF-ASSESSMENT AND ACTION PLAN

1 BACKGROUND

The State Hospitals Board for Scotland (TSH) is one of four high secure forensic mental health hospitals in the U.K. and is sited on a 60 acre campus. The hospital provides high quality forensic mental health assessment care, treatment and rehabilitation.

The Board reviewed its Service Strategy in October 2017, agreeing a State Hospital Service strategy 2017/20. This established three strategic priorities critical to the success of the organisation to ensure the delivery of high quality care; health inequalities, staff attendance and resilience and efficient use of resources. A delivery plan mapping timescales and governance arrangements for assurance on delivery was agreed by the Board. The key priorities and challenges as set out in the Service Strategy have not changed.

The Board undertook a Board Effectiveness Assessment in January 2018, with recommendations based on the results of the diagnostic tool agreed by the Board in April 2018.

The Board Chair advised Members to note the development of the Corporate Governance Blueprint at their meeting in October 2018, and then received a report to outline the development and introduction of the Blueprint for Good Governance at the private session in December 2018. The self -assessment was completed between 15 February and 1 March 2019.

A Board Development Session was arranged for 28 March for Board Members with supporting Directors, and facilitators. A briefing pack was issued in advance to ensure that the participants were aware of the survey results. The Programme for this event is attached at Appendix A.

2 SELF- ASSESSMENT

The Board Development Session allowed consideration of the results against the five functions of governance described in the Blueprint, as well as identifying the key factors that influenced the results. The session clarified the key priorities for the Board in the coming year, and an action plan to take these forward effectively. There was no significant variance in results between the respondent groups, with a similar range of views drawn from each.

Setting the Direction
What is working well Provision of leadership, support and guidance to the organisation including determining the organisation's purpose and ambition. Consideration and approval process around the strategic and operational policies and plans to deliver the policies and priorities of the Scottish Government. Agreement of the aims, objectives, standards and targets for service delivery in line with the Scottish Government's priorities.
Focus for improvement Allocation of budgets and approval of capital investments to deliver strategic and operational plans.

Key drivers

- Financial Savings Plan in 2017/18 as part of emergency savings action planning.
- Recognition of need for more robust processes to compare planned and actual spend and account for any variance.
- Re-start of tender process in capital project

Holding to Account

What is working well

That the Non-Executive Directors are able to monitor, scrutinise, challenge and then, if satisfied, support the Executive Leadership Team's day to day management of the organisation's activities. Effective safeguarding and accountability for public money to ensure resources are used in accordance with Best Value principles. Compliance with the requirements of relevant regulations or regulators.

Focus for improvement

Performance in ensuring oversight of the equitable systems for the pay arrangements for the Executive Leadership Team.

To ensure that continuous improvement is embedded in all aspects of service delivery.

Key drivers

- Possibility considered of lack of visibility in the process for Executive pay arrangements.
- Lack of opportunity to contribute or lead continuous improvement projects
- Attendance Management

Assessing Risk

What is working well

Effective identification of current and future corporate, clinical, legislative, financial and reputational risks.

Focus for improvement

Considering and approving risk management strategies and ensuring they are communicated to the organisation's staff.

Considering and agreeing the organisation's risk tolerance as well as for oversight of an effective risk management system that assesses level of risk, identifies mitigation and provides assurance that risk is being considered effectively.

Key drivers

- Period of reduced capacity within Risk Management
- Timescales for completion of risk reviews
- Internal audit 2018/19

Engaging Stakeholders

What is working well

Reporting on stewardship and performance and publishing an Annual Report and Accounts.

Contribution to the development of Scottish Government policies.

Focus for improvement Ensuring that priorities are clear, well communicated and understood by all stakeholders. Establishing and maintained public confidence in the organisation as a public body.
Key drivers o High level internal communication through bulletins and intranet to all staff not matched at local levels resulting in variance across the organisation. o Adverse media coverage experienced during 2018/19

Influencing Culture
What is working well Demonstrating the organisation's values and exemplifying effective governance through Board Members' individual behaviours.
Focus for improvement Promoting shared values that underpin policy and behaviours throughout the organisation and consistent with the organisation's purpose and ambition and creating cultural blueprint.
Key drivers o Differing cultural bias found across the hospital o Significant turnover in senior management team

3 RECOMMENDATIONS AND ACTIONS

The Board's Improvement Plan is attached at Appendix B which summarises the improvement actions being taken forward, as well as identifying the timescale and assurance arrangements for monitoring progress on delivery. The plan is linked to the five functions of the Corporate Governance Blueprint and identifies the key areas for improvement.

Governance assurance arrangements for regular and effective reporting on progress are outlined in the plan. Each governance route leads to the Board through clearly defined corporate governance structure of the Board.

The following areas are highlighted as key areas of focus and development with the anticipated benefits to be achieved through implementation of these recommendations.

Setting the Direction

The Board's Service Strategy and Strategy Map clearly define its mission statement and work will continue to actively cascade these priorities throughout the organisation to generate shared purpose and direction of travel. The Board will define its purpose as a strapline, to be used on corporate documentation, to encapsulate the essence of TSH and its values.

The Board will continue to ensure a coherent, whole system approach to strategic planning for delivery of care to our patients, workforce planning and effective use of the hospital estate.

The Board achieved breakeven position in 2018/19 financial year due to a range of actions taken throughout the year. A key pressure was overspend by the Nursing and AHP Directorate. This has been a major area of risk and concern albeit within the context of near 50% improvement on the

previous year. It is recognised that a high impact area of change was process controls such as limiting weekly overtime hours and the introduction of the nursing pool.

Introduction of the Health and Care (Staffing) (Scotland) Bill and the Nursing and Midwifery Workload and Workforce Planning Tools as part of a 'Common Staffing Method' will be implemented in collaboration with the National Workforce Advisors hosted through National Services Scotland. This will include review of nurse rostering and a focus on increasing workforce resilience. Workforce planning is an iterative process and the TSH Workforce Plan ought to be reviewed and updated however this should be timed in line with the development of the clinical model and application of the Common Staffing Method. With this in mind, it is anticipated that a new workforce plan should be produced by September 2019.

The Board will develop further robust processes to assist in the comparison of planned and actual spend and to account for any variance. A key driver in this was the financial savings plan was put into place for the final 6 weeks of the financial year 2017/18 as part of emergency savings action planning for year end. This was coordinated through engagement with joint staff side to ensure successful delivery of safe and effective are for patients during a short, clearly defined period of time. Although it was not necessary to take similar type of action during 2018/19, the continuing financial pressures underline the need to review existing practice and systems.

Holding to Account

The Board will continue in its drive to improve attendance management. This has been an area of key focus for the Board over the past 12 months through the Attendance Management Improvement Task Group (AMITG) which was reconvened in August 2018. The AMITG have progressed the implementation of an agreed action plan. There was significant early improvement, however, performance has been variable overall and it is recognised that focus must be maintained to achieve the target level consistently. There will be continued implementation of the plan alongside implementation of the Once for Scotland policies, with support from Human Resources to line managers to identify and act upon patterns of absence.

The Board will review the performance management framework including the assurance information systems in place to support review of performance. The Board will implement the updated guidance for Executive and Senior Management Performance Appraisal Arrangements - PCS (ESM) 2019/1 - with the stated aim to ensure standardised, consistently applied processes to enable a formal and honest assessment of performance as well as a wider contribution within the organisation in the development and wellbeing of staff in the context of valuing and leading people

A key focus will be the embedding a culture of quality across the organisation through project management. One of the key feedbacks from the TSH3030 - a quality improvement project which took place in November 2018 - was that often front line staff felt that they were being "given permission" to act in a way that they had not previously felt. The project was inclusive to all staff in all areas of the organisation and also engendered patient involvement in some projects.

Assessing Risk

An advisory review of risk management was carried out as part of the approved internal Audit Plan for 2018/19. This indicated that further work is required to ensure that risks and mitigating controls are properly defined and linked the appropriate strategic objective, to give focus on key areas of risk. This will be taken forward through staff training to ensure that risk management is embedded in day to day operations. Local risk registers will be developed with clear escalation lines defined for relevant risks to be transferred from the local registers to the corporate risk register.

There will be continued robust reporting of the risk register to the Audit Committee through the Risk, Finance and Performance Group. 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.

Engaging Stakeholders

There are effective arrangements in place to ensure that patients, carers and volunteers have a direct link to the Board as it actively seeks feedback from these groups during Board meetings throughout the year. There will be continued emphasis on this as it is recognised as a highly effective way to remind the Board of its key purpose.

The State Hospital's role as a national board for providing care in a high secure setting differentiates it from any other NHSScotland Board, and presents distinctive challenges in relation to engaging with the public. There will be particular focus on increasing understanding of and engagement in the work of the organisation.

The Board has historically always promoted Board meetings and the Annual Review to the local population - but rarely experiences attendance. TSH is a national board and in the past Board Meetings took place in different locations across Scotland. A key action is to commit to holding two meeting a year in another area - this could be at little cost by requesting use of facilities by other NHSScotland Boards. In future the Board will commit to holding the public part of the Annual Review in a local town hall in an attempt to engage the public and increase attendance.

The State Hospital has been the focus of negative publicity during the past year, particularly from September 2018 to date. These articles have focused around key areas: workforce planning, staff disciplinary process, clinical care of ID patients as well as security arrangements. This has included breach of confidentiality of patient and staff information with notification made to Information Commissioner Office (UK) as well as Police Scotland. The Board will review its communications strategy in relation to media engagement. This is recognised to be a challenging area on a number of levels. The media may not be a willing or reliable witness in presenting stories about the positive nature of the work undertaken within the hospital. The protection of patient confidentiality is of paramount importance. Further, even if information about individual patients is in the public domain the effect of any feature on the state hospital may have on the carers, families and friends involved in a wider sense must also be recognised.

The Board does not provide care to the local population in the way the territorial boards do, and this means that engagement locally cannot be promoted in the same way. However, the Board does play a key role in the local area as an employer and promotion of this is a key action which will also lend strength to the recruitment drive of the organisation overall particularly within nursing.

Influencing Culture

Consideration of the culture of the organisation points to pockets of differing cultural bias being found across the hospital. The month of November 2018 seemed to demonstrate this through the co-existing experiences of TSH3030 with a week of unofficial action which impacted upon the delivery of patient care as well as staff morale.

The Board has key objectives in place as part of staff recognition. A working group was set up meeting for the first time in April 2019, to take forward an action plan for a staff awards scheme. It is planned to have the process in place with nominations sought in June 2019 and the first ceremony in September 2019. In conjunction with this, it was agreed by the Senior Management Team in March 2020 that a recognition scheme for NHS Service should be implemented.

One of the key ways in which The State Hospital differs from other NHSScotland Boards is in the small size of the organisation based wholly in a single location. The advantages to this should be more fully realised. In November 2018, the Chief Executive held a series of staff engagement

sessions with staff throughout the hospital with a particular focus on attendance management. These were open informal sessions to encourage dialogue and feedback from staff on how to improve the Board's experience in this key area. In 2019/20 a programme of similar events will be plotted throughout the year led by the senior team. This will ensure regular, open, informal engagement on key areas of focus in the organisation throughout the year.

There will be focus on senior management visibility at key events in the hospital throughout the year - whether the events are patient or staff focussed. Examples include the Patient Learning Awards and Staff Awards. Senior medical staff presence will be encouraged at patient focussed events. During the course of the past year there has been significant turnover within the senior team including key post of Chief Executive, Security Director and Human Resources. Less turnover is expected in the coming year and this will support resilience and continuity in this area.

The Board notes the Scottish Government intention to appoint an Independent National Whistleblowing Champion and will ensure that links are established and grown as this new role develops.

The Improvement Plan will be added to the Board's workplan and submitted for review to each meeting of the Board.

BOARD DEVELOPMENT SESSION

28 March 2019
In the Boardroom at The State Hospital

The overall purpose of the board Development Session is to enable board members to:

- Understand the NHS Scotland Blueprint for Good Governance and what it means for us;
- Consider the outcomes of our recent self-assessment against the Good Governance Blueprint;
- Highlight areas of strength, challenge and identify any improvement actions to take forward;
- Consider how the enablers and support described in the blueprint can help us deliver the recommendations for improvement and board development;
- Reflect on and discuss the priorities, actions and how they will inform the Corporate Governance Report.

PROGRAMME

1.	**Introduction and setting the scene** • Purpose and format of the session • The Corporate Governance Blueprint and what it means for us	Chair
2.	**Results of the survey** • Themes • Agreement between results of both groups • Variance in results of groups • Anything unexpected • Factors driving the results	Organisational Development Lead
3.	**Recommendations for improvement** • What are your thoughts on the results? • What would you like to add/change? • How do we build on and maintain what we do well? • What are the areas where we need to focus for improvement and what benefits do we expect? • What are our priorities and why? • Feedback and discussion	Table discussion 1

28 March 2019
In the Boardroom at The State Hospital

4.	**Moving to action** • How do we action these priorities? • What are the enablers and support required for your priorities? • How will you ensure you have the right information? • Who leads on which priority and when? • How will we monitor progress/what is our assurance?	Table discussion 2
5.	**Review of the session and next steps**	Chair

APPENDIX B - THE STATE HOSPITALS BOARD FOR SCOTLAND - IMPROVEMENT PLAN

BLUEPRINT FUNCTION		ACTION	LEAD	ASSURANCE SYSTEM	TIMESCALE
SETTING THE DIRECTION	1	Reconfirm the Board's strategic direction and communicate through the Strategy Map and development of strapline statement for corporate documents.	CEO	Senior Management Team (SMT)	June 2019
	2	Review of effective rostering system within nursing as component of focus on effective workforce utilization and safe staffing legislation.	Director of Nursing and AHPs	SMT/ Business Objects Reports	March 2020
	3	Development of more robust processes to compare planned and actual spend and to account for any variance.	Director of Finance	SMT /Board	September 2019
HOLDING TO ACCOUNT	4	Ensure compliance with national guidelines in management of Executive pay and performance through remuneration Committee approval for annual ESM pay and performance cycle.	Chair /Interim HR Director	Remuneration Committee	Ongoing
	5	Ensure implementation of attendance management policy through support from HR to line managers help identify and act upon patterns of absence. Continued implementation of the action plan developed through the Attendance Management Improvement Task Group (AMITG).	Interim HR Director	AMITG/ SMT	October 2019
	6	Implementation and compliance with Once for Scotland HR policies within TSH. Focus on policy awareness through completion of metacompliance / staff bulletins/ staff training in Single Investigatory process.	Interim HR Director	Partnership Forum/SMT	December 2019
	7	Review performance framework and assurance information systems to support review of performance.	CEO	SMT	July 2019
ASSESSING RISK	8	Further development of risk management with focus on risk register to ensure this is clearly defined with set of mitigating measures against each risk which also have a focus on improvement actions.	Director of Finance	Audit Committee / Board	December 2019

ENGAGING STAKEHOLDERS	9	Review and develop the Communications Strategy to include proactive engagement with aim of addressing dissonance between strategic aims of the hospital and public perception of these aims.	CEO	Board	March 2020
	10	Promotion of The State Hospital as an employer in the local area. Increase number of modern apprenticeships. Participate in local school careers events, local and university recruitment fairs	Interim HR Director	SMT	March 2020
	11	Encourage carers / volunteers /staff / local population to attend public Board Meetings through additional promotion and links with local community.	Board Secretary	Board	June 2019
	12	Hold two Board Meeting each year at external locations to promote role as national Board.	Board Secretary	Board	April 2020
	13	Annual Review - Public Meeting to be held outside of the hospital to help engage public engagement and attendance.	Board Secretary	Board	April 2020
INFLUENCING CULTURE	14	Implement a Staff Recognition Scheme for long service as well as individual contribution to the organisation.	Interim HR Director	SMT	September 2019
	15	Embed a culture of quality across the organisation through initiatives such as TSH3030, Quality Forum and sharing our work more widely.	CEO	SMT	March 2020
	16	Senior Management visibility through regular front line staff engagement meetings with CEO / Directors' Group through a calendar of events to ensure regular engagement.	CEO	SMT	June 2019
	17	Senior Team / RMO presence at key events in hospital calendar e.g. patient learning awards/ sportsman dinner. Promote this through management structures.	CEO / Medical Director	SMT	June 2019
	18	Link in with Scottish Government once appointment of the Independent National Whistleblowing Champion has been appointed.	CEO	Board	April 2020
	19	Non Executive Director informal visits across TSH to help promote the values and behaviours of the organisation.	Chair	Board	June 2019

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2019
Agenda Reference:	Item No: 14
Sponsoring Director:	Finance & Performance Management Director
Author(s):	Acting Head of Financial Accounts
Title of Report:	Annual Review of Standing Documentation
Purpose of Report:	For review and approval

1 SITUATION

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

2 BACKGROUND

The Board is required, on an annual basis, to review and adopt any changes to Standing Documentation i.e. Standing Financial Instructions, Scheme of Delegation and Standing Orders. The Audit Committee reviewed the documents at their meeting on 28 March 2019 and their recommendation was then noted for the Board's adoption.

3 ASSESSMENT

3.1 Standing Financial Instructions

There are no amendments proposed to the Standing Financial Instructions.

3.2 Scheme of Delegation

There are no amendments proposed to the Scheme of Delegation.

3.3 Standing Orders

There are no amendments proposed to the Standing Orders.

4 RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Ensures that the Board's standing documentation is up to date in respect of Scottish Government guidance and possible changes to Senior staff's portfolios.
Workforce Implications	None
Financial Implications	None
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Audit Committee
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No identified implications.

THE STATE HOSPITALS BOARD FOR SCOTLAND

STANDING FINANCIAL INSTRUCTIONS

VERSION 14

Version Control Log		
Version	Date	Description
1		Approved by Board
2	11 May 06	Approved by Audit Committee on May 2006
2.1	5 June 06	Approved by the Board on June 2006
3.1	21 June 07	Above changes approved by Board June 2007
4.0	24 April 08	Approved by the Board June 2008
5.0	30 April 09	Annual review of SFIs
5.1	16 July 09	Approved by the Board June 2009
5.2	24 Sep 09	Changed to reflect portfolio changes. Approved by Audit Committee September 2009.
6	15 Apr 10	Approved by Board 17 June 2010
7	Apr 11	Approved by audit committee 7/4/11
8	19 Apr 12	Update all references with regard to circulars issued in year Update for SGHD name change to SGHSCD Update for revised CFS partnership agreement Update for key procurement principles Updated for staff title changes Update of SIC to Governance Statement
9	4 April 13	Approved by Audit Committee 25 April 2013 after removal of reference to Vice Chair
9.1	29 April 13	Approved by Board 2 May 2013
10	April 14	Annual review of SFI's – no changes made. Approved by Audit Committee 24 April 2014. Approved by Board 26 June 2014
11	April 15	Updated section 4.1.4 to include additional report. Updated section 16.1.3 from Finance Director to Security Director. Updated section 9.5.3 re authorisation of payroll change forms. Approved by Audit Committee 2 April 2015 after changes to reflect that Remuneration Committee is no longer a sub committee and changed section 14.3.1 & 14.3.5 to Public Sector Internal Audit Standards.
11.1	May 15	Added section 15.7 as per SG guidance re CFS
12	March 16	Updated section 2.6.2 from Nursing Director to Finance Director. Updated Section 4.1.4(c) to reflect changes in Annual Accounts reports. Updated section 9.7 to reflect updated guidance from SG. Approved by Audit Committee 24 March 2016.
12.1	June 16	Amended section 10.3 re tender waiver limit from £3k to £5k. Approved by Audit Committee & Board 23 June 2016.
13	March 17	Approved by Audit Committee 23 March 2017 subject to inclusion of statement re secondment of HR Director – see section 1.3.15 Approved by Board 4 May 2017

14	March 18	Updated section 2.6.2 to reflect depute Accountable Officer as being Nursing & AHP Director and not Finance Director. Updated section 3.6 to change Monitoring Returns to Financial Performance Returns. Updated section 5 in relation to Project Bank Accounts. Updated section 9.6 to reflect that payments to employees would be by bank credit only. Updated section 13.1.1 to include reference to General Data Protection Regulations. Updated section 16.1.10 to include new rules imposed in October 2017 around patient gambling. Approved by Audit Committee 5 April 2018. Approved by Board 28 June 2018

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1 INTRODUCTION

1.1 General

1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Financial Directions issued by the Scottish Ministers under the provisions of the National Health Service (Scotland) Act 1978, the National Health Service (Financial Provisions) (Scotland) Regulations 1974, Section 4, together with the subsequent guidance and requirements contained in The Health Act 1999, NHS Circular No 1974 (GEN) 88 and Annex, and NHS MEL 1994 (80) for the regulation of the conduct of the Board, its members and officers, in relation to financial matters they shall have effect as if incorporated in the Standing Orders (SOs) of the Board.

1.1.2 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Board. They are designed to ensure that its financial transactions are carried out in accordance with the law and Scottish Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Reservation of Powers to the Board and the Scheme of Delegation adopted by the Board.

1.1.3 These SFIs identify the financial responsibilities that apply to everyone working for the Board. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial operating procedures.

1.1.4 Statutory Instrument (1974) No 468 requires Finance Directors to design, implement and supervise systems of financial control and NHS Circular 1974 (Gen) 88 requires the Finance Director to:

- approve the financial systems;
- approve the duties of officers operating these systems; and
- maintain a written description of such approved financial systems, including a list of specific duties

1.1.5 As a result, the Finance Director must approve all financial procedures. Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Finance Director must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Board's SOs.

1.1.6 Failure to comply with SFIs and SOs is a disciplinary matter that could result in dismissal.

1.2 Interpretation

1.2.1 Any expression to which a meaning is given in Health Service legislation, or in the Financial Directions made under the legislation, shall have the same meaning in these instructions.

1.2.2 Wherever the title Chief Executive, Finance Director, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term "employee" is used, and where the context permits, it shall be deemed to include employees of third parties contracted to the Board when acting on behalf of the Board.

1.3 Responsibilities and Delegation

1.3.1 The Board exercises financial supervision and control by:

a) Formulating the financial strategy with due regard to Local Delivery Plans
b) Monitoring performance against plans and budgets by regular reports at Board meetings
c) Requiring the submission and approval of budgets within resource limits
d) Defining and approving essential features in respect of procedures and financial systems
e) Defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document.

1.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the "Reservation of Powers to the Board".

1.3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Board.

1.3.4 The Chief Executive of the NHS in Scotland shall appoint an Accountable Officer, accountable to the Scottish Parliament for the proper use of public funds by the Board. The Chief Executive of The State Hospital is the designated Board's Accountable Officer. The Chief Executive's duties as Accountable Officer are set out in Section 2.

1.3.5 The Chief Executive is ultimately accountable to the Board, and as Accountable Officer for the Board, to the Scottish Parliament, for ensuring that the Board meets its obligation to perform its functions within the available resources. The Chief Executive has overall Executive responsibility for the Board's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Board's system of internal control.

1.3.6 The Chief Executive shall be responsible for the implementation of the Board's financial policies and for co-ordinating any corrective action necessary to further these policies, after taking account of advice given by the Finance Director on all such matters. The Finance Director shall be accountable to the Board for this advice.

1.3.7 The Chief Executive may delegate such of his/her functions as Accountable Officer as are appropriate and in accordance with these Standing Financial Instructions and Accountable Officer Memorandum.

1.3.8 The Chief Executive will be responsible for signing the 'Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Board' as part of the Board's Annual Accounts.

1.3.9 The Chief Executive must ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.

1.3.10 The Finance Director is responsible for:

a) Implementing the Board's financial policies and for co-ordinating any corrective action necessary to further these policies
b) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions

c) Ensuring that sufficient records are maintained to show and explain the Board's transactions, in order to disclose, with reasonable accuracy, the financial position of the Board at any time

and, without prejudice to any other functions of directors and employees to the Board, the duties of the Finance Director include:

d) Providing financial information to the Board and the Scottish Government Health and Social Care Directorate (SGHSCD)
e) Setting the Board's accounting policies consistent with SGHSCD and Treasury guidance and generally accepted accounting practice
f) Preparing and maintaining such accounts, certificates, estimates, records and reports as the Board may require for the purpose of carrying out its statutory duties.

1.3.11 All directors and employees, severally and collectively, are responsible for:

a) The security of the property of the Board
b) Avoiding loss
c) Exercising economy and efficiency in the use of resources
d) Conforming with the requirements of:

- Standing Orders
- Standing Financial Instructions
- Scheme of Delegation
- Financial Operating Procedures

1.3.12 No action should be taken in a manner devised to avoid any of the requirements of, or the financial limits specified in, these governance documents.

1.3.13 Any contractor or employee of a contractor, who is empowered by the Board to commit the Board to expenditure or who is authorised to obtain income, shall comply with these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.14 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Finance Director.

1.3.15 For the period of the appointment of Interim Human Resources Director, responsibilities assigned to Human Resources Director within these Standing Financial Instructions and the Scheme of Delegation will be delegated to Chief Executive.

2 RESPONSIBILITIES OF CHIEF EXECUTIVE AS ACCOUNTABLE OFFICER

2.1 Introduction

2.1.1 Under the terms of Sections 14 and 15 of the Public Finance and Accountability (Scotland) Act 2000, the Principal Accounting Officer for the Scottish Government has designated the Chief Executive of The State Hospitals Board for Scotland as Accountable Officer.

2.1.2 Accountable Officers must comply with the terms of the Memorandum to National Health Service Accountable Officers, and any updated issued to them by the Principal Accountable Officer for the Scottish Government. The Memorandum was updated in July 2009.

2.2 General Responsibilities

2.2.1 The Accountable Officer is personally answerable to the Scottish Parliament for the propriety and regularity of the public finances for The Board. The Accountable Officer must ensure that The State Hospitals Board for Scotland takes account of all relevant financial considerations, including any issues of propriety, regularity or value for money, in considering policy proposals relating to expenditure, or income.

2.2.2 It is incumbent upon the Accountable Officer to combine his/her duties as Accountable Officer with their duty to The Board, to whom he/she is responsible, and from whom he/she derives his/her authority. The Board is in turn responsible to the Scottish Parliament in respect of its policies, actions and conduct.

2.2.3 The Accountable Officer has a personal duty of signing the Annual Accounts of the Board for which he/she has responsibility. Consequently, he/she may also have the further duty of being a witness before the Audit Committee of the Scottish Parliament, and be expected to deal with questions arising from the Accounts, or, more commonly, from reports made to Parliament by the Auditor General for Scotland.

2.2.4 The Accountable Officer must ensure that any arrangements for delegation promote good management and that he/she is supported by the necessary staff with an appropriate balance of skills. This requires careful selection and development of staff and the sufficient provision of special skills and services. He/she must ensure that staff are as conscientious in their approach to costs not borne directly by their component organisation (such as costs incurred by other public bodies, or financing costs, e.g. relating to banking and cash flow) as they would be were such costs directly borne.

2.3 Specific Responsibilities

2.3.1 The Accountable Officer must:

- Ensure that from the outset, proper financial systems are in place and applied, and that procedures and controls are reviewed from time to time to ensure their continuing relevance and reliability, especially at times of major changes
- Sign the Accounts and the associated Governance Statement assigned to him/her, and in doing so accept personal responsibility for ensuring that they are prepared under the principles and in the format directed by Scottish Ministers
- Ensure that proper financial procedures are followed, incorporating the principles of separation of duties and internal check, and that accounting records are maintained in a form suited to the requirements of the relevant Health Board Manual for Accounts
- Ensure that the public funds for which he/she is responsible are properly managed and safeguarded, with independent and effective checks of cash balances in the hands of any official

- Ensure that the assets for which he/she is responsible, such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate
- Ensure that, in the consideration of policy proposals relating to the resources for which he/she has responsibilities as Accountable Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and where necessary brought to the attention of the Board
- Ensure that any delegation of responsibility is accompanied by clear lines of control and accountability, together with reporting arrangements
- Ensure that effective management systems appropriate for the achievement of the organisation's objectives, including financial monitoring and control systems have been put in place
- Ensure that risks, whether to achievement of business objectives, regularity, propriety, or value for money, are identified, that their significance is assessed and that systems appropriate to the risks are in place in all areas to manage them
- Ensure that arrangements have been made to secure Best Value as set out in the Scottish Public Finance Manual
- Ensure that managers at all levels have a clear view of their objectives, and the means to assess and measure outputs, outcomes or performance in relation to these objectives
- Ensure managers at all levels are assigned well defined responsibilities for making the best use of resources (both those assumed by their own commands and any made available to organisations or individuals outside The State Hospitals Board for Scotland) including a critical scrutiny of output and value for money
- Ensure that managers at all levels have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively regarding regularity and propriety of expenditure

2.3.2 The Accountable Officer has a responsibility to ensure that the Board achieves high standards of regularity and propriety in the consumption of resources. Regularity involves compliance with relevant legislation (including the annual Budget Act), relevant guidance issued by the Scottish Ministers - in particular the Scottish Public Finance Manual - and any framework document (e.g. Management Statement / Financial Memorandum) setting out the accountability arrangements and other relevant matters. Propriety involves respecting the Parliament's intentions and conventions and adhering to values and behaviours appropriate to the public sector.

2.3.3 The Accountable Officer has a responsibility for ensuring compliance with parliamentary requirements in the control of expenditure. A fundamental requirement is that funds should be applied only to the extent and for the purposes authorised by Parliament in Budget Acts (or otherwise authorised by section 65 of the Scotland Act 1998). Parliament's attention must be drawn to losses or special payments by appropriate notation of the organisation's Accounts. In the case of expenditure approved under the Budget Act, any payments must be within the scope and amount specified in that Act.

2.3.4 In his/her stewardship of public funds all actions must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct. The Accountable Officer must not misuse his / her official position to further his / her private interests and care should be taken to avoid actual, potential, or perceived conflicts of interest.

2.4 Advice to the Body

2.4.1 In accordance with section 15(8) of the PFA Act the Accountable Officer has particular responsibility to ensure that, where he / she considers that any action that he / she is required to take is inconsistent with the proper performance of his / her duties as Accountable Officer, he / she obtain written authority from the body for which he / she is designated and to send a copy of this as soon as possible to the Auditor General. A copy of such written authority should also be sent to the Clerk to the Public Audit Committee.

The Accountable Officer should ensure that appropriate advice is tendered to the body on all matters of financial propriety and regularity and on the economic, efficient and effective use of resources. The Accountable Officer will need to determine how and in what terms such advice should be tendered, and whether in a particular case to make specific reference to his / her own duty as Accountable Officer to seek written authority and notify the Auditor General.

2.4.2 The Accountable Officer has particular responsibility to see that appropriate advice is tendered to the body on all matters of financial propriety and regularity and on the economic, efficient and effective use of resources. If he / she considers that the body is contemplating a course of action which is considered would infringe the requirements of financial regularity or propriety or that could not be defended as representing value for money within a framework of Best Value he / she should set out in writing the objection to the proposal and the reasons for this objection. If the body decides to proceed, he / she should seek written authority to take the action in question. In the case of a body sponsored by the Scottish Government the sponsor Directorate should be made aware of any such request in order that, where considered appropriate, it can inform the relevant Scottish Government Accountable Officer and Cabinet Secretary / Minister. Having received written authority he / she must comply with it, but should then, without undue delay, pass copies of the request for the written authority and the written authority itself to the Auditor General and the Clerk to the Public Audit Committee.

2.4.3 If because of the extreme urgency of the situation there is no time to submit advice in writing to the body in either of the eventualities referred to in paragraph 2.5.2 before the body takes a decision, the Accountable Officer must ensure that, if the body overrules the advice, both his / her advice and the body's instructions are recorded in writing immediately afterwards.

2.4.4 If the Accountable Officer is also a member of the Management Board of the body, he / she should ensure that his / her responsibilities as Accountable Officer do not conflict with those as a Board member. For example, if the body proposes action which as Accountable Officer he / she could not endorse and would therefore advise against he / she should, as a Board member, vote against such action, or ensure that opposition as a Board member as well as Accountable Officer is clearly recorded if no formal vote is taken. It will not be sufficient to protect his / her position as a Board member merely by abstaining from a decision which cannot be supported.

2.5 Appearance before the Public Audit Committee

2.5.1 Under section 23 of the PFA Act the Auditor General may initiate examinations into the economy, efficiency and effectiveness with which any part of the Scottish Administration, or certain other bodies, have used their resources in discharging their functions. The Accountable Officer may expect to be called upon to appear before the Public Audit Committee to give evidence on reports arising from any such examinations involving his / her body. The Accountable Officer will also be expected to answer the questions of the Committee concerning resources and accounts for which he / she is Accountable Officer and on related activities. He / she may be supported by other officials who may, if necessary, join in giving evidence or the Committee may agree to hear evidence from other officials in his / her absence.

2.5.2 He / she will be expected to furnish the Committee with explanations of any indications of weakness in the matters covered by paragraphs 2.3 above, to which their attention has been drawn by the Auditor General or about which they may wish to question him / her.

2.5.3 In practice, the Accountable Officer will have delegated authority widely, but cannot on that account disclaim responsibility. Nor, by convention, should he / she decline to answer questions where the events took place before his / her designation.

2.5.4 The Accountable Officer must make sure that any written evidence or evidence given when called as a witness before the Public Audit Committee is accurate. He / she should also ensure that he / she is adequately and accurately briefed on matters that are likely to arise at the hearing. He / she may ask the Committee for leave to supply information not within his / her immediate knowledge by means of a later note. Should it be discovered subsequently that the evidence provided to the Committee has contained errors, he / she should let this be made known to the Committee at the earliest possible moment.

2.5.5 In general, the rules and conventions governing appearances of officials before Committees of the Scottish Parliament apply, including the general convention that officials do not disclose the advice given to the body. Nevertheless, in a case where he / she was overruled by the body on a matter of propriety or regularity, his / her advice would be disclosed to the Committee. In a case where he / she were overruled by the body on the economic, efficient and effective use of resources the Auditor General will have made clear in the report to the Committee that he / she was overruled. He / she should, however, avoid disclosure of the precise terms of the advice given to the body or disassociation from the decision. Subject, where appropriate, to the body's agreement he / she should be ready to discuss the costs, benefits and risks of options considered and explain the reasoning for the decision taken. He / she may also be called on to satisfy the Committee that all relevant financial considerations were brought to the body's attention before the decision was taken.

2.6 Absence of Accountable Officer

2.6.1 The Accountable Officer should ensure that he / she is generally available for consultation, and that in any temporary period of unavailability due to illness or other cause, or during the normal period of annual leave, there will be a senior officer in the body who can act on his / her behalf if required.

2.6.2 In the event of the Accountable Officer not being available the Nursing & AHP Director shall deputise in any required capacity, as authorised to do so.

2.6.3 If it becomes clear to the body that he / she is so incapacitated that he / she will not be able to discharge these responsibilities over a period of four weeks or more, it should notify the Principal Accountable Officer of the NHS in Scotland so that he / she can appoint an Accountable Officer, pending return. The same applies if, exceptionally, he / she plans an absence of more than four weeks during which he / she cannot be contacted.

2.6.4 Where the Accountable Officer is unable by reason of incapacity or absence to sign the accounts in time for them to be submitted to the Auditor General the body may submit unsigned copies pending his / her return.

3 ALL LOCATIONS, ESTIMATES, PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

3.1 Preparation and Approval of the Financial Plan and Budgets

3.1.1 The Chief Executive will compile and submit to the Board for approval annually a strategic plan covering a three/ five year period (as specified by SGHSCD). This shall include financial targets and spending proposals and forecast limits of available resources. The annual strategic plan will contain:

a) A statement of the strategies and significant assumptions on which the plan is based
b) Details of major changes in workforce, delivery of services or resources required to achieve the plan
c) Details of the performance management arrangements in place, including national and local targets.

3.1.2 The Finance Director will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board before the start of the financial year. Where it is not possible to agree a full budget, a roll forward budget will be approved prior to the start of the financial year, with a full budget approved by end June. Such budgets will:

- Be in accordance with the aims and objectives set out in the strategic plan
- Accord with workload and workforce plans
- Be produced following discussion with appropriate budget holders
- Be prepared within the limits of available funds
- Identify the assumptions used in their preparation and potential risks
- Reflect SGHSCD indicative budgets

3.1.3 The Finance Director will monitor financial performance against budget and strategic plan, periodically review them, and report to the Board.

3.1.4 All budget holders must provide information as required by the Finance Director to enable budgets, plans, estimates and forecasts to be compiled.

3.2 Budgetary Delegation

3.2.1 The Chief Executive may, within limits approved by the Board, delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a) Amount of the budget
b) Purpose(s) of each budget heading
c) Individual and group responsibilities
d) Authority to exercise virement
e) Achievement of planned levels of service
f) The provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board in the Scheme of Delegation.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.2.5 Expenditure for which no provision has been made in approved plans and budgets and outwith delegated virement limits may only be incurred after authorisation by the Chief Executive or the Finance Director acting on their behalf, or the Board, dependant on the nature and level of expenditure.

3.3 Budgetary Control and Reporting

3.3.1 The Finance Director shall monitor financial performance against budget and plan, periodically review them, and report to the Board. There should be a locally agreed mechanism for the early identification and reporting of exceptional financial pressures that cannot be managed.

3.3.2 The Finance Director will devise and maintain systems of budgetary control. These will include:

a) Financial reports to the Board at each meeting in a form approved by the Board containing:

- Revenue resource and expenditure to date showing trends and forecast year-end position against budget
- Performance against statutory targets
- Capital project spend and projected outturn against plan
- Explanations of any material variances from plan
- Where necessary, details of any corrective action and the Chief Executive's and/or Finance Director's view of whether such actions are sufficient to correct the situation
- Changes in the resources available to the Board
- Report on budgetary transfers.

b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible
c) Investigation and reporting of variances from financial, workload and workforce budgets
d) Monitoring of management action to correct variances
e) Arrangements for the authorisation of budget transfers.

3.3.3 Each Budget Holder is responsible for ensuring that:

a) Any likely overspending or reduction of income which cannot be met by virement is not incurred without prior consent
b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement
c) No permanent employees other than those provided for in the budgeted establishment as approved by the Board are appointed without the approval of the Senior Management Team and signed off by the Finance Director.

3.3.4 The Finance Director has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.4 Cost Improvements and Income Generation

3.4.1 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the strategic plan and a balanced budget.

3.5 Capital Expenditure

3.5.1 The general rules applying to delegation SFI 3.2 and reporting SFI 3.3 also apply to capital expenditure. (The particular applications relating to capital expenditure are in SFI 7).

3.6 Financial Performance Returns

3.6.1 The Chief Executive is responsible for ensuring that the required financial performance returns are submitted to the SGHSCD.

4 ANNUAL ACCOUNTS AND REPORTS

4.1.1 The Board is responsible for ensuring proper accounting records are maintained which disclose with reasonable accuracy, at any time, the financial position of the Board and enable the Board to ensure that the accounts comply with the National Health Service (Scotland) Act 1978 and the requirements of the SGHSCD.

4.1.2 The Board, in regard to the preparation of accounts, is required to:

a) Select suitable accounting policies and then apply them consistently
b) Make judgements and estimates that are reasonable and prudent
c) State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts
d) Prepare the accounts on the going concern basis unless it is inappropriate to assume that the Board will continue to operate.

4.1.3 The Finance Director, on behalf of the Board, will:

a) Prepare, for the Board, periodic and annual financial reports in accordance with the accounting policies and guidance given by the SGHSCD and the Treasury, the Board's accounting policies, and generally accepted accounting practice
b) Prepare and submit annual financial reports to the Scottish Ministers certified in accordance with current guidelines
c) Submit financial returns to the Scottish Ministers for each financial year in accordance with the timetable prescribed by the SGHSCD.

4.1.4 The following statements will be completed and attached to the annual accounts:

a) Statement of the Chief Executive's Responsibilities as the Accountable Officer of the NHS Board
b) Statement of NHS Board Members' Responsibilities in Respect of the Accounts
c) A management commentary comprising of an Annual Report which includes a Performance Report and Accountability Report
d) Remuneration and Staff Report
e) Governance Statement

4.1.5 The Board's audited annual accounts must be presented to a public meeting, not later than 6 months after the Board's accounting date. The audited annual accounts shall not be presented until the Audit Committee has approved them in the first instance and then the Board and thereafter laid before the Scottish Parliament.

4.1.6 The Board will publish an annual report after the Annual Accounts have been laid before the Scottish Parliament in accordance with guidelines on local accountability, and present it at a public meeting, (MEL(1994) 80, Guidance to NHS Scotland, Preparation of Local NHS Annual Reports 2001-2002). The document will comply with the Boards Manual for Accounts.

5 BANK AND GOVERNMENT BANKING SERVICE (GBS)

5.1 General

5.1.1 The Finance Director is responsible for managing the Board's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will take into account guidance/directions issued from time to time by the SGHSCD.

5.1.2 The Board will implement Project Bank Accounts (in construction contracts) where the project value is greater than the monetary limits detailed within Scottish Government guidance "Implementing Project Bank Accounts in Construction Contracts" dated 20 December 2016. This guidance applies to relevant bodies in scope of the Scottish Public Finance Manual (SPFM).

5.1.3 No employee shall hold Board monies in any Bank accounts outwith those approved by the Board. The Finance Director shall be notified of all funds held on behalf of the Board. This should be taken to include Exchequer Funds, Patients Private Funds and Project Bank Accounts.

5.1.4 Banking arrangements shall comply with current guidance as in MEL (2000)39, HDL (2001) 49 and subsequent guidance.

5.2 Bank and GBS

5.2.1 The Finance Director is responsible for:

a) Establishing bank account(s) for the Board's exchequer funds
b) Establishing separate bank accounts for the Board's non-exchequer funds (including Project Bank Accounts)
c) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made
d) Reporting to the Board all arrangements made with the Board's bankers for accounts to be overdrawn.

5.3 Banking Procedures

5.3.1 The Finance Director will prepare detailed instructions on the operation of bank accounts, which must include:

a) The conditions under which each account is to be operated
b) The limit to be applied to any overdraft
c) Those authorised to sign cheques or other orders drawn on the Board's bank accounts, and the limits of their authority.

5.3.2 The Finance Director must advise the Board's bankers in writing of the conditions under which each account will be operated, including the Board's resolution. No other officer than the Finance Director shall open an account in the name of The State Hospital.

5.3.3 The Scottish Minister will be able to direct where Boards may invest temporary cash surpluses. This in practice will be restricted to GBS accounts with the effect of reducing overall exchequer borrowing. Temporary cash surpluses shall only be held in GBS account. Required amounts will be transferred to the commercial bank account as required to cover any salary or creditor payments. The amount of working cash held in commercial accounts should be limited to no more than £50,000. Any excess funds should be invested with the GBS accounts.

6 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The Finance Director is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Finance Director is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges

6.2.1 The Board shall follow the SGHSCD's guidance in setting prices for services.

6.2.2 The Finance Director is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the SGHSCD or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

6.2.3 All employees must inform the Head of Financial Accounts promptly of money due arising from transactions which they initiate/deal with, including all contracts, service agreements, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 Debt Recovery

6.3.1 The Finance Director is responsible for the appropriate recovery action on all outstanding debts and overpayments.

6.3.2 Income not received should be dealt with in accordance with losses procedures.

6.3.3 Overpayment when detected should be recovered.

6.3.4 The Finance Director shall establish procedures for the write-off of debts after all reasonable steps have been taken to secure payment.

6.4 Security of Cash, Cheques and Other Negotiable Instruments

6.4.1 The Finance Director is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable
b) Ordering and securely controlling any such stationery
c) Provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines and for absence cover
d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Board.

6.4.2 All officers whose duty it is to collect or hold cash shall be provided with a safe or with a lockable cash box, which will normally be deposited in a safe. The officer concerned shall hold only one key and all duplicates shall be lodged with the Finance department or other officer authorised by the Finance Director, and suitable receipts obtained. The loss of any key shall be reported immediately to the Finance Director. The Finance Director, on receipt of a satisfactory explanation, shall authorise the release of the duplicate key. The Finance Director shall arrange for all new safe keys to be dispatched directly to him/her from the manufacturers. The Finance Director shall be responsible for maintaining a register of authorised holders of safe keys.

6.4.3 The Finance Director shall prescribe the system for the transporting of cash and un-crossed pre-signed cheques and shall approve, where appropriate, the use of the services of a specialist security firm.

6.4.4 During the absence (e.g. on holiday) of the holder of a safe key or cash box key, the officer who acts his/her place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

6.4.5 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses. (See Section 15 – Disposals and Condemnations, Losses and Special Payments).

6.4.6 Official money shall not under any circumstances be used for the encashment of private cheques.

6.4.7 All cheques, postal orders, cash etc, shall be banked intact and promptly. Disbursements shall not be made from cash received, except under arrangements approved by the Finance Director.

6.4.8 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Board is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Board from responsibility for any loss.

6.4.9 Large sums of cash collected for unofficial purposes (e.g. for retirements, leavers) should not be retained at ward / department level. Such funds should be passed to the finance department for lodgement in the safe. Once the collection is complete the cash will be returned to the collector.

7 CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

7.1 Capital Investment

7.1.1 The Chief Executive:

a) Shall ensure that there is an adequate appraisal and approval process, detailed in the Financial Operating Procedures, in place for determining capital expenditure priorities and the effect of each proposal upon service plans. These should form part of the Boards' Property and Asset management strategy.
b) Is responsible for ensuring that a Capital programme, showing the full, lifetime cost of each project, is brought to the Board for approval at the start of each financial year, in a format agreed by the Board
c) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost
d) Shall ensure that the capital investment is not undertaken without confirmation of Board support and the availability of resources to finance all revenue consequences, including capital charges.

7.1.2 For every capital expenditure proposal over £2,000,000 (£1,000,000 if IM&T project) the Chief Executive shall ensure:

a) That a business case (in line with the guidance contained within the Scottish Capital Investment Manual) is produced, for the approval of the Board, setting out:

- An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs
- Appropriate project management and control arrangements

b) That the Finance Director has certified professionally to the costs and revenue consequences detailed in the business case.

7.1.3 For capital schemes where the contracts stipulate staged payments, the Chief Executive will issue procedures for their management.

7.1.4 The Finance Director shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure, including reporting to the Board.

7.1.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

7.1.6 The approval of the Chief Executive shall be required for any variations which exceed the lower of £25,000 or 10% of approved expenditure of any scheme.

7.1.7 The Chief Executive shall issue to the manager responsible for any scheme:

a) Authority to proceed to tender
b) Approval to accept a successful tender within established limits
c) Guidance on relevant legislation, SGHSCD requirements, Board procedures etc.

7.1.8 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with Scottish Capital Investment Manual guidance and the Board's Standing Orders.

7.1.9 The Finance Director shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

7.2 Asset Registers

7.2.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Finance Director concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year. The minimum data set to be held within the registers shall be as specified in CEL (2010)35 as issued by the SGHSCD.

7.2.2 Additions to the fixed asset register must be clearly identified and be validated by reference to:

a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties
b) Stores, requisitions and wages records for own materials and labour including appropriate overheads
c) Lease agreements in respect of assets held under a finance lease and capitalised.

7.2.3 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

7.2.4 The Finance Director shall approve procedures for reconciling balances on fixed asset accounts in ledgers against balances on fixed asset registers.

7.2.5 The value of each asset shall be revalued or indexed and depreciated in accordance with guidance issued by the SGHSCD.

7.3 Security of Assets

7.3.1 The overall control of fixed assets is the responsibility of the Chief Executive.

7.3.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including any donated assets) must be approved by the Finance Director. This procedure shall make provision for:

a) Recording managerial responsibility for each asset
b) Identification of additions and disposals
c) Identification of all repairs and maintenance expenses
d) Physical security of assets
e) The express prohibition of any unauthorised use or disposition of Board assets
f) Periodic verification of the existence of, condition of, and title to, assets recorded
g) Identification and reporting of all costs associated with the retention of an asset
h) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

7.3.3 The Finance Director shall prepare procedural instructions on the security and checking and disposal of assets (including cash, cheques and negotiable instrument, and also including donated assets).

7.3.4 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the Finance Director.

7.3.5 Each employee has a responsibility for the security of property of the Board and it is the responsibility of directors and senior employees in all disciplines to ensure appropriate routine security practices in relation to NHS property as may be determined by the Board are applied. Any breach of agreed security practices must be reported in accordance with instructions.

7.3.6 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Finance Director concerning the form of any register and the method of updating.

7.3.7 Any damage to the Board's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

7.3.8 Registers shall be maintained by the responsible officer for:

- Equipment on loan;
- Leased equipment.

7.3.9 Where practical, assets should be marked as Board property.

7.4 Sale of Property, Plant and Equipment,

7.4.1 There is a requirement to achieve best value for money when disposing of property, plant and equipment assets belonging to the Board. Competitive tendering should normally be undertaken in line with the requirements of SFI 10.3.

7.4.2 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

a) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer
b) Obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Board
c) Items to be disposed of with an estimated sale value of less than £5,000 this figure to be reviewed annually
d) Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract
e) Land or buildings concerning which SGHSCD guidance has been issued but subject to compliance with such guidance.
f) Assets that can be transferred to another NHS body at their Net Book value.

7.4.3 Managers must ensure that:

a) All assets are be disposed of in accordance with MEL(1996)7 'Sale of surplus and obsolete goods and equipment'
b) The Finance Director is notified of the disposal of any such assets
c) All proceeds from the disposal of such assets are notified to the Finance Director.

8 SERVICE LEVEL AGREEMENTS (SLAs)

8.1.1 Service Level Agreements between two NHS organisations, for example by Health Boards with Boards for the supply of healthcare services, are subject to the provisions of the NHS and Community Care Act 1990. Such contracts do not give rise to legal rights or liabilities but a dispute may be referred to SGHSCD.

8.1.2 Service level agreements provided by the independent healthcare sector on behalf of the NHS are subject to the provisions of HDL (2005) 41. This letter sets out the arrangements that should apply for ensuring the quality of services and identifies that the Chief Executive should ensure the necessary contracting and clinical governance arrangements are put in place.

8.1.3 The Chief Executive is responsible for ensuring Service Level Agreements are agreed and in place before 1 April each year, following discussion between the relevant Boards. The following areas should be covered:

a) Costing and pricing of services
b) Tendering of services
c) Terms and conditions for funding
d) Monitoring of service provision, quality and performance.

8.1.4 Service Level Agreements for The State Hospital providing services to other Boards should be so devised as to minimise risk whilst maximising the Board's opportunity to generate income. Any pricing at marginal cost must be undertaken by the Finance Director and reported to the Board where material. Non-recurrent income should not be used for recurrent purposes without the authority in writing of the Chief Executive.

9 TERMS OF SERVICE AND PAYMENT OF EXECUTIVE DIRECTORS AND EMPLOYEES

9.1 Remuneration and Terms of Service

9.1.1 The Board has established a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting (MEL(94) 80).

9.1.2 The Board will remunerate the Chairperson and Non-Executive Directors in accordance with instructions issued by Scottish Ministers.

9.1.3 The Remuneration Committee will:

a) Advise the Board about appropriate Remuneration and Terms of Service for the Chief Executive and other Executive Directors (and other senior employees), including:

- All aspects of salary (including any performance related elements/bonuses)
- Provisions for other benefits, including pensions and cars
- Arrangements for termination of employment and other contractual terms.

b) Make such recommendations to the Board on the Remuneration and Terms of Service of Executive Directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Board – having proper regard to the Board's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate.

c) Monitor and evaluate the performance of individual Executive Directors (and other senior employees)

d) Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking into account such national guidance as is appropriate.

9.1.4 The Remuneration Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for its decisions, but remain accountable for taking decisions on the Remuneration and Terms of Service of Executive Directors. Minutes of the Board's meetings should record such decisions.

9.1.5 The Board will approve proposals presented by the Chief Executive for setting of Remuneration and Terms and Conditions of service for those employees not covered by the Committee.

9.2 Funded Establishment

9.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

9.2.2 The funded establishment of any department may not be varied, after approval of the annual budget, without the approval of the Chief Executive through the Senior Management Team subject to section 3 of the Scheme of Delegation.

9.3 Staff Appointments

9.3.1 No director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary basis, or hire agency staff, or agree to changes in any aspect of remuneration:

a) Unless given delegated authority to do so by the Chief Executive
b) Within the limit of his/her approved budget and funded establishment
c) In accordance with procedures approved by the Human Resources Director.
d) In accordance with the relevant pay scales / Terms and Conditions of service.

9.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

9.3.3 The budget impact of all staff appointments must have the authorisation of the Finance Director or his/her delegated officer, before appointment.

9.4 Contracts of Employment

9.4.1 The Human Resources Director will be responsible for:

a) Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation
b) Dealing with variations to, or termination of, contracts of employment.

9.5 Pay and Payroll Documentation

9.5.1 The Human Resources Director is responsible for ensuring that proper arrangements are in place for:

a) The final determination of pay and expenses
b) Verification authorisation and documentation of payroll data
c) Verification and authorisation of expenses payments
d) Prescribing the form of appointment, notification of change and termination forms
e) Prescribing the form of completion of time records and other payroll notifications
f) Prescribing the form for claiming expenses
g) Ensuring the arrangements for the determination, verification and notification of pay and payroll data are supported by appropriate (contract) terms and conditions of service, adequate internal controls and audit review procedures.

9.5.2 Each Director and employee is responsible for complying with the systems in place in the Board for the prompt and accurate provision of information related to the verification of their personal entitlement to pay and expenses and for complying with appropriate Terms and Conditions of Service.

9.5.3 All payroll change forms must be authorised by the Finance Director.

9.6 Processing of Payroll

9.6.1 The Finance Director is responsible for:

a) Specifying timetables for submission of properly authorised time records, other payroll notifications and authorised expense claims
b) Making payment on agreed dates
c) Agreeing method of payment to be by bank credit (BACS).

9.6.2 The Finance Director will issue instructions regarding:

a) The timetable for receipt and preparation of payroll data and the payment of employees
b) Maintenance of subsidiary records for superannuation, income tax, social security benefits, arrestments and other authorised deductions from pay
c) Security and confidentiality of payroll information
d) Checks to be applied to completed payroll after processing
e) Authority to release payroll data under the provisions of the Data Protection Act
f) Method of payment to employees will be bank credit (BACS)
g) Procedures for payment by bank credit to employees
h) Procedures for the recall before payment of bank credits
i) The collection of payroll deductions and payment of these to appropriate bodies
j) Pay advances and their recovery
k) Maintenance of regular and independent reconciliation of pay control accounts
l) Separation of duties of compiling payroll and checking of payroll after processing
m) A system to ensure the recovery from employees or leavers of sums of money and/or property due by them to the Board
n) Ensuring payroll processing is supported by adequate internal controls and audit review procedures.

9.6.3 Appropriately nominated managers have delegated responsibility for:

a) Completing accurate roster records consistent with approved conditions of service, and other notifications in accordance with agreed timetables
b) Completing roster records and other notifications in accordance with the Human Resources Director's instructions and in the form prescribed by the him/her
c) Submitting commencement, change or termination forms in the prescribed form immediately upon knowing the effective date of the relevant date. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Human Resources Director must be informed immediately.

9.7 Settlement Agreements, Early Retirement and Redundancy

9.7.1 The Human Resources Director, jointly with the Finance Director is responsible for:

a) Ensuring compliance with the guidance issued by the Health Workforce and Performance Directorate in the situations described above.
b) Ensuring that detailed, accurate costings are produced showing the impact of any instances of early retirement/redundancy on the financial performance of the Board.

9.8 Relocation Expenses

9.8.1 The Human Resources Director is responsible for:

a) Preparing a policy relating to the payment of removal expenses and presenting it to the Board for approval
b) Maintaining detailed procedures for the implementation of this policy
c) Ensuring that monitoring and tracking arrangements are in place for the payment of such expenses.

9.9 Non Salary Rewards

9.9.1 The Scottish Public Finance Manual sets out arrangements for establishment of non salary reward schemes, and provides the following examples:

- Cash bonuses
- Amenities and recreational facilities

- Gifts, vouchers, and entertainment offered as rewards under recognition schemes
- Payment by the employer of its staffs' personal subscriptions to sports or leisure clubs
- Rewards leading to donations to a charity or other external body
- Provision of cars where they are needed for official purposes and are covered by an existing and agreed scheme which includes charging for any private use.

9.9.2 The Scottish Government Finance Pay Policy Team should be consulted prior to the implementation of any non-salary reward scheme to determine whether it will require approval under the Public Sector Pay Policy for Staff Pay Remits or Senior Appointments.

9.9.3 The tax implications for both employers and employees of the provision of all non-salary rewards – cash and non-cash – should be carefully considered. In considering such schemes, it may be appropriate for the Finance Director to seek expert PAYE advice.

9.9.4 When consulting about a proposed scheme, or advising employees of a scheme to be implemented, the Human Resource Director should ensure that mechanisms are in place to advise employees of the tax implications for recipients and how these are to be handled.

10 NON-PAY EXPENDITURE

10.1 Delegation of Authority

10.1.1 The Board will approve the total level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget holders.

10.1.2 The Finance Director will identify:

a) Managers who are authorised to place requisitions for the supply of goods and services
b) The maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Finance Director shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always seek to obtain the best value for money for the Board through the application of these SFIs, and of all relevant Financial Operating Procedures. In so doing, the advice of the Board's Procurement Manager shall be sought.

10.2.2 National contracts agreed by National Procurement, should be used wherever possible, HDL (2006)39, updated by CEL 05(2012). The Accelerated Procurement initiative was established by the NHS Chief Executive Officers' Group in August 2010. The group recognised the essential nature of the engagement between procurement professionals and the wider Health Board teams to maximise the delivery of benefits for NHSScotland, and to ensure that appropriate professional input from across the service is provided to assist in Best Value outcomes for procurement activity. This work was developed further and is now controlled within the NHSScotland Procurement Steering Group. The key principles of this engagement are set out below:

a) National, regional & local contracts: Where national, regional or local contracts exist (including framework arrangements) the overriding principle is that use of these contracts is mandatory. Only in exceptional circumstances and only with the authority of the Board's Procurement Manager or the Finance Director, based on existing schemes of delegation, shall goods or services be ordered out-with such contracts. Procurement leads will work with National Procurement and other national contracting organisations to ensure best value decisions are made, and that a record of exceptions is maintained for review.
b) Engagement: Technical User Groups (TUGs) should be established by each Health Board for key projects with decision making powers from their Executive Board through a scheme of delegation. Each TUG will be responsible for supplier award and product selection decision making within their Board for local contracts and will provide representation to national CAP (Clinical/Commodity Advisory Group) panels for national contract activity. The decision of the TUG will be mandatory across the Board and will be made prior to development of national contract tendering activities.
c) CAP Panel Membership: CAP panels will have a membership consistent with the principle of decision making based on the consensus of the majority of informed users. Boards should ensure that appropriate representation, based upon the clinical or commodity area concerned is released to and provided with the appropriate authority to input on behalf of a Board and/or clinical specialism.
d) Commitment Contracts: The CAP and TUG groups will work to the principle of seeking to award Commitment based contracts. This means where possible a supplier(s) will be selected for an agreed volume of business by each Board and such volumes aggregated to provide a national commitment level.

Where commitment cannot be provided, CAP and TUG groups will support the principles of reduced variation and increased consistency, commensurate with clinical and operational requirements.

e) eCommerce Systems: In support of governance and transparency each Board should adopt the Scottish Government national eCommerce solutions and associated business processes for all procurement activity. These solutions will include Public Contracts Scotland, Public Tenders Scotland, Collaborative Content Management and Pecos. Use of alternative or local systems for procurement activity must be approved by the Board's Procurement Manager or the Finance Director, based on existing schemes of delegation. Procurement leads will work with National Procurement and any other relevant bodies to ensure appropriate decisions are made.

f) Transparency: All awards whether from existing framework contracts or local tender processes will be established following the principles of openness and transparency. This requires clear specifications of need and award criteria against which competing offers can be assessed. All members of evaluation panels must confirm that they have no conflict of interest in relation to the specific procurement activity. Any individual wishing to challenge an award decision must also confirm likewise. Any member of staff who confirms a conflict of interest will not be able to be involved in such panels or challenges.

g) No Purchase Order */* No Payment: Each Board must implement a policy where no payment shall be made to any supplier where there is no pre-let purchase order. Only if a separately agreed payment mechanism has been pre-arranged should direct payments be made. Each supplier should be formally notified of this and the limit of the Board's liability if they proceed with supply without such order cover.

10.2.3 The Finance Director shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.2.4 The Finance Director will:

a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SFI 10.3 and reviewed regularly

b) Prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds

c) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

- A list of directors/employees (including specimens of their signatures) authorised to order goods/certify invoices and the limits of that authority.
- Certification that:

  - ✓ Goods have been duly received, examined and are in accordance with specification and the prices are correct
  - ✓ Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct
  - ✓ In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined
  - ✓ Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained

- ✓ The setting of thresholds for matching invoices to orders and good received notes – above which additional budget holder authorisation is required
- ✓ The account is arithmetically correct
- ✓ The account is in order for payment

- A timetable and system for submission to the Finance Director of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.
- Instructions to employees regarding the handling and payment of accounts within the Finance Department

d) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

10.2.5 Prepayments are only permitted where exceptional circumstances apply. In such instances:

- Prepayments are only permitted where the financial advantages outweigh the disadvantages and the intention is not to circumvent cash limits.
- The appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Board, if the supplier is at some time during the course of the prepayment agreement, unable to meet his commitments. The report must include a statement of support from the Procurement Manager for the proposed prepayment agreement.
- The Finance Director will need to be satisfied with the proposed arrangements before contractual arrangements proceed.
- The budget manager/holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or the Chief Executive if problems are encountered.
- Regardless of the arrangements for paying suppliers, the Finance Director shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for payment.

10.2.6 Official Orders must:

a) Be consecutively numbered
b) Be in a format approved by the Finance Director
c) State the Board's terms and conditions of trade
d) Only be issued to, and used by, those duly authorised by the Chief Executive.

10.2.7 Managers must ensure that they comply fully with the guidance and limits specified by the Finance Director and that:

a) All contracts, leases, tenancy agreements and other commitments which may result in a liability are notified to the Finance Director in advance of any commitment being made
b) Contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement and comply with the White Paper on Standards, Quality and International Competitiveness (CMND 8621)
c) Officers are also expected to use their discretion in obtaining more than the minimum number of quotations if they have doubts about the competitiveness of those obtained
d) Where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the SGHD – MEL (1994)4
e) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

- Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars; conventional hospitality, such as lunches in the course of working visits
- Any officer who receives an offer shall notify his/her manager as soon as practicable. The manager will consult with the Finance Director (and/or Chief Executive) on what action is to be taken

- Visits at suppliers' expense to inspect equipment etc. must not be undertaken without the prior approval of the Chief Executive

f) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Finance Director on behalf of the Chief Executive
g) All goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash
h) Verbal orders must only be issued very exceptionally – by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order"
i) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds
j) Goods are not taken on trial or loan in circumstances that could commit the Board to a future uncompetitive purchase
k) Advice is sought from the appropriate supplies advisor, and the Finance Director (and/or the Chief Executive) is consulted if this advice is not acceptable
l) Changes to the list of directors/employees authorised to certify invoices are notified to, and agreed with, the Finance Director
m) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Finance Director
n) Purchases via Purchasing Cards are in accordance with instructions issued by the Finance Director
o) Petty cash records are maintained in a form as determined by the Finance Director.

10.3 Tendering Procedures

10.3.1 The procedure for making all contracts by or on behalf of the Board shall comply with these Standing Financial Instructions.

10.3.2 Directives by the Council of the European Union prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in Standing Orders and Standing Financial Instructions.

10.3.3 The Board shall comply as far as is practicable with the requirements of the "Scottish Capital Investment Manual". In the case of management consultancy contracts the Board shall comply as far as is practicable with SGHSCD guidance "The Use of Management Consultants by Scottish Health Authorities" (MEL (1994) 4).

10.3.4 Where the estimated value of the contract is £10,000 or greater (exclusive of VAT), competitive tenders will be invited for:

- The supply of all goods, materials and manufactured articles not available to the Board through national contracts
- For the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the SGHSCD)
- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens)
- For disposals of assets.

10.3.5 The Chief Executive and Finance Director may dispense with the requirements for competitive tendering or quotations if they jointly agree that it is not possible or desirable to undertake or obtain having regard for all the circumstances. Such decisions and their reasons must be recorded. Formal tendering procedures may be waived with the approval of the Chief Executive and Finance Director where:

a) The time scale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or
b) Specialist expertise is required and is available from only one source; or
c) The task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or
d) There is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
e) The Product has been used within the hospital or other secure units and meets a security need. You must provide evidence of other similar products and the reason why these will not suit. (statement from Security Director is required)or
f) As provided for in the Scottish Capital Investment Manual.

10.3.6 The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

10.3.7 Where it is decided that competitive tendering is not applicable and should be waived by virtue of the above, the fact of the waiver and the reasons must be documented and reported by the Chief Executive to the Board in a formal meeting and recorded in a register kept for that purpose.

10.3.8 Except where 10.3.5 or a requirement under 10.3.2, applies, the Board shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate. This would normally comprise no less than three, firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

10.3.9 The Board shall ensure that normally the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. Where in the opinion of the Finance Director it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive. Suppliers shall normally be chosen in rotation from the list unless the approval of the Chief Executive or nominated officer is given.

10.3.10 Tendering procedures are set out in a separate Financial Operating Procedure.

10.3.11 Quotations are required where formal tendering procedures are waived under 10.3.5 a) or c) and where the intended expenditure or income exceeds, or is reasonably expected to exceed £5,000.

10.3.12 Where quotations are required under 10.3.4 they should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Board.

10.3.13 Quotations should be in writing unless the Chief Executive or nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

10.3.14 All quotations should be treated as confidential and should be retained for inspection.

10.3.15 The Chief Executive or nominated officer should evaluate the quotations and select the one which gives the best value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

10.3.16 Non-competitive quotations in writing may be obtained for the following purposes:

a) The supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or their nominated officer, possible or desirable to obtain competitive quotations
b) The goods/services are required urgently; and

c) Where tenders or quotations are not required, because expenditure is below £5,000, the Board shall procure goods and services in accordance with procurement procedures prepared by the Finance Director.

10.4 Contracts

10.4.1 The Board may only enter into contracts within its statutory powers and shall comply with:

a) Standing Orders
b) Standing Financial Instructions
c) EU Directives and other statutory provisions
d) Any relevant directions including the Scottish Capital Investment Manual and guidance on the Use of Management Consultants (MEL(1994)4)
e) Such of the NHS Standard Contract Conditions as are applicable
f) The key procurement principles set out in CEL 05(2012).

10.4.2 Where appropriate, contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

10.4.3 In all contracts made the Board shall endeavour to obtain best value for money. The Chief Executive shall formally nominate an officer who shall oversee and manage each contract on behalf of the Board.

10.4.4 All contracts entered into by the Board shall contain clauses, standard examples of which are detailed in the Procurement Policy, empowering the Board to:

a) Cancel the contract and recover all losses in full where a company or their representative has offered, given or agreed to give, any inducement to Board staff
b) Recover all losses in full or enforce specific performance where goods or services are not delivered in line with contract terms.

10.4.5 Contracts involving “Funds Held on behalf of the Board” shall be made individually to a specific named fund and shall comply with the requirements of the Charities Acts and regulations.

10.4.6 The Finance Director shall ensure that the arrangements for financial control and the financial and technical audit of building and engineering contracts and property transactions comply with guidance contained within The Property Transaction Handbook CEL (2011)08 and SCIM CEL (2009)19.

10.5 Grants and Similar Payments

10.5.1 Any grants or similar payments to local authorities and voluntary organisations or other bodies shall comply with procedures laid down by the Finance Director which shall be in accordance with the relevant Acts.

10.5.2 The financial limits for officers’ approval of grants or similar payments are set out in the Scheme of Delegation.

10.6 In-house Services

10.6.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Board may also determine from time to time that in-house services should be market tested by competitive tendering.

10.6.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

a) Service specification group, comprising the Chief Executive or nominated officer(s) and specialist(s)
b) In-house tender group, comprising representatives of the in-house team, a nominee of the Chief Executive and technical support
c) Evaluation group, comprising normally a specialist officer, a procurement officer and a Finance Director representative. For services having a likely annual expenditure exceeding £250,000, a Non-Executive Director should be a member of the evaluation group.

10.6.3 All groups should work independently of each other but individual officers may be a member of more than one group. No member of the in-house tender group may, however, participate in the evaluation of tenders.

10.6.4 The evaluation group shall make recommendations to the Board.

10.6.5 The Chief Executive shall nominate an officer to oversee and manage the contract.

11 STORES AND RECEIPT OF GOODS

11.1.1 Subject to the responsibility of the Finance Director for the systems of control, overall responsibility for the control of stores shall be delegated to the Procurement Manager by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Finance Director. The control of Pharmaceutical stocks shall be the responsibility of a nominated pharmaceutical officer; the control of fuel oil and wood fuel of a designated facilities manager.

11.1.2 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the nominated managers.

11.1.3 Wherever practicable, stocks should be marked as health service property.

11.1.4 The Finance Director shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

11.1.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Finance Director.

11.1.6 The nominated managers shall be responsible for a system approved by the Finance Director for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Finance Director any evidence of significant overstocking and of any negligence or malpractice (see also 15, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

11.1.7 Stock levels should be kept to a minimum consistent with operational efficiency.

11.1.8 Stocktaking arrangements shall be agreed with the Finance Director and there shall be a physical check covering all items in store at least once a year.

11.1.9 Those stores designated by the Finance Director as comprising more than seven days of normal use should be:

a) Subjected to annual or continuous stock-take
b) Valued at the lower of cost and net realisable value.

12 RISK MANAGEMENT AND INSURANCE

12.1.1 The Chief Executive shall ensure that the Board has a programme of risk management which will be approved and monitored by the Board.

12.1.2 The programme of risk management shall include:

a) A process for identifying and quantifying risks and potential liabilities
b) Engendering among all levels of staff a positive attitude towards the identification and control of risk
c) Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk
d) Contingency plans to offset the impact of adverse events, including a business continuity plan
e) Audit arrangements including; incident reporting and review, internal audit, clinical audit, health and safety review
f) Arrangements to review and update the risk management programme
g) Development of a financial risk management strategy to cope with possible in-year variations to the initially set budgets.

12.1.3 The existence, integration and evaluation of the above elements will provide a basis for the Audit Committee to provide appropriate assurance to the Directors that the necessary controls are in place to allow the Directors to sign the Governance Statement in keeping with Corporate Governance in the NHS.

12.1.4 The Finance Director shall ensure that appropriate insurance arrangements exist in accordance with the risk management programme.

13 INFORMATION TECHNOLOGY

13.1.1 The Finance Director is responsible for the accuracy and security of the computerised financial data of the Board and shall:

a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Board's data, programs and computer hardware for which she/ he is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 and General Data Protection Regulations (EU) 2016/679 (GDPR).
b) Ensure that adequate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system
c) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment
d) Ensure that the Board is compliant with information regulation and legislation
e) Ensure that electronic signatures are only used with the written approval of the Finance Director
f) Ensure that adequate controls exist for all acquisition/disposal of computer equipment
g) Ensure that an adequate audit trail exists through the computerised system and that such computer audit reviews as he may consider necessary are being carried out
h) Ensure that contingency planning, including business continuity, is undertaken and that adequate contingency arrangements are in place.

13.1.2 The Finance Director shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

13.1.3 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Health Boards /Boards in the area wish to sponsor jointly) all responsible directors and employees will send to the Finance Director:

a) Details of the outline design of the system
b) Contract details and/or standard contract conditions
c) In the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

These should form part of the national e-Health platform and be procured using framework agreements as set out in section 10.2.2, unless not suitable for the organisations due to cost or functionality.

13.1.4 The Finance Director shall ensure that for contracts for computer services for financial applications with another body, the Board periodically seek assurances that adequate controls are in operation, such as service audits.

13.1.5 Where computer systems have an impact on corporate financial systems the Finance Director shall satisfy him/herself that:

a) Systems acquisition, development and maintenance are in line with corporate policies such as the eHealth Strategy
b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that an audit trail exists
c) Systems are appropriate for future business need as well as the present
d) Finance Directorate staff have access to such data
e) Such computer audit reviews as are considered necessary are being carried out.

13.1.6 The Associate Medical Director shall devise and implement any necessary procedures to protect the Board and individuals from inappropriate use or misuse of patient confidential information held on computer files after taking account of the Data Protection Act 1998 and General Data Protection Regulations (EU) 2016/679 (GDPR). The appointed Information Governance and Data Security Officer will provide the same assurances over all other non patient data.

13.1.7 The Finance Director shall devise and implement any necessary procedures to comply with the Freedom of Information (Scotland) Act 2002.

14 AUDIT

14.1 Audit Committee

14.1.1 In accordance with Standing Orders the Board shall formally establish an Audit Committee, with clearly defined terms of reference, which will consider:

a) Internal control and corporate governance, including ensuring that relevant controls are in place and that appropriate assurances can be provided to allow the directors to sign the required statements
b) Internal audit
c) External audit
d) Standing orders and standing financial instructions
e) Accounting policies
f) Annual accounts (including the schedules of losses and compensations).

14.1.2 Where the Audit Committee is satisfied there is evidence of ultra vires transactions, evidence of improper acts, or any other issue, the Chair of the Audit Committee should raise the matter at a meeting of the Board or convene an emergency Board meeting if required. Exceptionally, the matter may need to be referred to the SGHSCD.

14.1.3 It is the responsibility of the Audit Committee with the guidance of the Finance Director to ensure that both an effective and cost effective internal audit service is provided. The Finance Director will retender Internal Audit services at least every five years. The Review panel will include the Chairman of the Audit Committee, the Chief Executive and the Finance Director and may also include other members of the Audit Committee. Tendering will be done on the basis of Technical ability, a Qualitative assessment and affordability.

14.2 Finance Director

14.2.1 The Finance Director is responsible for:

a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control, including the establishment of an effective internal audit function
b) Ensuring that Internal Audit is adequate and meets the NHS mandatory audit standards
c) With regard to the Governance Statement, arranging for the provision of the necessary compliance evidence which would:

- Identify and disclose where there is a significant control weakness
- Show where a control has been introduced during the financial year;

d) Developing and documenting an effective Fraud, Theft and Other Financial Irregularity Policy, and
e) Investigating cases of fraud, misappropriation or other irregularities, in consultation with the Chief Internal Auditor, Counter Fraud Service and the Police, where appropriate and shall notify the Chief Executive and Audit Committee
f) Ensuring that the Chief Internal Auditor prepares a detailed operational plan each financial year for approval by the Audit Committee
g) Ensuring that an annual internal audit report is prepared by the Chief Internal Auditor, in accordance with the timetable laid down by the Audit Committee, for the consideration of the Audit Committee and the Board. The report must cover:

- A clear statement on the effectiveness of internal control
- Major internal control weaknesses discovered
- Progress on the implementation of internal audit recommendations
- Progress against plan over the previous year.

14.2.2 The Finance Director or designated auditors are entitled without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature
b) Access at all reasonable times to any land, premises or employees of the Board
c) The production of any cash, stores or other property of the Board under an employee's control
d) Explanations concerning any matter under investigation.

14.3 Internal Audit

14.3.1 The role, objectives and scope of Internal Audit are set out in the mandatory Public Sector Internal Audit Standards.

14.3.2 Internal Audit will review, appraise and report upon:

a) The extent of compliance with and the financial effect of relevant established policies, plans and procedures
b) The adequacy and application of financial and other related management controls, including internal financial controls
c) The suitability of financial and other related management data
d) The extent to which the Board's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

- Fraud and other offences
- Poor risk assessment
- Waste, extravagance, inefficient administration
- Poor value for money or other causes.

14.3.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Finance Director must be notified immediately.

14.3.4 The Chief Internal Auditor, or appointed representative, will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairperson and Chief Executive of the Board.

14.3.5 The Chief Internal Auditor shall be accountable to the Finance Director. The reporting and follow-up systems for internal audit shall be agreed between the Finance Director, the Audit Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standardsl. The reporting and follow-up systems shall be reviewed at least every 3 years.

14.3.6 The Chief Internal Auditor shall issue reports in accordance with the Internal Audit reporting mechanism agreed by the Audit Committee. Failure to take any necessary remedial action within a reasonable period shall be reported to the Chief Executive. Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation of the objectivity of the audit, the Chief Internal Auditor shall seek the advice of the Chairperson of the Board.

14.4 External Audit

14.4.1 The external auditor is concerned with providing an independent assurance of the Board's financial stewardship including value for money, probity, material accuracy, compliance with guidelines and accepted accounting practice for NHS accounts. Responsibility for securing the audit of the Board rests with Audit Scotland. The appointed External Auditor's statutory duties are contained in the Public Finance and Accountability (Scotland) Act 2000.

14.4.2 The external auditor has a general duty to satisfy him/herself that:

a) The Board's accounts have been properly prepared in accordance with directions given under s86(1) of the National Health Service (Scotland) Act 1978
b) Proper accounting practices have been observed in preparation of the accounts
c) The Board has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources
d) The Internal Audit function is adequate.

14.4.3 In addition to these responsibilities, Audit Scotland's Code of Audit Practice requires the appointed auditor to consider:

a) Whether the statement of accounts presents a true and fair view of the financial position of the Board
b) The Board's main financial systems
c) The arrangements in place at the Board for prevention and detection of fraud and corruption
d) Aspects of the performance of particular services and activities
e) The Board's management arrangements to secure economy, efficiency and effectiveness in the use of resources.

14.4.4 The Board's Audit Committee provides a forum through which Non-Executive Directors can secure an independent view of any major activity within the appointed auditor's remit. The Audit Committee has a responsibility to ensure that the Board receives a cost-effective service and that co-operation with senior managers and Internal Audit is appropriate.

15 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

15.1 Disposals and Condemnations

15.1.1 The Finance Director shall maintain detailed procedures for the disposal of assets (excluding land) including condemnations, and ensure that these are notified to managers.

15.1.2 When it is decided to dispose of an asset, the head of department or authorised deputy will determine and advise the Finance Director of the estimated market value of the item, taking account of professional advice where appropriate.

15.1.3 All unserviceable articles shall be:

a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Finance Director
b) Recorded by the relevant officer, in a form approved by the Finance Director, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Finance Director.
c) The relevant officer shall ensure that any article disposed of, is done so in accordance with appropriate guidance or regulations.
d) The relevant officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Finance Director who will take the appropriate action.

15.1.4 The Security Director will ensure that the Board complies with the Property Transactions Handbook and will ensure that detailed procedures are in place for the disposal of land.

15.2 Losses and Special Payments

15.2.1 The Finance Director must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

15.2.2 Special payments are defined in more detail in the Scottish Public Finance Manual. The main types which may be relevant to the State Hospital are:

- A compensation payment is one made in respect of unfair dismissal in respect of personal injuries, traffic accidents, damage to property etc, suffered by staff or by others.
- Special severance payments are paid to employees beyond and above normal statutory or contractual requirements when leaving employment in public service whether they resign, are dismissed or reach an agreed termination of contract. See the section of the SPFM on Severance, Early Retirement and Redundancy Terms.
- Ex gratia payments are payments made where there is no legal obligation to pay. There must always, however, be good public policy grounds for making such payments. Into this category will fall some out of court settlements, such as cases where the pursuer has no legal case but the Board wants to stop the litigation because it is costly in time and resources. It would not however include cases where the settlement is a negotiated price to settle a potentially higher legal liability. Other examples of ex gratia payments would be payments as compensation for distress or loss arising from a perceived failure of the Board but where there was no legal obligation to pay.

15.2.3 Within limits delegated to it by the SGHSCD (CEL 10 (2010), the Board, following the recommendation of the Audit Committee, shall review the Summary of Losses and Special Payments which shall be prepared by the Finance Director in the form laid down in the Health Board Manual for Accounts, SFR 18.

	No of Cases	£	Delegated Limit
Theft / Arson / Wilful Damage			
Cash			10,000
Stores/procurement			20,000
Equipment			10,000
Contracts			10,000
Payroll			10,000
Buildings & Fixtures			20,000
Other			10,000
Fraud, Embezzlement & other irregularities (inc. attempted fraud)			
Cash			10,000
Stores/procurement			20,000
Equipment			10,000
Contracts			10,000
Payroll			10,000
Other			10,000
Nugatory & Fruitless Payments			10,000
Claims Abandoned:			
(a) Private Accommodation			10,000
(b) Road Traffic Acts			20,000
(c) Other			10,000
Stores Losses:			
Incidents of the Service			
- Fire			20,000
- Flood			20,000
- Accident			20,000
Deterioration in Store			20,000
Stocktaking Discrepancies			20,000
Other Causes			20,000
Losses of Furniture & Equipment and Bedding & Linen in circulation:			
Incidents of the Service – Fire			10,000
- Flood			10,000
- Accident			10,000
Disclosed at physical check			10,000
Other Causes			10,000
Compensation Payments - legal obligation			
Clinical			250,000
Non-clinical			100,000
Ex-gratia payments:			
Extra-contractual Payments			10,000
Compensation Payments - ex-gratia - Clinical			250,000
Compensation Payments - ex-gratia - Non Clinical			100,000
Compensation Payments - ex-gratia - Financial Loss			25,000
Other Payments			2,500
Damage to Buildings and Fixtures:			
Incidents of the Service – Fire			
- Fire			20,000
- Flood			20,000
- Accident			20,000
- Other Causes			20,000
Extra-Statutory & Extra-regulationary Payments			0
Gifts in cash or kind			10,000
Other Losses			10,000

15.2.4 The Finance Director shall be authorised to take any necessary steps to safeguard the Board's interests in bankruptcies and company liquidations.

15.2.5 For any loss, the Finance Director should consider whether any insurance claim can be made.

15.2.6 The Board shall delegate to the Chief Executive and the Finance Director, acting jointly, its responsibility for the approval of losses and authorisation of special payments for such categories or values of losses as within limits to the Board by the SGHSCD.

15.2.7 The Finance Director shall maintain a Losses and Special Payments Register in which write-off action is recorded.

15.2.8 No losses or special payments exceeding delegated limits (CEL 10 (2010)) shall be written off or made without the prior approval of the SGHSCD.

15.3 Theft, Fraud, Embezzlement, Corruption and Other Financial Irregularities

15.3.1 The Finance Director must prepare a 'fraud response plan', incorporating the requirements of HDL (2004) 23, updated by CEL(2009)18, that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

15.3.2 The Finance Director will be the nominated contact for the National Fraud Initiative (NFI) and will authorise the release of the required data for this purpose. The Finance Director may delegate the NFI investigation and reporting requirements, to suitable representatives. The Finance Director will ensure that all staff receive the required notifications that their information will be used for this purpose.

15.3.3 The following procedures should be followed, as a minimum, in cases of suspected theft, fraud, embezzlement, corruption or other financial irregularities to comply with Scottish Government Health Department Circular No HDL(2002)88 This procedure also applies to any non-public funds.

15.3.4 The Chief Executive has the responsibility to designate an officer within the Board with specific responsibility for co-ordinating action where there are reasonable grounds for believing that an item of property, including cash, has been stolen.

15.3.5 It is the designated officer's responsibility to inform as he/she deems appropriate the police, the Counter Fraud Services (CFS), the appropriate director, the Appointed Auditor and Internal Auditor where such an occurrence is suspected.

15.3.6 Where any officer of the Board has grounds to suspect that any of the above activities has occurred, his or her local manager should be notified without delay. Local managers should in turn immediately notify the Board's Finance Director, who should ensure consultation with the CFS, normally by the Fraud Liaison Officer. It is essential that preliminary enquiries are carried out in strict confidence and with as much speed as possible.

15.3.7 If, in exceptional circumstances, the Finance Director and the Fraud Liaison Officer are unavailable the local manager will report the circumstances to the Chief Executive who will be responsible for informing the CFS. As soon as possible thereafter the Director of Finance should be advised of the situation.

15.3.8 Where preliminary investigations suggest that prima facie grounds exist for believing that a criminal offence has been committed, the CFS will undertake the investigation, on behalf of, and in co-operation with, the Board. At all stages the Finance Director and the Fraud Liaison Officer will be kept informed of developments on such cases. All referrals to the CFS must also be copied to the Appointed Auditor.

15.3.9 The Chief Executive has also the responsibility to designate an officer within the Board as Counter Fraud Champion. The role is a strategic one, and focuses on spearheading change in culture and attitudes towards NHS fraud. Full background to this role is included within CEL 3 (2008). As such the role of Champion will complement the role of the Fraud Liaison Officer and includes responsibility for:

- Raising the profile of counter fraud initiatives and publicity
- Ensuring recommendations from investigation reports by NHSScotland Counter Fraud Services (CFS) are implemented
- Monitor implementation of CFS recommendations and ensure compliance with them
- Set clear guidelines and measures for monitoring the effectiveness of implementation.

15.4 Remedial action

15.4.1 As with all categories of loss, once the circumstances of a case are known the Finance Director will require to take immediate steps to ensure that so far as possible these do not recur. However, no such action will be taken if it would prove prejudicial to the effective prosecution of the case. It will be necessary to identify any defects in the control systems, which may have enabled the initial loss to occur, and to decide on any measures to prevent recurrence.

15.5 Reporting to the SGHSCD

15.5.1 Under Enhanced Reporting of NHS Fraud & Attempted Fraud CEL (2010)10 an annual return SFR18 must be completed, as part of the annual account process, to report all cases of Fraud to the SGHSCD. There may be occasions where the nature of scale of the alleged offence or the position of the person or persons involved, could give rise to national or local controversy and publicity. Moreover, there may be cases where the alleged fraud appears to have been of a particularly ingenious nature or where it concerns an organisation with which other health sector bodies may also have dealings. In all such cases, the SGHSCD must be notified of the main circumstance of the case at the same time as an approach is made to the CFS. However all significant or unusual incidents involving patients' finds or endowments should be reported to the SGHSCD.

15.6 Responses to Press Enquiries

15.6.1 Where the publicity surrounding a particular case of alleged financial irregularity attracts enquiries from the press or other media, the Chief Executive should ensure that the relevant officials are fully aware of the importance of avoiding issuing any statements, which may be regarded as prejudicial to the outcome of criminal proceedings.

15.7 Counter Fraud Services (CFS) – Access to Data

15.7.1 CFS work closely with the Board and may at times require access to evidence relating to ongoing investigations. Scottish Government Health & Social Care Directorate endorse that Boards should support the important role played by CFS and that any CFS staff acting on the Finance Director's behalf should be allowed access to the following:

- All records, documents and correspondence relating to relevant transactions
- At all reasonable times, access to any premises or land of The State Hospital
- The production or identification by any employee of the Board, cash, stores or other property under the employee's control

16 PATIENTS' PROPERTY

16.1.1 The Board has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients.

16.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission that the Board will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

16.1.3 The Security Director must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16.1.4 Where SGHSCD instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Finance Director.

16.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained. Any payment by the Hospital towards funeral expenses should be approved by the Finance Director.

16.1.6 Staff should be informed, on appointment, formally in writing by the Human Resources Director and by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

16.1.8 The Finance Director shall prepare an abstract of receipts and payments of patients' private funds in the form laid down in the Health Board Accounts Manual. This abstract shall be audited independently and presented to the Audit Committee annually.

16.1.9 In general staff are not allowed to receive benefit from any patient's Will. If staff become aware of an intention to include themselves in a Will, staff should discourage such action. This should be reported to the appropriate manager. Anyone receiving a bequest should report this to their line manager to determine further action. Except in cases of the direst emergency, staff should not be involved in witnessing or otherwise in the making of a patient's Will. Any reference of such matters by a patient to a member of staff should immediately be communicated to Advocacy or the Board management, who may arrange for a local solicitor's services to be made available to the patient, if that is wished.

16.1.10 In order to comply with the Gambling Act 2005, patients are not allowed to gamble or place bets. Clinical staff should therefore not approve any requests from patients to withdraw funds for this purpose.

17 FUNDS HELD ON TRUST

17.1.1 Standing Orders (SOs) identify the Board's responsibilities as a corporate Trustee for the management of funds it holds on Trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Board, the Trustee responsibilities must be discharged separately and full recognition given to the dual accountabilities to the Charity Commission for charitable funds held on Trust and to the Scottish Ministers for all funds held on Trust.

17.1.2 The reserved powers of the Board and the Scheme of Delegation clarify responsibility for decisions regarding the dispersal of funds held on Board. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate Trustee.

17.1.3 The over-riding principle is that the integrity of each fund must be maintained and statutory and Board obligations met. Materiality must be assessed separately from Exchequer activities and funds.

17.1.4 The Finance Director shall prepare aggregated annual accounts for funds held on Trust by the Board, to be audited independently and presented to the Audit Committee annually, with the auditor invited to attend the meeting.

17.1.5 CEL (2009)40 Guidance for NHS Boards on accepting charitable donations should be adhered to.

18 RETENTION OF DOCUMENTS

18.1.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in SHM 58/60, NHS MEL (1993)152 “Guidance for the Retention and Destruction of Health Records” and HDL (2006) 28 “The Management, Retention and Disposal of Administrative Records”, The Scottish Government records management: NHS code of practice (Scotland) version 2.1: 11 January 2012.

18.1.2 The documents held in archives shall be capable of retrieval by authorised persons.

18.1.3 Documents held under the above guidance shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

19 STANDARDS OF BUSINESS CONDUCT

19.1 General Responsibility

19.1.1 It shall be the responsibility of the Chief Executive to:

- Ensure that the Scottish Government Health and Social Care Directorate guidelines on standards of business conduct for NHS staff (MEL (1994) 48) are brought to the attention of all staff, and effectively implemented
- Develop local policies and the processes to implement them, in consultation with staff and local staff representatives
- Ensure that such policies are kept up to date.

19.1.2 The Ethical Standards in Public Life etc. (Scotland) Act 2000 provides a code of conduct for members of The State Hospitals Board for Scotland. This code was incorporated into Board Standing Orders in May 2003. The principles that apply to gifts and hospitality set out in Standing Orders (Section 3) apply equally to all staff.

19.2 Acceptance of Gifts and Hospitality

19.2.1 The acceptance of gifts, hospitality or consideration of any kind from contractors and other suppliers of goods or services as an inducement or reward is not permitted under the Corruption Acts 1906 and 1916. In the event of a contractor or other supplier of goods or services making such an offer to any officer, either for their personal benefit or the "benefit" of the Board, the guidance given in HSG(93)5 and NHS Circular HDL (2003) 62 (or subsequent guidance issued by the Scottish Government Health and Social Care Department) must be followed. Initially, the matter must be reported to an individual's line manager, or the relevant Director. Acceptance, or refusal, of gifts or hospitality must be entered in a Register of Hospitality and Interests, which will be maintained by the Finance Director. The register will also record details of hospitality provided by the Board's employees:

a) Articles of a low intrinsic value, such as business diaries or calendars, need not be refused
b) Care should also be taken in accepting hospitality such as lunches and dinners, corporate hospitality events etc. All such offers should be reported to the officers line manager before accepting.
c) Visits at suppliers expense to inspect equipment etc should not be undertaken without the prior approval of the Chief Executive and in the case of the Chief Executive by the prior approval of the Chairman. Costs associated with such visits will be borne by The State Hospital.
d) If officers are involved in the acquisition of goods and services they should adhere to the ethical code of the Institute of Purchasing and Supply.
e) Officers should ensure that the acceptance of commercial sponsorship will not influence or jeopardise purchasing decisions.

19.3 Private Transactions

19.3.1 Where offers of goods or services do not involve inducement or reward, employees should still not accept gifts from commercial sources other than inexpensive articles such as calendars or diaries. If any such gifts should arrive unsolicited, the advice of the Finance Director should be sought.

19.4 Declaration of Interest

19.4.1 Employees having official dealings with contractors and other suppliers of goods or services should avoid transacting any kind of private business with them by means other than normal commercial channels. No favour or preference as regards price or otherwise which is not generally available should be sought or accepted.

19.4.2 In accordance with Standing Order 5, the Chief Executive shall be advised of declared pecuniary interests of Directors or senior staff for recording in the Register of Hospitality and Interests.

19.4.3 The Finance Director is responsible for putting in place arrangements for staff to declare interests. In accordance with Data Protection principles, access is strictly controlled on a need to know basis. The only department likely to be passed this information would be the Procurement Department where there may be concern about the possibility of entering into contracts with organisations which could conflict with registered interests.

Annex 1 Minimum Financial Controls
(extract from guidance on preparation of Statement of Internal Control March 2010)

Corporate Governance	
The Control Environment	
Public Finance & Accountability (Scotland) Act 2000 HDL(2003)11	Code of Corporate Governance
SSI(2001)301/2 MEL(1994)80	Standing Orders
MEL(1994)80, Annex 4 MEL(1992)35	Scheme of Reservation and Delegation
Appointed Officer Memorandum SSI(2001) 301/2	Accountable Officer Responsibilities
MEL(1994)80, MEL(1996)42 HDL(2002)25, SGHD Audit Committee Handbook	Audit Committee
HDL(2002)11, MEL(1996)42	Internal Audit function
Section 2 of the National Health Service Reform (Scotland) Act 2004 HDL(2002)11	Structures of assurance including CHPS
The Community Care (Joint Working etc.) (Scotland) Regulations 2002 CCD5/2005 CCD11/2002 Governance for Joint Services (Paper by Audit Scotland, Scottish Government & COSLA)	Partnerships including Joint Futures
Identification and Evaluation of Risks and Objectives	
HDL(2006)12 HDL(2004)46	Local Development Plan and regional planning
MEL(1994)15, MEL(1999)14, MEL(1994)80	Risk Management
Control Processes	
	Compliance with laws and regulations

Monitoring and Corrective Action	
MEL(1994)80, Annex 5	Performance reporting
MEL(1994)80, Annex 9	Policies, procedures and control frameworks
Best Value in Public Services – Secondary Guidance to Accountable Officers	Best Value
Clinical Governance	
MEL(1998)75, MEL(1998)29, MEL(2000)29, HDL(2005)41	Clinical Governance Committee
HIS Standards	Health Improvement Scotland Reports
Staff Governance	
HDL(2004)39, HDL(2005)52 Staff Governance Standard	Staff Governance Committee
HDL(2006)54, HDL(2006)23 HDL(2002)64, MEL(1994)80, Annex 1	Remuneration Committee
KSF/Agenda for Change guidance	Performance management and development
Financial Governance	
SI(1994)No. 468	Financial reporting
MEL(1994)80 NHS 1974(GEN)88	Standing Financial Instructions
MEL(1994)48 Standards Commission	Standards of Business Conduct Model Code of Conduct
HDL(2005)5 MEL(1994)48 RIPSA CEL11(2013)	Fraud Theft & Corruption Policy and Response Plan
NHS 1974(GEN)88	Budgetary control system
SI(94) No 468, MEL(1994)80, Annex 9 HDL(2001)49	Financial Procedures

MEL(1992)35 &59 ,MEL(1998)9	Acquisition, use, disposal and safeguarding of assets
MEL(1992)18 HDL(2002)87, MEL(1996)48, SCIM	Capital investment control and project management
MEL(1992)8 MEL(1992)9	Property transactions procedures Delegation of authority: land transactions
Annual Accounts Manual Capital Accounting Manual SPFM	Financial accounting and annual accounts presentation Capital accounting policy and guidance Financial policies and guidance for Scottish central government bodies
Schedule 6, part 11,section 6(1) 1990 Health Act Accountable Officer Memorandum	Arrangements to ensure resources are used effectively, efficiently and economically
Scottish Government IFRS Technical Application Notes	Application of International Financial Reporting Standards from 2009/10 and the International Financial Reporting Manual issued by HM Treasury
Health Workforce & Performance Directorate Guidance 13 March 2015	Settlement Agreements
Information Governance	
MEL(1994)64 HDL(2005)46 NHSScotland eHealth Strategy Board guidance	IM&T strategy
HDL(2006)41 MEL(1992)14 MEL(1992)45 NHS Information System Security Manual issued under MEL(1994)75	Information Security Policy
NHS Scotland Information Governance Standards	Information Governance Toolkit and annual improvement plan

THE STATE HOSPITALS BOARD FOR SCOTLAND

SCHEME OF DELEGATION

VERSION 11

Version Control Log		
Version	**Date**	**Description**
1	July 2005	Approved By Board
2	May 2006	Annual Review presented to Audit Committee.
2.1	5 June 2006	Approved by the Board on 22 June 06.
3.0	11 June 2007	Approved by the Board on 21 June 2007.
3.1	24 April 2008	Approved by the Board on 19 June 2008.
4.0	30 April 2009	Presented to Audit Committee on 30 April 2009. Detailed Scheme – No change Financial limits • 13.6 – Constraint text "subject to appointment of bankers by Board" removed • 14.3 (d) – "Annually" added to Virement of Budget "per event over £25,000 and up to £100,000" Several instances referring to SEHD updated to SGHD.
4.1	16 July 2009	Approved by the Board 18 June 2009
4.2	24 September 2009	Changed to reflect portfolio changes. Approved by Audit Committee 24 September 2009.
4.3	April 11	Changes proposed to board
	June 11	Changes approved by the board
4.4	April 12	Changes approved by the board
5	April 13	Changes to SFI references to agree to SFI's Approved by Audit Committee on 25 April 2013
5.1	April 13	Approved by Board 2 May 2013
6	April 14	Changes to SO references to agree to SO's. Changes to responsibilities to reflect portfolio changes and changes in staff. Financial limits amended to reflect limits in Pecos system • 14.8 a) Capital value changed from £1.800 to £2,400 • 14.8 b) eHealth capital value added - value up to £4,000 and value up to £24,000 Approved by Audit Committee 24 April 2014. Approved by Board 26 June 2014.

7	April 15	Amended PFPI to Equality & Involvement Added Achievement of savings to 14.3 Management of Budgets Changes to 16.1.3 re change in responsibility of patients property. Approved by Audit Committee 2 April 2015 after changes to reflect that Remuneration Committee is no longer a sub committee.
8	March 16	Changes to responsibilities to reflect portfolio changes re L&D PO approval 14.7 – added in Procurement Team Leader Asset disposals 14.10 – removed Security Director limit up to £10k and replaced with Finance Director. Added authorised deputy.
8.1	June 16	Financial limit for waiver of tenders 14.9 increased from £3k to £5k. Approved by Audit Committee and Board 23 June 2016.
9	March 17	Changed Nursing Director to Director of Nursing & AHP and removed reference to General Manager. Approved by Audit Committee 23 March 2017 Approved by Board 4 May 2017
10	March 18	Section 3 & 13.5 - change financial monitoring forms to Financial Performance Returns. Clinical Effectiveness Strategy 6.2 replaced with Quality Assurance and Improvement Strategy. IM&T Security11.8 – change title of authorised deputy to Information Governance and Data Security Officer. Approved by Audit Committee 5 April 2018
11	June 18	Section 14.7 –-Pay Revenue Expenditure – Requisitioning / Ordering of Goods and Services 14.7c – change to >£15k - <£20k 14.7d – change to >£10k - <£15k 14.7e – change to >£5k - <£10k 14.7f – change to >£1k - <£5k Approved by Audit Committee 28 June 2018

1. DELEGATION OF POWERS

1.1 Delegation to Committees

1.1.1 Under Standing Order (SO) B20, the Board may determine that certain of its powers shall be exercised by committees. Under SO D27 each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board) as the Board shall decide. In accordance with SO D28d committees may not delegate executive powers to sub-committees unless expressly authorised by the Board.

1.1.2 Under the SO D27c the committees established by the Board are:

Clinical Governance Committee
Staff Governance Committee
Audit (Finance) Committee
Remuneration Committee

2. SCHEME OF DELEGATION TO OFFICERS

2.1 Role of the Chief Executive

2.1.1 All powers to the Board which have not been retained as reserved by the Board or delegated to a committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions he/she shall perform personally and which functions have been delegated to other Directors and Officers. This scheme will be reviewed annually in March of each year.

2.1.2 The Chief Executive is accountable to the Board and as Accountable Officer is also accountable to the Principal Accountable Officer of the NHS in Scotland and the Scottish Parliament for ensuring that the Board meets its obligation to perform its functions within available financial resources.

2.1.3 The Chief Executive shall have overall executive responsibility for the Hospital's activities and shall be responsible to the Board for ensuring that its financial obligations and targets are met and shall have overall responsibility for the Board's system of internal financial control.

2.1.4 All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. As Accountable Officer the Chief Executive is accountable to the Principal Accountable Officer of the Scottish Government Health and Social Care Directorate (SGHSCD) for the funds entrusted to the Board.

2.2 Caution over the Use of Delegated Powers

2.2.1 Powers are delegated to Directors and Officers on the understanding that they would not exercise delegated powers in a manner that in their judgement was likely to be a cause for public concern.

2.3 Directors' Ability to Delegate their own Delegated Powers

2.3.1 The Scheme of Delegation shows the "top level" of delegation within the Board. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Board.

2.4 Absence of Directors and Officers to Whom Powers have been Delegated

2.4.1 In the absence of a Director or Officer to whom powers have been delegated those powers shall be exercised by that Director or Officer's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent powers delegated to him/her shall be exercised in accordance with the Accountable Officer Memorandum.

2.4.2 Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive (CE), the Finance Director (FD) and other Directors. These responsibilities are summarised below.

2.4.3 Certain matters need to be covered in the Scheme of Delegation that are not covered by SFIs or SOs as they do not specify the responsible Officer.

2.4.4 This Scheme of Delegation covers only matters delegated by the Board to Directors and certain other specific matters referred to in SFIs. Each Director is responsible for the delegation within their sphere of responsibility. They should produce a Scheme of Delegation covering their area of responsibility and in particular the Scheme of Delegation should include how their budget responsibility and procedures for approval of expenditure are delegated.

3. SCHEME OF DELEGATION ARISING FROM STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

	SO Reference	Delegated to	Duties Delegated
	A 4	CE	Maintenance of Register of Board Members Interests

	SFI Reference	Delegated to	Duties Delegated
	1.1.5	FD	Approval of all financial procedures.
	1.3.9	CE	To ensure all employees and directors, present and future, are notified of and understand Standing Financial Instructions.
	1.3.10	FD	Responsible for implementing the Board's financial policies and co-ordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented.
	1.3.10	FD	Maintaining an effective system of internal financial control
	1.3.10	FD	Ensuring that sufficient records are maintained to show and explain the Board's transactions
	1.3.14	ALL DIRECTORS AND EMPLOYEES	Ensuring that the form in which financial records are kept and the manner in which directors and employees discharge their duties is to the satisfaction of the Finance Director.
	3.1.1	CE	Submit to the Board an annual strategic plan covering 3 year period.
	3.1.2 & 3.1.3	FD	Submit budgets to Board and monitor performance against budget and strategic plan.
	3.2	CE	Delegate management of budgets to budget holders.
	3.3	FD	Devise and maintain systems of budgetary control.
	3.3	FD	Deliver adequate training on an ongoing basis to budget holders to enable them to manage effectively.
	3.4	CE	Identifying and implementing cost improvements and income generation initiatives.
	3.6	CE	Ensuring that the required financial performance returns are submitted to the SGHSCD.
	4	FD	Prepare annual accounts, financial returns and supporting papers
	5.1	FD	Managing the Board's banking arrangements
	6.1	FD	Designing, maintaining and ensuring compliance with income systems.
	7.1	CE	Capital programme investment process, and scheme of delegation for capital investment management.
	7.1.4	FD	Procedures for the regular reporting of expenditure and commitment, including reporting to the Board.
	7.1.9	FD	Procedures for financial management of capital investment.

	SFI Reference	Delegated to	Duties Delegated
	7.2	CE	Maintenance of asset registers.
	7.2.4	FD	Procedures for reconciling balances on ledgers to fixed asset registers.
	7.3	CE	Overall responsibility for fixed assets.
	7.3.2	FD	Asset control procedures.
	8	CE	Agreeing service agreements for provision of patient services.
	9.1	HR Director	Application of pay and expenses rates within arrangements approved by Remuneration Committee and Scottish Government circulars and guidance.
	9.2	CE	Variation of funded establishment from annual budget.
	9.3	CE	Delegation of authority to engage, re-engage, regrade employees, hire agency staff, or agree changes in remuneration.
	9.4	HR Director	Contracts of employment.
	9.5	HR Director	Pay and Payroll documentation.
	9.6	FD	Processing of payroll.
	9.7	HR Director / FD	Early retirement and redundancy policy and procedures.
	9.8	HR Director	Removal expenses policy and procedures.
	10.1.1	CE	Determine, and set out, level of delegation of non-pay expenditure to budget managers.
	10.1.2 & 10.1.3	FD	Identify managers who are authorised to place requisitions including maximum levels and set out procedures on the seeking of professional advice
	10.2	FD	Procedures for seeking advice on supply of goods and services.
	10.2.3	FD	Prompt payment of accounts.
	10.2.4	FD	Advise the Board regarding setting thresholds for quotations or tenders.
	10.2.4	FD	Designing a system of verification for all non pay amounts payable.
	10.2.6	CE	Authorise who may use and be issued with official orders.
	10.3.5	CE / FD	Dispensing with need for competitive tendering or quotations.
	10.5	FD	Procedures for payment of grants to local authorities and voluntary organisations.
	10.6	CE	Best value achieved for all services provided under contract or in-house.
	11.1.1	CE	Identify person with overall responsibility for control for stores.
	11.1.3	FD	Procedures and systems to regulate the stores.
	11.1.7 & 11.1.8	FD	Stocktaking arrangements.
	12.1.1	CE	Risk management programme including Health and Safety.
	12.1.4	FD	Insurance arrangements.

	SFI Reference	Delegated to	Duties Delegated
	13.1.1	FD	Responsible for accuracy and security of computerised financial data.
	13.1.2	FD	Development of new financial systems and amendments to existing systems.
	13.1.4 & 13.1.5	FD	Contracts for computer services for financial applications
	13.1.6	Associate MD	Procedures to comply with the Data Protection Act.
	13.1.7	FD	Procedures to comply with the Freedom of Information Act.
	14.2.1	FD	Developing and implementing Fraud, Theft and Irregularity Policy.
	14.2.1	FD	Investigate fraud or other irregularity in consultation with Chief Internal Auditor and Counter Fraud Services.
	14.3	FD	Arrangements to report on effectiveness of internal control.
	14.3	FD	Arrangements for internal audit.
	14.3	Chief Internal Auditor (CIA)	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
	15.1	FD	Procedures for disposal of assets including condemnations.
	15.1.4	Security Director	Procedures for disposal of land including compliance with Property Transactions Handbook.
	15.2	FD	Maintain procedures for recording and accounting for losses and special payments; maintaining a register.
	15.2.8	CE & FD	Approval of losses and authorisation of special payments within limits set by SGHSCD.
	15.3	FD	Preparing a “Fraud Response Plan”
	15.3.4	CE	Designating a Fraud Liaison Officer.
	15.3	Fraud Liaison Officer	Notifying police, Counter Fraud Service, appropriate Director, appointed Auditor and Internal Audit in respect of theft.
	15.3	Counter Fraud Services	Investigating instances of *prima facie* grounds for believing a criminal offence has been committed.
	16.1.2	CE	Ensure patients or guardians informed of extent of Board’s liability or responsibility for patients property brought into Health Service property.
	16.1.3	Security Director	Provide detailed written instructions on collection, custody, investment, recording, safekeeping and disposal of patients' property.
	16.1.5	FD	Approval of payment towards costs of funeral expenses.
	16.1.6	HR Director	Advise staff on appointment of their responsibilities and duties in respect of the administration of patients’ property.

	SFI Reference	Delegated to	Duties Delegated
	16.1.8	FD	Preparing an abstract of receipts and payments for patients' funds, for presentation to the Audit Committee annually; with independent audit.
	17	FD	Preparing aggregated annual accounts for funds held on Trust by the Board; with independent audit.
	18.1.1	CE	Retention of document procedures.
	19.1	CE	Standards of Business Conduct policy.
	19.2	FD	Maintain a Register of Gifts and Hospitality.
	19.4	CE	Maintain Register of Board members interests
	19.4	FD	Maintain a Register of staff members interests

THE STATE HOSPITALS BOARD FOR SCOTLAND
SCHEME OF DELEGATION

1. Organisational Scope / Profile

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
1.1 Preparation and Maintenance of Service Directory	Chief Executive	Director of Nursing & AHP	N/A	CG & RM Standards

2. Corporate Governance

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
2.1 Maintenance of Register of Board Member Interests	Chief Executive	N/A	N/A	Standing Orders A4
2.2 Scheme of Delegation Responsibility for preparation and update of Scheme	Chief Executive	Finance Director	N/A	CG & RM standards, SG standards, Governance Statement
2.3 Sealing of Documents	Chief Executive	N/A	N/A	Standing Orders E28

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
2.4 Distribution of all relevant new legislation, regulations, good practice and case law	Chief Executive	N/A	N/A	CG & RM standards
3. Communications				
3.1 Preparation of Communications Strategy				
Overall communications framework	Chief Executive	Head of Communications	N/A	
Internal (staff)	Chief Executive	Head of Communications	N/A	SG Standards
External	Chief Executive	Head of Communications	N/A	CG & RM Standards
Patients and Carers	Director of Nursing & AHP	Involvement & Equality Lead	N/A	CG & RM Standards

4. Planning and Performance

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
4.1 Preparation and Implementation of the Delivery Plan	Chief Executive	Finance Director	as per supporting Financial Plan	SGHSCD letter CG & RM standards
4.2 Preparation of Corporate Objectives, Targets, Measures	Chief Executive	Finance Director	as above	SGHSCD letter CG & RM standards
4.3 Performance management systems	Finance Director	N/A	N/A	CG & RM standards
4.4 Service Level Agreements with other Health Boards	Chief Executive	Finance Director	all	CG & RM standards
4.5 Partnership Agreements	Chief Executive	N/A	all	

5. Risk Management

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
5.1 Preparation of Risk Management Strategy	Chief Executive	Finance Director	N/A	CG & RM standards Statement of Internal Control
5.2 Policies and Procedures				
Risk Management	Finance Director	Risk Manager	N/A	CG & RM standards
Child Protection	Director of Nursing & AHP	N/A	N/A	
Prescribing	Associate Medical Director	N/A	N/A	HDL(2007)12 Safer management of controlled drugs - Accountable Officer status delegated to Associate Medical Director
Health and Safety	Chief Executive	Finance Director	N/A	HSG 65 (Health & Safety Executive) and associated regulations
5.3 Emergency and Continuity Planning	Security Director	N/A	N/A	CG & RM standards
5.4 Insurance Arrangements	Finance Director	Procurement Manager	N/A	SFI 12

6. Clinical Governance

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
6.1 Clinical Governance Strategy	Medical Director	N/A	within existing resources	CG & RM standards
6.2 Quality Assurance and Improvement Strategy	Medical Director	N/A	within existing resources	CG & RM standards
6.3 Research Governance Compliance with research governance standards	Associate Medical Director	N/A	N/A	CG & RM Standards Research Governance Standards
Approval of Research and Development Studies including associated clinical trials and indemnity agreements for commercial studies	Associate Medical Director	N/A	N/A	Research Governance Standards
6.4 Legal Claims				
Clinical negligence (negotiated settlements)	Finance Director	Chief Executive	< £25k	
Personal injury claims involving negligence where legal advice has been obtained and guidance applied	Finance Director	Chief Executive	< £25k	
All other claims	Chief Executive	Finance Director	> £25k	Scottish Government approval is required for all claims in excess of £100,000

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
6.5 Complaints				
Responding to complaints	Chief Executive	Deputy Chief Executive	N/A	Complaints guidance
Maintenance of complaints procedures and reporting	Finance Director	Risk Manager	N/A	Complaints guidance
6.6 Knowledge Services	Director of Nursing & AHP	N/A	within existing resources	CG &HIS standards

7. Equality & Involvement

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
7.1 Designated Director for Equality & Involvement	Director of Nursing & AHP	N/A	N/A	CG & RM standards Equality & Involvement Self Assessment
7.2 Policies and Procedures				CG & RM standards Equality & Involvement Self Assessment
Equality/Diversity (Human Rights, Race, Disability, Gender, etc)	Director of Nursing & AHP	N/A	N/A	
Advocacy	Director of Nursing & AHP	N/A	N/A	
Carers	Director of Nursing & AHP	Equality & Involvement Lead	N/A	
Volunteering	Director of Nursing & AHP	Equality & Involvement Lead	N/A	
Spiritual and Pastoral Care	Director of Nursing & AHP	Equality & Involvement Lead	N/A	
Patient and Carer Information and Communications	Director of Nursing & AHP	Equality & Involvement Lead	N/A	

8. Access, transfer, referral, discharge

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
8.1 Monitoring of Waiting Times				
- Psychological Therapies	Director of Nursing & AHP	N/A	N/A	Delivery Plan
- Patient Activity and Recreational Services	Director of Nursing & AHP	N/A	N/A	Delivery Plan
8.2 Public Information on access to services	Director of Nursing & AHP	N/A	N/A	CG & RM Standards
8.3 Access Policy	Medical Director	N/A	N/A	CG & RM Standards
8.4 Discharge Strategy and Policy	Medical Director	Associate Medical Director	N/A	CG & RM Standards
8.5 Clinical Supervision Policy	Medical Director & Director of Nursing & AHP	N/A	N/A	CG & RM Standards
8.6 Consent Policy	Medical Director	N/A	N/A	CG & RM Standards

9. Healthcare Associated Infection

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
9.1 Compliance and adherence to national standards in healthcare acquired infection	Director of Nursing & AHP	N/A	Within available resources	Infection Control Standards SGHSCD guidance
9.2 Compliance and adherence to national standards in				
decontamination	Security Director	N/A	Within available resources	SGHSCD guidance
cleaning	Security Director	N/A	Within available resources	SGHSCD guidance

10. Health Promotion and Education

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
10.1 Health Education and Health Promotion Activities	Director of Nursing & AHP	N/A	as per financial plan	CG & RM Standards
10.2 Public Health Information dissemination	Director of Nursing & AHP	N/A	N/A	CG & RM Standards

11. Information Management

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
11.1 Information Management Systems & Strategy	Finance Director	Head of eHealth	within programme plan	CG & RM Standards National eHealth Strategy
11.2 Clinical Responsibility for eHealth Strategy	Medical Director	Associate Medical Director	N/A	CG & RM Standards
11.3 Information Governance Framework	Finance Director	Head of eHealth	N/A	CG & RM Standards Information Governance Standards
11.4 Data Protection Act **- patient related data** **- staff related data**	Caldicott Guardian HR Director	Head of eHealth Head of eHealth	N/A	CG & RM Standards Information Governance Standards
11.5 Freedom of Information Act	Finance Director	Head of eHealth	N/A	CG & RM Standards Information Governance Standards
11.6 Caldicott Guardian	Medical Director	Associate Medical Director	N/A	CG & RM Standards Information Governance Standards

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
11.7 Records Management				
- clinical records	Caldicott Guardian	Health Records Manager	N/A	CG & RM Standards
- non clinical records	Finance Director	N/A	N/A	Information Governance Standards
11.8 Information Management & Technology Security	Finance Director	eHealth Security Officer	N/A	CG & RM Standards Information Governance Standards
11.9 Data Quality	Finance Director	Health Records Manager	N/A	CG & RM Standards Information Governance Standards

12. Staff Governance

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
12.1 Staff Governance Standards Implementation of Staff Governance Standards action plan	HR Director	N/A	N/A	Staff Governance Standards
HR policies and procedures	HR Director	N/A	Within existing resources	PIN guidelines

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
12.2 Pay Modernisation Benefits Realisation Plans	HR Director	N/A	N/A	SGHSCD guidance
12.3 Workforce Planning	HR Director	N/A	N/A	SGHSCD guidance
12.4 Contracts of employment	HR Director	N/A	N/A	Staff Governance Standards PIN guidelines
12.5 Systems for Professional registration and CPD	Medical Director & Director of Nursing & AHP	N/A	N/A	CG & RM Standards
12.6 Learning and Development Plans	HR Director	N/A	N/A	Staff Governance Standards Development Plan
12.7 Whistleblowing Policy	HR Director	N/A	N/A	PIN guidelines Counter Fraud Service Partnership Agreement

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
12.8 Disciplinary Action and Appeal				
a) Decision to dismiss	Any Director in consultation with HR Director	N/A	N/A	
b) Appeal against disciplinary action short of dismissal	Manager of Disciplinary decision maker	N/A	N/A	Subject to no involvement in disciplinary action
c) Appeal against disciplinary action short of dismissal (action taken by Director)	Chief Executive	N/A	N/A	
d) Appeal against disciplinary action short of dismissal (action taken by Chief Executive)	Staff Governance Committee	N/A	N/A	
e) Appeal against dismissal	Chief Executive	N/A	N/A	
f) Appeal against disciplinary action in respect of Directors	Remuneration Committee	N/A	N/A	
g) Appeal against disciplinary action in respect of the Chief Executive	Full Board or special Committee with delegated authority	N/A	N/A	Subject to members not having been involved in disciplinary action
12.9 Senior Employees Remuneration				
Remuneration and performance of Directors and Senior Managers	Remuneration Committee	N/A	N/A	SGHSCD guidance

13. Financial controls (subject to compliance with Standing Orders and Standing Financial Instructions)

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
Financial/Organisational Governance **13.1 System for funding decisions and business planning**	Finance Director	N/A	N/A	
13.2 Preparation of Financial Plans	Finance Director	Head of Management Accounts	Allocation Letter	
13.3 Preparation of budgets	Finance Director	Head of Management Accounts	Per Financial Plan	
13.4 Financial Systems and Operating Procedures	Finance Director	Head of Financial Accounts	N/A	
13.5 Financial Performance Reporting System	Finance Director	Head of Financial Accounts	N/A	
13.6 Maintenance / Operation of Bank Accounts	Finance Director	Head of Financial Accounts	N/A	
13.7 Annual Accounts signatories	Chairperson Chief Executive Finance Director	N/A	N/A	In accordance with Scottish Accounts Manual

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
13.8 Audit Certificate	Appointed Auditors	N/A	N/A	In accordance with Scottish Accounts Manual
13.9 Systems for administration of patients funds	Finance Director	Head of Financial Accounts	N/A	
13.10 Fraud, Theft and Irregularity Policy	Finance Director	Fraud Liaison Officer	N/A	

14. Financial limits (subject to compliance with Standing Orders and Standing Financial Instructions)

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.1 Authority to commit expenditure for which no provision has been made in approved plans/ budgets	Chief Executive Finance Director	Finance Director N/A	£100k £25k	
14.2 Virement of Budget within approved Resource Limit for items where no provision has been made in approved plans/ budgets	Chief Executive	Finance Director	£100k	
14.3 Management of Budgets Responsibility for keeping expenditure within budgets				
a) at individual budget level (pay and non-pay)	Nominated budget-holders	Named Deputies	Budget notified	
b) at service level	Directors	Named Deputies	Budget notified	
c) for reserves and contingencies	Finance Director	Head of Management Accounts		
d) achievement of savings	Directors Chief Executive	Named Deputies	Savings notified	

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
e) Virement of Budget between Directors				Subject to maximum virement limit of Chief Executive
- per event up to £25,000	Directors	Named Deputies	< £25k	
- per event over £25,000 and up to £100,000 annually	Chief Executive	Finance Director	> £25k < £100k	
f) Virement of Budget between Directors				
- non recurring	Finance Director	N/A	< £100k	
-recurring	Chief Executive	N/A	< £100k	
14.4 Engagement of staff not on establishment				
All staff (ie bank/agency/locums)				
a) where aggregate commitment in any one year is less than £5,000	Directors	Finance Director	< £5k	
b) where aggregate commitment in any one year is more than £5,000 but less than £25,000	Finance Director	Chief Executive	> £5k < £25k	
c) where aggregate commitment in any one year is more than £25,000	Chief Executive	N/A	> £25k	
14.5 Setting of Fees and Charges	Finance Director	N/A	N/A	
14.6 Agreement/ Licences				
a) Granting and termination of leases with annual rent less than £25,000	Finance Director	N/A	< £25k	
b) Granting and termination of leases with annual rent more than £25,000	CE and FD jointly	N/A	> £25k	
c) Preparation & signature of all tenancy licences for all staff subject to Board policy on accommodation	Finance Director	N/A	N/A	

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
d) Extensions to existing leases	Chief Executive and Finance Director jointly	N/A	N/A	
e) Letting of premises to outside organisations	Chief Executive	N/A	N/A	
f) Approval of rent based on professional assessment	Finance Director	N/A	N/A	
14.7 Non-Pay Revenue Expenditure - Requisitioning/				
Ordering of Goods and Services				
a) Value over £100,000	Board	N/A	>£100k	
b) Annual Value over £20,000 and up to £100,000	Chief Executive	Finance Director, Deputy Chief Exec	>£20k < £100k	Subject to containment within overall Board resources
	Procurement Manager (PO only)	Procurement Team Leader, Head of Financial Accounts, Finance Director (PO only)		
c) Annual Value over £15,000 and up to £20,000	Finance Director	Chief Exec, Deputy Chief Exec	>£15k < £20k	Subject to containment within overall Board resources
	Procurement Manager (PO only)	Procurement Team Leader, Head of Financial Accounts, Finance Director (PO only)		

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
d) Annual Value over £10,000 and up to £15,000	Budget Director	Finance Director, Chief Exec, Deputy Chief Exec	>£10k < £15k	Subject to containment within overall delegated funds for Directorate
	Procurement Manager (PO only)	Procurement Team Leader, Head of Financial Accounts, Finance Director (PO only)		
e) Annual Value over £5,000 and up to £10,000	Budget Manager	Budget Director	>£5k < £10k	Subject to containment within overall delegated funds for budget manager
	Procurement Manager (PO only)	Procurement Team Leader, Head of Financial Accounts (PO only)		
f) Annual Value over £1,000 and up to £5,000	Budget holder	Budget Manager	>£1k < £5	Subject to containment within overall delegated funds for budget holder
	Procurement Manager (PO only)	Procurement Team Leader (PO only)		
		Head of Financial Accounts (PO only)		
g) Annual Value up to £1,000	Budget holder	Budget Manager	< £1k	Subject to containment within overall delegated funds for budget holder
	Procurement Manager (PO only)	Procurement Team Leader (PO only)		
		Head of Financial Accounts (PO only)		
h) Orders exceeding a 12 month period over £50,000 and up to £100,000	Chief Executive	Deputy Chief Exec, Finance Director	> £50k < £100k	Subject to containment within overall Board resources
i) Orders exceeding a 12 month period and up to £50,000	Finance Director	Chief Executive	< £50k	Subject to containment within overall Board resources

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
j) Subsequent variations to contract	Finance Director	Chief Executive	N/A	Subject to containment within delegated limits and within budget
k) Specific exceptions to above limits – Utilities – up to £25,000	Estates Manager	Estates Co-ordinator, Security Director	< £25k	Subject to containment within budget
- Laundry - up to £5,000	Estates Manager	Estates Co-ordinator		
- Decontamination – up to £3,000	Estates Manager	Estates Co-ordinator		
- Shop Trading Account – up to £5,000	Designated budget holders	N/A	< £5k	Countersigned by Procurement Manager (PO only)
l) Consolidated orders up to £10,000	Procurement Manager	Procurement Team Leader	< £10k	Subject to individual items authorised as above
m) Invoice matching queries	Procurement Manager / Head of Financial Accounts	Assistant Management Accountant	<£100 or 10% whichever is lower	Above this level re-authorisation by the budget holder is required
n) Approval of removal expenses packages	Chief Executive	Deputy Chief Executive	<£8k	Taxable Threshold. In exceptional circumstances a higher level may be considered, reasons to be documented
DELEGATION TO INDIVIDUAL OFFICERS TO BE APPROVED BY FINANCE DIRECTOR				

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.8 Capital schemes a) Non IM&T capital schemes - approval and authorisation to proceed				
-value over £ 2,000,000	Board and SGHSCD jointly	N/A	> £2.0m	HDL (2005) 16
- value between £ 500,000 and £ 2,000,000	Chief Executive and Board jointly	N/A	> £0.5m < £2.0m	Internal business case required for £ 1.0m
- value up to £ 500,000	Chief Executive	Deputy Chief Executive	< £0.5m	
- value up to £ 10,000	Finance Director	N/A	<£0.01m	
b) eHealth capital schemes - approval and authorisation to proceed				
-value over £ 1,000,000	Board and SGHSCD jointly	N/A	> £1.0m	HDL (2005) 16
- value between £100,000 and £ 1,000,000	Chief Executive and Board jointly	N/A	> £0.1m < £1.0m	Internal business case required for £ 0.5m
- value up to £100,000	Chief Executive	Deputy Chief Executive	< £0.1m	
- value up to £20,000	Finance Director	N/A		
- value up to £5,000	Head of eHealth	N/A		
c) Selection of professional advisors	Chief Executive	N/A	N/A	subject to containment within approved budget
d) Approval of variations to contract				
-value up to £ 100,000	Chief Executive	Deputy Chief Executive	> £25k < £100k	
- value up to £ 25,000 or 10% of approved expenditure of any scheme whichever is the lower	Security Director or Finance Director	N/A	< £25k	or 10% of approved spend whichever is lower

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.9 Quotation, Tendering and Contract Procedures				
a) Quotations Three minimum quotations for goods/services for spend over £5,000 and up to £10,000	Procurement Manager	N/A	>£5k < £10k	refer to tendering procedures
b) Tenders Three minimum quotations for goods/services for spend over £10,000 and up to £100,000	Finance Director	N/A	>£10k < £100k	refer to tendering procedures
Three minimum quotations for goods/services for spend over £100,000	Chief Executive	N/A	>£100k	subject to EU regulations
c) Waiving of quotations & tenders subject to SOs	Chief Executive & Finance Director	N/A	N/A	
d) Arrangements for opening tenders	Procurement Manager	N/A	N/A	

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.10 Condemning & Disposal of Assets (excluding heritable property) Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively				
- with current /estimated purchase price up to £50,000	Finance Director	Head of Financial Accounts	< £50k	
- with current/estimated purchase price over £50,000	Chief Executive	N/A	> £50k	
14.11 Condemnations, Losses and Special Payments				
a) Compensation Payments made under legal obligation - ex gratia				
- over £100,000	Board	N/A	> £100k	requires SGHSCD approval
- between £25,000 and £100,000	Chief Executive	Deputy Chief Executive	>£25k < £100k	
- up to £25,000	Finance Director	N/A	< £25k	
b) Other ex-gratia payments - other payments				
- over £5,000	Board	N/A	> £ 5k	requires SGHSCD approval
- up to £5,000	Chief Executive	N/A	< £5k	

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
c) Stores/stock losses due to - theft, fraud, arson ; incidents of the service; or disclosed at check				
- over £20,000	Board	N/A	> £20k	requires SGHSCD approval
- up to £20,000	Finance Director & Chief Executive	N/A	< £20k	
d) Routine stores write on / write off disclosed at check - up to £100	Head of Financial Accounts	N/A	< £100	
- over £100	Finance Director	N/A	> £100	
e) Losses of cash due to theft, fraud, overpayment and others				
- over £5,000	Board	N/A	> £5k	requires SGHSCD approval
- up to £5,000	Finance Director & Chief Executive	N/A	< £5k	
f) Abandoned Claims				
- over £5,000	Board	N/A	> £5k	requires SGHSCD approval
- up to £5,000	Finance Director & Chief Executive	N/A	< £5k	
g) Damage to buildings				
- over £20,000	Board	N/A	> £20k	requires SGHSCD approval
- up to £20,000	Finance Director & Chief Executive	N/A	< £20k	

STATE HOSPITALS BOARD FOR SCOTLAND

STANDING ORDERS

Version 13

Version Control Log		
Version	**Date**	**Description**
7	24 Nov 2008	Section 24 includes reference to the Board putting in place a Hospitality Policy. This is currently in draft and will be provided to the Audit Committee in January 09 for approval. Section 26 updated to reflect change in approval mechanism of Committee minutes. Paragraph 27 clarification of ex-officio status. This is also reflected in the terms of reference of committees.
7.1	15 Jan 2009	Amended for Board comments
7.2	19 April 2012	
8	30 April 2013	Amended for Audit Committee comments
8.1	June 2013	Approved by Board June 2013
9	April 2014	Paragraph 20b amended to reflect reference to 20(a) (changed from 21(a). Paragraph D27e amended as per Audit Committee on 24 April 2014. Approved by Board 26 June 2014
10	April 2015	Approved by Audit Committee 2 April 2015 after following changes made: Paragraph B9(a) amended to reflect Board meets every second month.

		Paragraph B12© amended to remove reference to Sub Committee. Paragraph B12(e) amended in respect of meetings being quorate as per their Terms of Reference.
11	March 2016	Section 5 – added sentence re annual confirmation of Declaration of Interests. Section 20(a) – amended limits for disposal of assets from £25,000 to £50,000 to agree with SFI's.
12	March 2017	Approved by Audit Committee 23 March 2017 Approved by Board 4 May 2017
13	March 2018	Approved by Audit Committee 5 April 2018 Approved by Board 28 June 2018

FOREWORD

Standing Orders, together with Standing Financial Instructions, provide a regular framework for the business conduct of the Board. They fulfil the dual role of protecting the Board's interests and protecting staff from any possible accusation that they have acted less than properly.

The Standing Orders, Scheme of Delegations and Standing Financial Instructions provide a comprehensive business framework. All executive and non-executive directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

Failure to comply with standing orders and standing financial instructions is a disciplinary matter which could result in dismissal.

STANDING ORDERS

For regulating the business and proceedings of the State Hospitals Board for Scotland, and its Committees made under the terms of the Health Boards (Membership and Procedure) (No 2) Regulations 1991 (S.I. 1991 No.809 (S74)), and the mandatory elements of NHS Circular MEL (1994) 80.

The Standing Orders of the Board shall apply, where applicable, to all Committees and Sub-Committees of the Board.

The Ethical Standards in Public Life etc. (Scotland) Act 2000 introduced a Members' Model Code of Conduct and the Board adopted the Code in July 2002.

A MEMBERS' CODE OF CONDUCT

1 Introduction

The Scottish public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties for The State Hospitals Board for Scotland. You must meet those expectations by ensuring that your conduct is above reproach.

The Ethical Standards in Public Life etc. (Scotland) Act 2000 provides for new Codes of Conduct for local authority councillors and members of relevant public bodies; imposes on councils and relevant public bodies a duty to help their members to comply with the relevant code; and establishes a Standards Commission for Scotland to oversee the new framework and deal with alleged breaches of the codes.

This Code covers members of The State Hospitals Board for Scotland. As a member of the State Hospitals Board for Scotland, it is your responsibility to make sure that you are familiar with, and that your actions comply with, the provisions of this Code of Conduct.

Guidance on the Code of Conduct

You must observe the rules of conduct contained in this Code. It is your personal responsibility to comply with these and review regularly, and at least annually, your personal circumstances with this in mind, particularly when your circumstances change. You must not at any time advocate or encourage any action contrary to the Code of Conduct.

The Code has been developed in line with the key principles listed in section 2 and provides additional information on how the principles should be interpreted and applied in practice. No Code can provide for all circumstances and if you are uncertain about how the rules apply, you should seek advice from the Chairperson, or the Chief Executive. You may also choose to consult your own legal advisers and, on detailed financial and commercial matters, seek advice from other relevant professionals.

Enforcement

Section 2 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 sets out the provisions for dealing with alleged breaches of this Code of Conduct and the sanctions that shall be applied if the Standards Commission finds that there has been a breach of the Code. Those sanctions are outlined in Annex A.

2 Key Principles of the Code of Conduct

The general principles upon which this Model Code of Conduct are based are:

Public Service

You have a duty to act in accordance with the core tasks and in the interests of the State Hospitals Board for Scotland of which you are a member.

Selflessness

You have a duty to take decisions solely in terms of public interest. You must not act in order to gain financial or other material benefit for yourself, family or friends.

Integrity

You must not place yourself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence you in the performance of your duties.

Objectivity

You must make decisions solely on merit when carrying out public business.

Accountability and Stewardship

You are accountable for your decisions and actions to the public. You have a duty to consider issues on their merits, taking account of the views of others and must ensure that the State Hospital uses its resources prudently and in accordance with the law.

Openness

You have a duty to be as open as possible about your decisions and actions, giving reasons for your decisions and restricting information only when the wider public interest clearly demands, or in the interests of patient confidentiality.

Honesty

You have a duty to act honestly. You must declare any private interests relating to your public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

You have a duty to promote and support these principles by leadership and example, to maintain and strengthen the public's trust and confidence in the integrity of the State Hospitals Board for Scotland and its members in conducting public business.

Respect

You must respect fellow members and employees of the State Hospital and the role they play, treating them with courtesy at all times.

You should apply the principles of this Code to your dealings with fellow members of the State Hospitals Board for Scotland and its employees.

3 General Conduct

Relationships with Employees of the State Hospital

You will treat any staff employed by the State Hospital with courtesy and respect. It is expected that employees will show you the same consideration in return.

Allowances

You must comply with any rules of the State Hospital regarding remuneration, allowances and expenses.

Gifts and Hospitality

You must never canvass or seek gifts or hospitality.

You are responsible for your decisions connected with the offer or acceptance of gifts or hospitality and for avoiding the risk of damage to public confidence in the State Hospitals Board for Scotland. As a general guide, it is usually appropriate to refuse offers except:

(a) isolated gifts of a trivial character or inexpensive seasonal gifts such as a calendar or diary, or other simple items of office equipment of modest value;

(b) normal hospitality associated with your duties and which would reasonably be regarded as inappropriate to refuse; or

(c) gifts received on behalf of the State Hospitals Board for Scotland.

You must not accept any offer by way of gift or hospitality which could give rise to a reasonable suspicion of influence on your part to show favour, or disadvantage, to any individual or organisation. You should also consider whether there may be any reasonable perception that any gift received by your spouse or co-habitee or by any company in which you have a controlling interest, or by a partnership of which you are a partner, can or would influence your judgement. The term “gift” includes benefits such as relief from indebtedness, loan concessions, or provision of services at a cost below that generally charged to members of the public.

You must not accept repeated hospitality from the same source. You must record details of any gifts and hospitality received and the record must be made available for public inspection.

You must not accept any offer of a gift or hospitality from any individual or organisation which stands to gain or benefit from a decision made by the State Hospitals Board for Scotland may be involved in determining, or who is seeking to do business with your organisation, and which a person might reasonably consider could have a bearing on your judgement. If you are making a visit to inspect equipment, vehicles, land or property, then as a general rule you should ensure that the State Hospitals Board for Scotland pays for the costs of these visits.

Confidentiality Requirements

There may be times when you will be required to treat discussions, documents or other information relating to the work of the State Hospitals Board for Scotland in a confidential manner. You will often receive information of a private nature which is not yet public, or which perhaps would not be intended to be public. There are provisions in legislation on the categories of confidential and exempt information and you must always respect and comply with the requirement to keep such information private.

It is unacceptable to disclose any information to which you have privileged access, for example derived from a confidential document, either orally or in writing. In the case of other documents and information, you are requested to exercise your judgement as to what should or should not be made available to outside bodies or individuals. In any event, such information should never be used for the purpose of personal or financial gain, or used in such a way as to bring the State Hospitals Board for Scotland into disrepute.

Use of Public Body Facilities

Members of the State Hospitals Board for Scotland must not misuse facilities, equipment, stationery, telephony and services, or use them for party political or campaigning activities. Use of such equipment and services, etc must be in accordance with the State Hospitals Board for Scotland policy and rules on their usage.

Appointment to Partner Organisations

You may be appointed, or nominated by the State Hospitals Board for Scotland, as a member of another body or organisation. If so, you are bound by the rules of conduct of these organisations and should observe the rules of this Code in carrying out the duties of that body. No NHS body is permitted to nominate a person to be a director of another Company.

4 Registration of Interests

The following paragraphs set out the kinds of interests, financial and otherwise which you have to register. These are called "Registerable Interests". You must, at all times, ensure that these interests are registered, when you are appointed and whenever your circumstances change in such a way as to require change or an addition to your entry in the State Hospitals Board for Scotland Register.

The Board will maintain a formal Register of Members' Interest, which should be available to the public, on request from Corporate Services, at the State Hospital, Carstairs. The Register will include details of all directorships and other relevant and material interests which have been declared by the Chairperson, executive and non-executive Board Directors/Members.

This Code sets out the categories of interests, which you must register. Annex B contains key definitions to help you decide what is required when registering your interests under any particular category. These categories are listed below with explanatory notes designed to help you decide what is required when registering your interests under any particular category.

Category One: Remuneration

You have a Registerable Interest where you receive remuneration by virtue of being:

- employed;
- self-employed;
- the holder of an office;
- a director of an undertaking;
- a partner in a firm; or
- undertaking a trade, profession or vocation or any other work.

The amount of remuneration does not require to be registered and remuneration received as a Member does not have to be registered.

If a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under category two, "Related Undertakings".

If you receive any allowances in relation to membership of any organisation, the fact that you receive such an allowance must be registered.

When registering employment, you must give the name of the employer, the nature of its business, and the nature of the post held in the organisation.

When registering self-employment, you must provide the name and give details of the nature of the business. When registering an interest in a partnership, you must give the name of the partnership and the nature of its business.

Where you undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and its regularity. For example, if you write for a newspaper, you must give the name of the publication, and the frequency of articles for which you are paid.

When registering a directorship, it is necessary to provide the registered name of the undertaking in which the directorship is held and the nature of its business.

Registration of a pension is not required as this falls outside the scope of the category.

Category Two: Related Undertakings

You must register any directorships held which are themselves not remunerated but where the company (or other undertaking) in question is a subsidiary of, or a parent of, a company (or other undertaking) in which you hold a remunerated directorship.

You must register the name of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which you are a director and from which you receive remuneration.

The situations to which the above paragraphs apply are as follows:

- you are a director of a board of an undertaking and receive remuneration – declared under category one – and
- you are a director of a parent or subsidiary undertaking but do not receive remuneration in that capacity.

Category Three: Contracts

You have a registerable interest where you (or a firm in which you are a partner, or an undertaking in which you are a director or in which you have shares of a value as described in category 5 below) have made a contract with the State Hospitals Board for Scotland of which you are a member:

(i) under which goods or services are to be provided, or works are to be executed; and

(ii) which has not been fully discharged.

You must register a description of the contract, including its duration, but excluding the consideration.

Category Four: Houses, Land and Buildings

You have a registerable interest where you own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of the State Hospitals Board for Scotland.

The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any interests in houses, land and buildings could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision-making. If in doubt, you may consult with the Standards Commission.

Category Five: Shares and Securities

You have a registerable interest where you have an interest in shares which constitute a holding in a company or organisation which may be significant to, of relevance to, or bear upon, the work and operation of the State Hospitals Board for Scotland. You are not required to register the value of such interests.

The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any interests in shares and securities could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision-making. If in doubt, you may consult with the Standards Commission.

Category Six: Non–Financial Interests

You may also have a registerable interest if you have non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of the State Hospitals Board for Scotland. It is important that relevant interests such as membership or holding office in other public bodies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described.

The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any non-financial interest could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision-making. If in doubt, you may consult with the Standards Commission.

5 Declaration of Interests

Introduction

The key principles of the Code, especially those in relation to integrity, honesty and openness, are given further practical effect by the requirement for you to declare certain interests in proceedings of the State Hospitals Board for Scotland. Together with the rules on registration of interests, this ensures transparency of your interests which might influence, or be thought to influence, your actions.

Public bodies inevitably have dealings with a wide variety of organisations and individuals and this Code indicates the circumstances in which a business or personal interest must be declared. Public confidence in the State Hospitals Board for Scotland and its members depends on it being clearly understood that decisions are taken in the public interest and not for any other reason.

In considering whether to make a declaration in any proceedings, you must consider not only whether you will be influenced but whether anybody else would think that you might be influenced by the interest. You must keep in mind that the test is whether a member of the public, acting reasonably, might think that a particular interest could influence you.

If you feel that, in the context of the matter being considered, your involvement is neither capable of being viewed as more significant than that of an ordinary member of the public, nor likely to be perceived by the public as wrong, you may continue to attend the meeting and participate in both discussion and voting. The relevant interest must however be declared. It is your responsibility to judge whether an interest is sufficiently relevant to particular proceedings to require a declaration and you are advised to err on the side of caution. You may also seek advice from the Standards Commission.

At the time Board Members' interests are declared, they should be recorded in the Board minutes. The minutes containing information about the interests of Board Members should be drawn to the attention of the Board's internal and external auditors. Any changes should also be declared within 4 weeks of the change occurring and recorded in the Board minutes.

Any remuneration, compensation or allowances payable to a Chairperson or other non-executive Member by virtue of paragraph 4 of Part I, or paragraph 13 of Part II, of Schedule I of the National Health Service (Scotland) Act of 1978 or any amendment thereof, shall not be treated as a pecuniary interest for the purpose of these Standing Orders.

Interests which Require Declaration

Interests which require to be declared may be financial or non-financial. They may or may not be interests which are registerable under this Code. Most of the interests to be declared will be your personal interests but, on occasion, you will have to consider whether the interests of other persons require you to make a declaration.

Shares and Securities

Any financial interest which is registerable must be declared. You may have to declare interests in shares and securities, over and above those registerable under category five of section 4 of this Code. You may, for example, in the course of employment or self-employment, be engaged in providing professional advice to a person whose interests are a component of a matter to be dealt with by a Board.

You have a declarable interest where an interest becomes of direct relevance to a matter before the body on which you serve and you have shares comprised in the share capital of a company or other body and the nominal value of the shares is:

(i) greater than 1% of the issued share capital of the company or other body; or

(ii) greater than £25,000.

You are required to declare the name of the company only, not the size or nature of the holding.

Houses, Land and Buildings

Any interest in houses, land and buildings which is registerable under category four of section 4 of this Code must be declared, as well as any similar interests which arise as a result of specific discussions or operations of the State Hospitals Board for Scotland.

Non-Financial Interests

If you have a registered non-financial interest under category six of section 4 of this Code you have recognised that it is significant. There is therefore a very strong presumption that this interest will be declared where there is any link between a matter which requires your attention as a member of the State Hospitals Board for Scotland and the registered interest. Non-financial interests include membership or holding office in other public bodies, clubs, societies,

trade unions and organisations including voluntary organisations. They become declarable if and when members of the public might reasonably think they could influence your actions, speeches or votes in the decisions of the State Hospitals Board for Scotland.

You may serve on other bodies as a result of express nomination or appointment by the State Hospitals Board for Scotland or otherwise by virtue of being a member of the State Hospitals Board for Scotland. You must always remember the public interest points towards transparency particularly where there is a possible divergence of interest between different public authorities.

You will also have other private and personal interests and may serve, or be associated with, bodies, societies and organisations as a result of your private and personal interests and not because of your role as a member of the State Hospitals Board for Scotland. In the context of any particular matter you will have to decide whether to declare a non-financial interest. You should declare an interest unless you believe that, in the particular circumstances, the interest is irrelevant or without significance. In reaching a view you should consider whether the interest (whether taking the form of association or the holding of office) would be seen by a member of the public acting reasonably in a different light because it is the interest of a person who is a member as opposed to the interest of an ordinary member of the public.

Interests of Other Persons

The Code requires only your interests to be registered. You may, however, have to consider whether you should declare an interest in regard to the financial interests of your spouse or cohabitee which are known to you. You may have to give similar consideration to any known non-financial interest of a spouse or cohabitee. You have to ask yourself whether a member of the public acting reasonably would regard these interests as effectively the same as your interests in the sense of potential effect on your responsibilities as a member of the State Hospitals Board for Scotland.

The interests known to you, both financial and non-financial, of relatives and close friends may have to be declared. This Code does not attempt the task of defining “relative” or “friend”. The key principle is the need for transparency in regard to any interest which might (regardless of the precise description of relationship) be objectively regarded by a member of the public, acting reasonably, as potentially affecting your responsibilities as a member of the State Hospitals Board for Scotland.

Making a Declaration

You must consider at the earliest stage possible whether you have an interest to declare in relation to any matter which is to be considered. You should consider whether agendas for meetings raise any issue of declaration of interest. Your declaration of interest must be made as soon as practicable at a meeting where that interest arises. If you do identify the need for a declaration of interest only when a particular matter is being discussed you must declare the interest as soon as you realise it is necessary.

The oral statement of declaration of interest should identify the item or items of business to which it relates. The statement should begin with the words “I declare an interest”. The statement must be sufficiently informative to enable those at the meeting to understand the nature of your interest but need not give a detailed description of the interest.

A “Declaration of Interests Form” is required to be completed on an annual basis.

Effect of Declaration

Declaring a financial interest has the effect of prohibiting any participation in discussion and voting. A declaration of a non-financial interest involves a further exercise of judgement on

your part. You must consider the relationship between the interests which have been declared and the particular matter to be considered and relevant individual circumstances surrounding the particular matter.

In the final analysis the conclusive test is whether, in the particular circumstances of the item of business, and knowing all the relevant facts, a member of the public acting reasonably would consider that you might be influenced by the interest in your role as a member of the State Hospitals Board for Scotland and that it would therefore be wrong to take part in any discussion or decision-making. If you, in conscience, believe that your continued presence would not fall foul of this objective test, then declaring an interest will not preclude your involvement in discussion or voting. If you are not confident about the application of this objective yardstick, you must play no part in discussion and must leave the meeting room until discussion of the particular item is concluded.

Dispensations

In very limited circumstances dispensations can be granted by the Standards Commission in relation to the existence of financial and non-financial interests which would otherwise prohibit you from taking part and voting on matters coming before your public body and its committees. Applications for dispensations will be considered by the Standards Commission and should be made as soon as possible in order to allow proper consideration of the application in advance of meetings where dispensation is sought. You should not take part in the consideration of the matter in question until the application has been granted.

6 Lobbying and Access to Members of Public Bodies

In order for the State Hospitals Board for Scotland to fulfil its commitment to being open and accessible, it needs to encourage participation by organisations and individuals in the decision-making process. Clearly however, the desire to involve the public and other interest groups in the decision-making process must take account of the need to ensure transparency and probity in the way in which the State Hospitals Board for Scotland conducts its business.

You will need to be able to consider evidence and arguments advanced by a wide range of organisations and individuals in order to perform your duties effectively. Some of these organisations and individuals will make their views known directly to individual members. The rules in this Code set out how you should conduct yourself in your contacts with those who would seek to influence you. They are designed to encourage proper interaction between members of public bodies, those they represent and interest groups.

Rules and Guidance

You must not, in relation to contact with any person or organisation who lobbies, do anything which contravenes this Code of Conduct or any other relevant rule of the State Hospitals Board for Scotland or any statutory provision.

You must not, in relation to contact with any person or organisation who lobbies, act in any way which could bring discredit upon the State Hospitals Board for Scotland.

The public must be assured that no person or organisation will gain better access to, or treatment by, you as a result of employing a company or individual to lobby on a fee basis on their behalf. You must not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which you accord any other person or organisation who lobbies or approaches you. Nor should those lobbying on a fee basis on behalf of clients be given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming from another member of the State Hospitals Board for Scotland.

Before taking any action as a result of being lobbied, you should seek to satisfy yourself about the identity of the person or organisation who is lobbying and the motive for lobbying. You may choose to act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that you know the basis on which you are being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code.

You should not accept any paid work

(a) which would involve you lobbying on behalf of any person or organisation or any clients of a person or organisation.

(b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence the State Hospitals Board for Scotland and its members. This does not prohibit you from being remunerated for activity which may arise because of, or relate to, membership of the State Hospitals Board for Scotland, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

If you have concerns about the approach or methods used by any person or organisation in their contacts with you, you must seek the guidance of the State Hospitals Board for Scotland.

The Members Model Code should be read in conjunction with Standing Financial Instructions of the State Hospitals Board for Scotland.

7 Training and Development of Members

The Chairperson of the Board is responsible for ensuring that all executive and non-executive Members make a full contribution to the Board's affairs and must, in consequence, determine the training and development needs of Members and ensure that any gaps in knowledge or experience are resolved.

B MEETINGS OF THE BOARD AND COMMITTEES

8 General

a) The Chief Executive shall cause notices of all meetings of the Board and Committees, together with a note of the agenda and of any Committee minutes and reports which are to be submitted to such meetings, to be delivered or sent by post so as to reach each Member of the Board five clear days before the date of the meeting. Failure of delivery of any notice shall not invalidate the proceedings of the meeting to which the notice refers.

b) At every meeting of the Board the Chairperson, if present, shall preside.

9 Ordinary Meetings of the Board

a) The ordinary meetings of the Board shall, unless the Board otherwise agrees, be held on the third Thursday of every second month at the State Hospital, Carstairs or at such place and at such time as the Board shall determine.

b) No business shall be transacted at ordinary meetings of the Board other than that specified in the agenda unless it has been notified to the Chairperson prior to the meeting and has the consent of the majority of the Members of the Board present.

10 Special Meetings of the Board

a) The Chairperson may call a special meeting of the Board at any time as required, or on receiving a requisition in writing for that purpose signed by one third of the whole number of Members of the Board (including at least two non-executive Members), of which meeting at least three clear days notice shall be given and specifying the business proposed to be transacted at the meeting. Such meetings shall be held within fourteen days of receipt of the requisition.

b) No business shall be transacted at a special meeting of the Board other than that specified in the requisition.

11 Annual Presentation of Accounts

At the appropriate Public Board Meeting, normally June, the Board shall present its annual report, audited accounts and any report on these accounts by the appointed auditor.

12 Quorum

No business shall be transacted at a meeting of the Board unless at least one third of the whole number of Members of the Board is present; of whom a majority should be non-executive Members.

If within thirty minutes after the time appointed for the meeting, a quorum of members is not present, the meeting shall stand adjourned, and the Chief Executive will arrange for it to be minuted that, owing to the want of the necessary quorum, no business was transacted.

An ordinary meeting shall be held to be adjourned until the next ordinary meeting unless otherwise stated and at that meeting the business left over at the adjourned meeting shall be entitled to preference over other business.

A special meeting standing adjourned shall be held to be adjourned *sine die.*

The proceedings at meetings of the Board or its committees shall not be invalidated by any vacancy in its membership or by any defect in the appointment of any member thereof.

13 Notice of Motion and Order of Debate

a) A motion which is contradictory to a resolution of the Board shall not be competent within six months of the date of adoption of such resolution unless:

i) the consent of two thirds of the Members of the Board present and voting be obtained; or

ii) notice of the motion, having been signed by at least one-third of the whole number of Board Members, shall be given to the Chief Executive at least fourteen days in advance of the meeting, and shall be specified in the circular calling the meeting. All Board Members shall be notified at least seven days in advance of the meeting of the inclusion of the motion in the circular; or

iii) in the case of emergency (involving such matters as a substantial change of circumstances, an illegality, a miscarriage of justice, a breach of ethics or the like).

b) Any motion or amendment shall, if required by the Chairperson of the meeting, be reduced to writing, and after being seconded shall not be withdrawn without the leave of the Board and Committee. No motion or amendment shall be spoken upon except by the mover until it has been seconded.

c) No member shall have the right to speak more than once on any motion or amendment except on a point of order in explanation of some material part of his/her speech which he/she believes to have been misunderstood.

d) A member formally seconding a motion or amendment will be deemed to have spoken in the debate.

e) The mover of any original motion shall have the right to reply. In replying he/she shall not introduce new matter and shall be confined strictly to answering observations made in debate. Immediately after, the Chairperson of the meeting shall put the question without further debate.

f) When an amendment upon an original motion has been moved and seconded, no further amendment may be moved until the previous one has been disposed of. If an amendment be rejected, other amendments may be moved on the original motion. If an amendment be carried, the motion as amended shall take the place of the original motion and shall become the question upon which further amendments may be moved.

g) The duration of speeches may, unless otherwise determined by a simple majority of Members present and voting, be limited by the Chairperson of the meeting to ten minutes for the mover, five minutes for the seconder and three minutes for other speakers.

h) The ruling of the Chairperson of the meeting on all points of order and on the order of debate shall be final. Members should address the chair. The Chairperson shall call upon Members to speak.

14 Closure of Debate or Adjournment

A motion of adjournment of any meeting of the Board or Committee; or adjournment of any debate on any question, or the closure of the debate shall be put to the meeting after being seconded, without discussion. Unless the time and place are specified in the motion for adjournment, the adjournment shall be until the next ordinary meeting of the Board and the Committee.

15 Voting

a) If it be so decided by not less than one third of the members attending a meeting on act of or question, coming or arising before, a meeting of the Board or a Committee shall be done and decided by a majority of the Members present and voting at the meeting and, in the case of an equality of votes, the person presiding at the meeting shall, in addition to his/her deliberate vote, have a casting vote.

b) The number of votes cast for and against motions and amendments shall be recorded in the minutes.

16 Emergency Powers of Chairperson

The Chairperson is empowered to act for the Board between meetings of the Board in emergency situations of a financial nature not covered by the Board's scheme of financial delegation.

Such action will be reported to the Board at the next meeting.

17 Delegations and Deputations

a) Any individual or organisation wishing to make representation to the Board will be heard if:

i) a written application setting forth the subject matter on which a hearing is requested has been lodged with the Chief Executive at least 21 days in advance of the Board Meeting which the delegation wishes to address, and

ii) the Chairperson has considered the request and has agreed to recommend that the delegation or deputation should attend the Board Meeting.

b) When a delegation or deputation is received by the Board, Members may put to the delegation or deputation pertinent questions, but no Members shall express an opinion upon or discuss the subject matter until the delegation has withdrawn from the Board meeting.

c) The terms of Standing Orders apply to delegations and deputations.

18 Communications with the Press & Public

No communication on behalf of the Board shall be made to the Press & Public except through the Chief Executive, Directors and the Head of Communications. Meetings of the Board are open to the Press and the Public. Meetings of the Sub-Committees are not open to the Press and Public.

19 Suspension and Disqualification of Members

Any member disregarding the authority of the Chairperson or who obstructs the meeting or conducts himself/herself offensively shall be suspended for the remainder of the meeting if a motion (which shall be determined without discussion) for his/her suspension is carried. Any person so suspended shall forthwith leave the meeting and shall not, without the consent of the meeting, return. If a person so suspended refuses, when required by the Chairperson to leave the meeting, he/she may immediately be removed from the meeting by any person authorised by the Chairperson so to do.

20 Scheme of Delegation

The Board will reserve certain decisions to itself and will delegate all other decisions to the Directors, through the Chief Executive. Any changes to the Scheme of Delegation will be made with prior agreement of the Board.

a) Matters on which decisions on, and/or approval of, are retained by the Board or authorised Committee or Sub-Committee;

* Strategy, business plans and budgets;
* Standing Orders;
* Standing Financial Instructions;
* appointment of Chief Executive and any Director;
* the establishment, terms of reference and reporting arrangements for all Committees and Sub-Committees;
* capital expenditure plans exceeding £25,000;
* disposal of assets exceeding £50,000;
* recommendations from all Committees and Sub-Committees (where powers are not delegated);
* Annual Report and Annual Accounts;
* financial and performance reporting arrangements;
* financial audit arrangements
* security audit arrangements.

b) All other decisions:

* all decisions, other than those included in paragraph 20 (a), are delegated (as detailed in the Standing Financial Instructions) to senior management through the Chief Executive and include the undernoted matters:
  - issuing, receiving and opening of tenders;
  - delegation of budgets and approval to spend funds;
  - operation of all detailed financial matters including bank accounts and banking procedures;
  - management of non-exchequer funds;
  - arrangements for the management of land, buildings and other assets belonging to or leased by the Board;
  - management and control of computer systems and facilities;
  - recording and monitoring of payments for losses and compensation ;
  - making ex-gratia payments (up to a maximum of £25,000);
  - health and safety arrangements;
  - data protection arrangements.
* authorisation limits related to the scheme of delegation and, where indicated, details of the officers who have been delegated responsibility, are included within the Standing Financial Instructions.

21 Annual Report

The Board will publish an Annual Report on its performance.

The Report will be prepared in accordance with the requirements set out from time to time by the Scottish Government on behalf of the First Minister and will include, interalia, details of remuneration from NHS sources paid to Members of the Board and matters related to the Patients Charter.

22 Annual Accounts

The Board will produce a set of Annual Accounts in accordance with the requirements set out by the Scottish Government on behalf of the First Minister.

23 Standards of Business Conduct for Staff

The Board will incorporate in its Terms and Conditions of Employment, a code of business conduct, which will include guidance issued from time to time by the Scottish Government and the Board will ensure that this is drawn to the attention of all staff and directly employed contractors. Additionally, the Board will put in place a policy for the management of Hospitality and compliance with this policy will be monitored by the Audit Committee.

C MINUTES

24 Recording of Names of Members Present

The names of Members present at a meeting of the Board or of a Committee of the Board shall be recorded in the minutes. Where a Member is not present for the whole of a meeting this shall also be recorded.

25 Preparation, Approval and Distribution of Board and Committee Minutes

a) Minutes of the proceedings of a meeting of the Board shall be drawn up by, or on behalf of the Chief Executive and shall be circulated to members in draft form within ten days. The minutes shall be submitted to the next ensuing meeting of the Board for approval as a record of the meeting and signed by the person presiding at that next ensuing meeting.

b) Minutes of the proceedings of a meeting of Committee shall be drawn up by, or on behalf of, the Chief Executive and submitted for approval to the Board at the first ordinary meeting of the Board held after the meeting of the Committee.

c) Copies of the approved minutes of every meeting of the Board shall be forwarded to the Scottish Government by the Chief Executive not later than one week before the date of the next Board meeting.

D COMMITTEES

26 Chairperson and Chief Executive

The Chairperson of the Board, and the Chief Executive, shall both be members, ex-officio of all Committees with the exception of the Audit Committee and the Committees whose constitution is determined by Statute. An ex-officio member is a member of a body (a board, committee, etc.) who is part of it by virtue of holding another office. Depending on the Committee terms of reference, such a member may or may not have the power to vote in the Committee's decisions.

27 Appointment of Committees

a) The Board may, and if so directed by the First Minister shall, appoint Committees and Sub-Committees or other groups, for such purposes as they may determine, subject to such restrictions or conditions as the Board may think fit, or as the First Minister may direct.

b) Standing Committees shall be appointed annually by the Board in the month of April each year. Casual vacancies in the Committees may be filled by the Board at their next ordinary meeting following a vacancy occurring.

c) The Board shall appoint among any such standing Committees a Clinical Governance Committee, a Staff Governance Committee, an Audit (Finance) Committee and a Remuneration Committee.

d) Committees of the Board may appoint Sub-Committees as may be considered necessary.

e) No business shall be transacted at a meeting of a Committee or Sub-Committee of the Board unless the meeting is quorate as defined in the Committee's individual Terms of Reference.

E COMMON SEAL

28 The Common Seal of the Board shall be kept by the Chief Executive in a suitable place secured by a sufficient lock and he/she shall be responsible for its safe custody and its use. All deeds and other documents to which the common seal shall require to be affixed shall be attested by a Member of the Board and by the Chief Executive who shall maintain a register of use. (The Board has approved the Chief Executive as the person acting as "Secretary" for the purpose of the application of the Board Common Seal, to accord with the terms of the National Health Service (Scotland) Act 1978, Schedule I, part I Paragraph 9).

F SUSPENSION AND ALTERATION OF STANDING ORDERS

29 Suspension of Standing Orders

Any Standing Order may be suspended with the consent of two thirds of the Members present and voting.

30 Rescinding or Alteration of Standing Orders

It shall only be competent to rescind or alter any of the Standing Orders by resolutions of the Board to that effect.

31 Review of Standing Orders

The Board shall review Standing Orders from time to time and shall make any new Standing Order or alteration to any existing Standing Order which may seem to be required for the better conduct of the business of the Board, or as the First Minister may direct.

G BREACH OF STANDING ORDERS

32 The Chief Executive or his/her appointee will draw to the attention of the Chairperson of a meeting any apparent breach of the terms of these Standing Orders.

H INTERPRETATION

33 Unless the context determines otherwise the masculine includes the feminine, the singular the plural, the Committee the Sub-Committee, etc.

I STANDING FINANCIAL INSTRUCTIONS

34 The Board's approved Standing Financial Instructions will form part of these Standing Orders.

ANNEX A

SANCTIONS AVAILABLE TO THE STANDARDS COMMISSION FOR BREACH OF THE CODE

(a) censure – the Commission may reprimand the member but otherwise take no action against them;

(b) suspension – of the member for a maximum period of one year from attending one or more, but not all, of the following:

i) all meetings of the State Hospitals Board for Scotland;

ii) all meetings of one or more committees or sub-committees of the State Hospitals Board for Scotland;

iii) all meetings of any other public body on which that member is a representative or nominee of the public body of which they are a member.

(c) suspension – for a period not exceeding one year, of the member's entitlement to attend all of the meetings referred to in (b) above;

(d) disqualification – removing the member from membership of the State Hospitals Board for Scotland for a period of no more than five years.

Where a member has been suspended, the Standards Commission may direct that any remuneration or allowance received from membership of the State Hospitals Board for Scotland be reduced, or not paid.

Where the Standards Commission disqualifies a member of the State Hospitals Board for Scotland, it may go on to impose the following further sanctions:

(a) where the member of the State Hospitals Board for Scotland is also a councillor, the Standards Commission may disqualify that member (for a period of no more than five years) from being nominated for election as, or from being elected, a councillor. Disqualification of a councillor has the effect of disqualifying that member from the State Hospitals Board for Scotland and terminating membership of any committee, sub-committee, joint committee, joint board or any other body on which that member sits as a representative of their local authority.

(b) direct that the member be removed from membership, and disqualified in respect of membership, of any other devolved public body (provided the Members' Code applicable to that body is then in force).

Full details of the sanctions are set out in Section 19 of the Act.

ANNEX B

DEFINITIONS

"Remuneration" includes any salary, wage, share of profits, fee, expenses, other monetary benefit or benefit in kind. This would include, for example, the provision of a company car or travelling expenses by an employer.

"Undertaking" means: a body corporate or partnership; or an unincorporated association carrying on a trade or business, with or without a view to a profit.

"Related Undertaking" is a parent or subsidiary company of a principal undertaking of which you are also a director. You will receive remuneration for the principal undertaking though you will not receive remuneration as director of the related undertaking.

"Parent Undertaking" is an undertaking in relation to another undertaking, a subsidiary undertaking, if a) it holds a majority of the voting rights in the undertaking; or b) it is a member of the undertaking and has the right to appoint or remove a majority of its board of directors; or c) it has the right to exercise a dominant influence over the undertaking (i) by virtue of provisions contained in the undertaking's memorandum or articles or (ii) by virtue of a control contract; or d) it is a councillor of the undertaking and controls alone, pursuant to an agreement with other shareholders or councillors, a majority of the voting rights in the undertaking**.**

Group of companies" has the same meaning as "group" in section 262(1) of the Companies Act 1985. A "group", within s262 (1) of the Companies Act 1985, means a parent undertaking and its subsidiary undertakings.

"Public body" means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000.

"A person" means a single individual or legal person and includes a group of companies.

"Any person" includes individuals, incorporated and unincorporated bodies, trade unions, charities and voluntary organisations.

"Spouse" does not include a former spouse or a spouse who is living separately and apart from you.

"Cohabitee" includes a person, whether of the opposite sex or not, who is living with you in a relationship similar to that of husband and wife.

"Chair" includes Board Convener or any person discharging similar functions under alternative decision-making structures.

Approved as an Accurate Record

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the meeting of the Audit Committee held on Thursday 24 January 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

PRESENT:

Non Executive Director	David McConnell **[Chair]**
Non Executive Director	Bill Brackenridge
Employee Director	Anne Gillan

IN ATTENDANCE:

Internal

Chief Executive	Jim Crichton
Chair	Terry Currie
Finance and Performance Management Director	Robin McNaught
Head of Corporate Planning and Business Support	Monica Merson

External

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

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting. Apologies for absence were noted from Mrs Maire Whitehead.

NOTED

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted.

NOTED

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on Thursday 20 September 2018. Mr McConnell advised Members that he had recently met with the former Chair of the Committee, Mrs Carmichael, for a handover around the work of the Committee. He also noted that the April meeting of the Committee had been moved to 28 March 2019.

NOTED

4 MATTERS ARISING AND ACTION NOTES UPDATE

Members received and noted the Action Notes. Mr Crichton advised Members that action point four had been progressed with the meetings with Directors and reporting to internal auditors progressed within the target timescale. Ms Sandilands advised that action point five had been progressed as

appropriate. Members were therefore able to note that all actions were complete or included in this meeting's agenda.

NOTED

5 ANNUAL UPDATE ON RESILIENCE ARRANGEMENTS

A report was submitted by the Director of Security, Estates and Facilities which provided an update on the governance of resilience and emergency security arrangements within The State Hospital (TSH). Ms Merson summarised the report for Members and emphasised the robust nature of work planning in this area.

Members were content to note the paper as well as the associated workplan of the Resilience Committee.

NOTED

6 ATTENDANCE MANAGEMENT UPDATE

A report was submitted by the Interim Director of Human Resources (HR) which provided Members with an update on staff absence throughout the organisation through the most recent data available to November 2018. Members noted that they had received this update following internal audit reporting and given the focus for the organisation in this area.

Ms Sandilands was in attendance to summarise the key points of the report, and Members noted that although there had been improvement during August and September 2018, sickness attendance had deteriorated in the subsequent period. Members recognised the continuing work of the HR department in conjunction with line managers in this area. At the same time, they sought assurance that there was an appropriate focus on recognising patterns of absence, and application of policy consistently at all levels throughout the organisation.

There was discussion around specific areas to interrogate whether there were discernible patterns within the reporting available. The Committee asked for more detail around the improvement in long term absences in February.

Action - Ms Sandilands

There was further discussion around the national picture and how TSH compared to other Health Boards. Ms Sandilands confirmed that in key areas such as the aging nature of the workforce as well as levels of absence due to mental health, TSH was within similar parameters to other Boards.

The Committee noted the upcoming introduction of 'Once for Scotland' national guidelines for HR expected within the next quarter. The Committee emphasised the continuing importance of this area, and particularly any impact on patient care as a result of staff absence. Members thanked Ms Sandilands for her report and attendance at the committee.

NOTED

7 FRAUD UPDATE

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

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

NOTED

8 FRUAD ACTION PLAN

The Committee received and noted the paper which provided an update on Board engagement with Counter Fraud Services and noted that there were no specific areas of concern. Mr McNaught was asked to update minor detail regarding to annual return within the paper.

Action - Mr McNaught

NOTED

9 CORPORATE RISK REGISTER UPDATE

The Committee received a paper from the Director of Finance and Performance Management which provided an update on the current risk registers, and the proposal that two new risks should be included in the Corporate Risk Register as follows:

- Cyber Security / Data Protection Breach due to computer infection
- Compliance with mandatory PMVA Level 2 training

The Committee noted the paper and approved the inclusion of these risks to the register at the recommended gradings. Members also discussed EU withdrawal and agreed that this should also be added to the corporate risk register.

Members discussed the recent serious incident of breach of confidentiality in the media, and asked for assurance around training and engagement with staff on this issue throughout their employment. It was noted that communication had been sent to all staff to remind them of their responsibilities in this area, and the serious nature of any breach. It was noted that professionally registered staff will receive reminders of their responsibilities in this area and there was concern around the wider workforce. The Committee asked for further assurance in this area.

Action – Mr Crichton / Mr Richards

NOTED

10 PROGRESS REPORT 2018/19

The Committee received a report from RSMUK which outlined the progress made against the internal audit plan for 2018/19. Mr Maccuzzio summarised the report and advised that further internal audit work was being progressed to yearend. A report would be brought as an update on the position at the March meeting of the Committee.

NOTED

11 MANAGEMENT ACTION TRACKING REPORT

The Committee received and noted the tracking report from RSMUK in relation to management actions taken forward in response to internal audit recommendations.

NOTED

12 PATIENT FUNDS AND PROPERTY REVIEW INTERNAL AUDIT REPORT

The Committee was asked to note a report from RSMUK which provided internal audit opinion on the management of patient funds and property within the hospital. Mr Hussain summarised the content of the report for the Committee with internal audit opinion being that the Board could take

substantial assurance in relation to controls in place to manage patient funds, and partial assurance in relation to controls and systems in place to manage patient property.

Members focussed on the findings for management of patient property and noted the joint responsibility in this area between security and nursing colleagues. Members sought assurance that the discrepancies found in some areas were being subjected to rigorous review and noted the need for joint working in this area to enable the required improvement. Members were assured that this was being taken forward through the Directors of Nursing and Security, Estates and Facilities.

It was noted that there should be a review of patients' receipt of funds when the patient may not meet the Scottish Government requirements for entitlement to same.

Action – Mr McNaught

NOTED

13 AUDIT RISK ANALYSIS AND PLAN

Members received a report from Scott Moncrieff in their role as external auditor and Ms Karen Jones was in attendance to provide a high level summary of this.

Members discussed the arrangements for the handover of responsibilities for governance from Mr Currie and Mr Crichton as Chair and CEO respectively given that they would retire at the end of the current financial year, and received assurance that letters of assurance would be signed at the end to enable handover to the new Chair and CEO.

Ms Jones confirmed that internal and external auditors liaised where appropriate.

The Committee approved the content of the report

APPROVED

14 AUDIT SCOTLAND NATIONAL REPORTS 2017/18

The Committee received a report from the Director of Finance and Performance Management as a summary of work progressed by Audit Scotland since the date of the last meeting of this Audit Committee and noting EU withdrawal as a specific risk.

The Committee noted the content of this update.

NOTED

15 OPERATIONAL PLAN UPDATE

Mr McNaught provided a verbal update to the effect that national guidance was awaited in this area, and that this was expected shortly.

NOTED

16 RISK, FINANCE AND PERFORMANCE GROUP TERMS OF REFERENCE AND MINUTES

The Committee received and noted the work progressed to date by this group, which would continue to report to the Audit Committee, and approved the Terms of Reference for the group.

APPROVED

17 EFFECTIVENESS OF AUDIT COMMITTEE

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

The Committee had completed the Self Assessment Checklist, in line with the Scottish Government Handbook in late 2016, with recommendations being identified through this process.

Members considered and discussed each of the recommendations in the report. The first recommendation i.e. to continue self assessment was agreed with continuing self-assessment planned on a two yearly basis. It was noted that with the appointment of Mr McConnell the second recommendation could be considered to have been completed given his experience with finance and audit.

The Committee considered recommendation three –

The Board should develop specific induction material for new members of the Audit Committee. This could include a copy of the Audit Committee Handbook; Terms of Reference; Corporate Risk Register; etc.

Members agreed that in a small Board specific induction material would not be required for each standing committee as may be the case in larger boards. Non-Executive induction arrangements should be reviewed by the Board Secretary. This should encompass refresher training and engagement for all non executive members of the board.

Action – Ms Smith

In relation to recommendation four –

Due to the size of the Board, Audit Committee Members are Members of other Board Standing Committees. The Committee should be aware of potential conflicts of interest related to involvement of members in other Committees.

Members considered this was also difficult in a small board and agreed that awareness of this potential for conflict of interest was high among members and that there should be focus to ensure this remained the case.

The Committee approved the recommendations in the report save for come variance as noted in this minute.

APPROVED

18 ANY OTHER BUSINESS

There were no further items of competent business.

NOTED

19 DATE AND TIME OF NEXT MEETING

The next meeting would take place on 28 March 2019 in the Boardroom, The State Hospital, Carstairs.

The meeting ended at 11.35am

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 April 2019
Agenda Reference:	Item No: 16
Sponsoring Director:	Chief Executive Officer
Author(s):	Board Secretary
Title of Report:	Chief Executive's Report
Purpose of Report:	For Information

1 BACKGROUND

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

2 GENERAL ISSUES OF NOTE

The Chief Executive will provide the Board with a verbal update.

3 PATIENT SAFETY UPDATE

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

Improving Observation Practice (IOP) Workstream

- Qualitative Case study completed
- Quantitative Research paper commenced looking at risk and engagement improvement in regards Improving Observation Practice (IOP)
- Next stage of learning sessions ¾ completed with positive feedback
- Arran test ward continue no Level 3 observations
- Ongoing roll out of clinical pause in Arran
- Continues specific involvement within Iona 2
- Next stage Zonal/flexible observations (piloted successfully in Iona 1)
- GAP analysis completed for policy rewrite (Observation policy)

Communication at Transition

Patient Support Plans have been implemented and are an individually tailored guide that promotes person centred care. This is in the early stages of implementation. This topic was presented to the last Patient Safety group.

Safer Medicines Management

The electronic PRN form has been implemented across all wards. Improvements have been seen with the completion of the forms. Work will now be undertaken collecting data on omitted medications.

Least Restrictive Practice

The Clinical Pause has been rolled out to all Hubs. Dr Skilling presented the Clinical Pause work at the Journal Club in December.

Dr Skilling attended the Lewis Local Clinical Forum on 15/4/19 to present the Clinical Pause to the Lewis team. All Hubs have now had a formal intro session with Dr Skilling and the Clinical Pause process is now live on RiO. Mull, Iona and Arran have all held Clinical Pauses so far. It is hoped and anticipated that the process will continue to iteratively change and improve with ongoing PDSAs/feedback.

Dr Skilling has also presented Clinical Pause work at the National SPSP MH IOP leads meeting, and the IHI Forum (poster) and has been invited to Rohallion Clinic to present there.

Leadership and Culture
Leadership walkrounds have been programmed for 2019. At the time of this report, 3 walkrounds have been carried out in both clinical and non-clinical areas. Agreed actions are highlighted at the Chief Executive Business Meeting and are monitored through the Patient Safety Group.

Nationally, SPSP MH have launched new safety principles:

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

Analysis is ongoing to align existing work, both within the group and outwith, to ensure coverage of all areas, where appropriate. The new safety principles, along with the existing policy review around the publication of From Observation to Intervention, are the focus of the group's priorities at the moment.

Eight staff had the opportunity to attend the recent IHI/BMJ International Forum on Quality and Safety in Healthcare, held in Glasgow as well as representatives attending MH2019 Improve day. Learning from these events will be taken forward both by the Patient Safety and QI Group.

4 HEALTHCARE ASSOCIATED INFECTION (HAI)

This is a summary of the Infection Control activity from 1st January – 31st March (unless otherwise stated)
Key Points:

- The submission of the hand hygiene audits continues to be a key priority which is monitored and reported both to this Board, Infection Control Committee and Senior Ward staff routinely. There has been a notable improvement in submissions since April. The Senior Nurse for Infection Control will continue to contact individual wards which are non compliant to allow a late submission.

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

- The antimicrobial prescribing is minimal in comparison to other NHS Boards; however the prescribing that occurs within The State Hospital is being monitored by the antimicrobial pharmacist and the Infection Control Committee quarterly with no trends or areas identified for concern.

Audit Activity:

Hand Hygiene

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

January
10 out of a possible 12 were submitted

February
10 out of a possible 12 were submitted

March
12 out of a possible 12 were submitted

The overall hand hygiene compliance within the hubs varies between 80-100%, Skye Centre 40-80% and health centre consistently attaining 100%.

Following approval by the Senior Management Team both the product and the location of the hand gel within the Skye Centre was changed. This change occurred in September, early indications would show that the positioning and change in product has not made any significant difference. Nationally Hand Hygiene products are being reviewed and following the Commodities Advisory Panel Recommendations the products used within the hospital may have to change. Until this has been agreed to further changes to products will occur.

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

DATIX INCIDENTS FOR INFECTION CONTROL

There were a total of 29 incidents for the period under the Category of Infection Control, all of which relate to clinical waste (safe management of linen). This has been addressed with the Senior Nurse for Infection Control and senior ward based nursing staff. Close monitoring will continue.

All DATIX incidents are reviewed by the Senior Nursing Staff, clinical teams (as required) and the Infection Control Committee quarterly.

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

Following the poor compliance with the 4 core modules the ICC agreed to provide a 3month extension to date over 85% of staff have completed all 4 core modules.

This will continue to be reviewed by the ICC quarterly.

Environmental Health Inspection:
South Lanarkshire Environmental Health visited the hospital to undertake an audit of the main kitchen, ward kitchens and therapeutic kitchens. This was a positive inspection with no recommendations made.

Hepatitis C Treatment
During this review period we have had 0 patients eligible to commence treatment.

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

5 PATIENT ADMISSION / DISCHARGES

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

The following table outlines the high level position during 1 February until 31 March 2019.

	MMI	LD	Total
Bed Complement (as at 31/03/19)	125	15	140
Staffed Beds (ie those actually available) (as at 31/03/19)	117	15	132
Admissions (from 01/02/19 – 31/03/19)	8	0	8
Discharges / Transfers (from 01/02/19 – 31/03/19)	4	0	4
Average Bed Occupancy February – March 2019	-	-	108 90% of available beds 77% of all beds

6 RECOMMENDATION

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 20 JUNE 2019
1pm

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

A G E N D A

1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 25 April February 2019	For Approval	TSH(M)19/03
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 19/34
5.	**Chair's Report**	For Noting	Verbal
	CLINICAL GOVERNANCE		
6.	**Clinical Governance Committee – Annual Report 2018/19** Report by the Committee Chair	For Approval	Paper No. 19/35
7.	**Review of the Clinical Service Delivery Model – Update** Report by the Medical Director	For Noting	Paper No. 19/36
8.	**Health and Care Staffing – Update** Report by the Director of Nursing and AHPs	For Noting	Paper No. 19/37
9.	**Skye Centre – 12 Monthly Report** Report by the Director of Nursing and AHPs	For Noting	Paper No. 19/38
10.	**Clinical Governance Committee** Draft Minutes – 9 May 2019	For Noting	CG(M)19/02
	STAFF GOVERNANCE		
11.	**Staff Governance Committee – Annual Report 2018/19** Report by the Committee Chair	For Approval	Paper No. 19/39
12.	**Remuneration Committee – Annual Report 2018/19** Report by the Committee Chair	For Approval	Paper No. 19/40
13.	**Response to Report to the Cabinet Secretary for Health and**	For	Verbal

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

CORPORATE GOVERNANCE

16.	**Audit Committee – Annual Report 2018/19** Report by the Committee Chair	For Approval	Paper No. 19/42
17.	**Annual Accounts for year ended 31 March 2019** Report by the Director of Finance & Performance Management	For Approval	Paper No. 19/43
18.	**Finance Report to 31 May 2019** Report by the Director of Finance & Performance Management	For Noting	Paper No. 19/44
19.	**Annual Review of Standing Documentation** Report by the Director of Finance & Performance Management	For Approval	Paper No. 19/45
20.	**Property and Asset Management Strategy** Report by the Director of Security, Estates and Facilities	For Approval	Paper No. 19/46
21.	**Performance Report 2018/19** Report by the Director of Finance & Performance Management	For Noting	Paper No. 19/47
22.	**Corporate Governance – Improvement Plan Update** Report by the Board Secretary	For Noting	Paper No. 19/48
23.	**Audit Committee** Draft Minutes – 28 March 2019	For Noting	A(M)19/02
24.	**Chief Executive's Report**	For Noting	Paper No. 19/49
25.	**Any Other Business**		
26.	**Date and Time of next meeting** 22 August 2019, 1pm in the Boardroom At The State Hospital, Carstairs, ML11 8RP		

27. EXCLUSION OF PUBLIC AND PRESS

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

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

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

Chaired by Non-Executive Director: Bill Brackenridge

Present:

Employee Director	Tom Hair
Chief Executive	Gary Jenkins
Non Executive Director	Nicholas Johnston
Non Executive Director	David McConnell
Finance and Performance Management Director	Robin McNaught
Director of Nursing and AHPs	Mark Richards
Medical Director	Lindsay Thomson
Non- Executive Director	Maire Whitehead

In attendance:

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

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

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

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

NOTED

2 CONFLICTS OF INTEREST

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

NOTED

3 MINUTES OF THE PREVIOUS MEETING

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

APPROVED

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

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

NOTED

5 CHAIR'S REPORT

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

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

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

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

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

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

NOTED

6 PATIENT, CARER AND VOLUNTEER STORIES - A CARER STORY

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

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

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

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

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

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

Action - Mr Richards

NOTED

7 REVIEW OF THE CLINICAL MODEL - UPDATE

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

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

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

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

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

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

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

Action - Professor Thomson

NOTED

8 CLINICAL GOVERNANCE COMMITTEE – CHAIR'S REPORT

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

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

NOTED

9 ATTENDANCE MANAGEMENT IMPROVEMENT TASK GROUP

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

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

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

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

Action - Ms Sandilands

NOTED

10 STAFF GOVERNANCE COMMITTEE

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

NOTED

11 FINANCE REPORT AS AT 31 MARCH 2019

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

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

Action – Mr McNaught

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

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

NOTED

12 DRAFT OPERATIONAL PLAN

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

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

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

Action - Mr Jenkins

AGREED

13 CORPORATE GOVERNANCE BLUEPRINT

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

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

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

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

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

Action – Ms Smith

APPROVED

14 ANNUAL REVIEW OF STANDING DOCUMENTATION

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

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

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

Action Mr McNaught/ Ms Smith

NOTED

15 AUDIT COMMITTEE

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

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

NOTED

16 CHIEF EXECUTIVE'S REPORT

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

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

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

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

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

Members were content to note this report.

NOTED

17 ANY OTHER BUSINESS

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

NOTED

18 DATE AND TIME OF NEXT MEETING

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

NOTED

19 EXCLUSION OF PUBLIC AND PRESS

Members approved a motion to exclude the public and press during consideration of the items

listed at Part II of the agenda in view of the confidential nature of the business to be transacted.

AGREED

ADOPTED BY THE BOARD

CHAIR _____
(Signed Mr Terry Currie)

DATE 25 April 2019

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

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

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

Paper No. 19/35

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item 6
Sponsoring Director:	Medical Director
Author(s):	Medical Director/Clinical Effectiveness Team Leader
Title of Report:	Clinical Governance Annual Stock Take
Purpose of Report:	For approval

1 Situation

The attached Clinical Governance Committee Annual report outlines the wide range of activity overseen by the Committee during 2018/19. The stock take also includes the Committee's Terms of Reference, Reporting Structures and Work Programme.

2 Background

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

- A review of reporting structures within the hospital.
- A review of the committee's work programme for forthcoming years.
- A review of the committee's terms of reference.
- An annual report summarising the work of the groups and departments that report to the Clinical Governance Committee.

3 Assessment

Governance Reporting Arrangements
A diagram to show how each group within the hospital reports and escalates any issues.

Terms of Reference
The Committee's Terms of Reference are subject to annual review.

Programme of Work
The programme of work sets out the topics that will be presented to the committee over the coming months.

Clinical Governance Committee Annual report
The report summarises the work of the Clinical Governance Committee and highlights particular areas of good practice along with matters of concern that have been discussed throughout the year.

4 Recommendation

The Committee is asked to approve the Governance Reporting Arrangements, Terms of Reference, Programme of Work and the Clinical Governance Committee Annual Report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	As outlined within report
Workforce Implications	n/a
Financial Implications	n/a
Route To Board Which groups were involved in contributing to the paper and recommendations?	Clinical Governance Committee
Risk Assessment (Outline any significant risks and associated mitigation)	n/a
Assessment of Impact on Stakeholder Experience	n/a
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE ANNUAL REPORT

1 April 2018 – 31 March 2019

1. Introduction

The State Hospital, like all NHS organisations, has a statutory responsibility to establish clinical governance arrangements to ensure continuous improvement in the quality of care and treatment provided to patients. The national requirements for clinical governance have been the subject of substantial guidance, from the *Clinical Governance and Risk Management Standards* published by NHS Quality Improvement Scotland (NHS QIS) in 2005, to *Better Health, Better Care*, published by NHS Scotland in 2007, and subsequently through the Scottish Government's publication of the *Healthcare Improvement Strategy for NHS Scotland* in 2010 which outlines 3 main quality ambitions:

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

The underlying principle of effective clinical governance is that systems and processes provide the framework for patients to receive the best possible care. This report provides an overview of the work of the Clinical Governance Committee during 2017/18 and examples of good practice and matters of concern

2. Committee Chair, Committee Members and Attendees

Committee Chair
Nicholas Johnston, Non-Executive Director

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

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

3. Meetings during 2018/19

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

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

4. Reports Considered by the Committee during the Year

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

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

4.1 12 Monthly Internal Governance Reports

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

Fitness to Practice
The Committee received a report in relation to Fitness to Practise at its May meeting. The reporting period covered was 1 April 2017 - 31 March 2018. The report was submitted to the Committee for information in respect of the process for monitoring professional registration status at The State Hospital thus providing assurance that all relevant staff hold current professional registration as appropriate. The system was verified monthly for all areas of clinical practice. The Committee noted the report and agreed that it should also be flagged to the Staff Governance Committee.

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

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

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

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

CPA/MAPPA
At the August meeting the Committee noted the report covering the period 1 July 2017 - 30 June 2018 and supported the future areas of work. 97% of transfers were managed through the CPA process. The report evidenced successful implementation of the principles of the Clinical Model. The report identified a number of key areas in relation to Multi Disciplinary CPA attendance; Patient and Carer Involvement; and Strategic Engagement and Representation. During the reporting year the vacant CPA Administrator post was reviewed. In light of the consistently lower number of patients the post was not filled. A contingency plan has been agreed with the clinical secretary coordinator to provide CPA administrative support in the absence of the Social Work PA/Administrator, as required.

Patient Safety
In August the Committee received and approved the Patient Safety Report covering the period 1 July 2017 - 30 June 2018. The report noted that the Hospital continues to influence nationally through developing, implementing and sharing its SPSP Mental Health programmes of activity. The report provided an update in respect of progress with all five mental health workstreams, i.e. Leadership and Culture; Communication at Transitions; Safer Medicines Management; Violence, Restraint and Seclusion Reduction; and Risk Assessment and Planning. A range of areas within the report was discussed by the Committee members in relation to the programme of Leadership Walkrounds emphasising the need to ensure commitment to these; the introduction of EssenCES, Clinical Pause and DASA and the trends in observation practice and the staffing associated with this.

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

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

Physical Health Steering Group
In November the Committee received and noted the 12 month rolling report from the Physical Health Steering covering the period 1 October 2017 - 30 September 2018. The report noted the developments and progress made in the 5 key strands for which the Physical Health Steering Group had responsibility. These related to Primary Care (including long term conditions); Physical Activity; Nutrition and Weight Management; Food, Fluid and Nutrition and National Guidelines and Standards. For each of these areas, details were provided of the work undertaken and the performance against local performance management targets.

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

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

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

Clinical Governance Group
At the February meeting the Committee received and noted the second 12 monthly report from the Clinical Governance Group covering the period 1 January 2018 - 31 December 2018. The report provided a summary of the work of the Clinical Governance Group over the past 12 months. As well as overseeing the reports that go to the Clinical Governance Committee other key pieces of work included: ensuring that the supporting healthy

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

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

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

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

4.2 Standing Items Considered by the Committee during the Year

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

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

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

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

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

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

Patient Movement Statistical Information
The Committee received and noted 2 reports during the year at its May and November meetings. The May report covered the reporting period 1 September 2017 - 31 March 2018 and the November report covered 1 April 2018 - 30 September 2018. These reports provided an overview of bed occupancy, area and source of admission, delay between referral and admission, admissions of young people (under 18), 'exceptional circumstances' admissions, appeals against excessive security, discharges and transfers and number of patients on the transfer list.

Incident Reporting and Patient Restrictions Report
The quarterly Incident Reporting and Patient Restrictions report was considered at the Clinical Governance Committee at every meeting. The report showed the type and the amount of incidents received through the incident reporting system DATIX, as well as all the restrictions applied to patients during the periods under review. The report provided more information of the various incidents that had occurred in relation to PAA activations; the use of handcuffs; patient seclusions; withheld mail; urinalysis results; security incidents; communication/information incidents; those relating to equipment, facilities and property; and prohibited items brought in by staff which were now recorded in DATIX.

5. Discussion Items During the Year

The discussion items during 2017/18 picked up on 2 out of the 3 priority areas for the hospital. The 2 areas were: Clinical Outcome Measures and Healthy Choices (linking to obesity). The third priority, Physical Activity was discussed at the November 2018 meeting.

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

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

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

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

The Committee noted the presentation.

6. Special Topics/Items for Approval

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

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

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

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

7. Areas of Good Practice Identified by the Committee

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

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

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

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

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

8. Matters of Concern to the Committee

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

9. Conclusion

From the review of the performance of the Clinical Governance Committee, it can be confirmed that the Committee has met in line with the Terms of Reference, and has fulfilled its remit. Based on assurances received and information presented to the Committee, adequate and effective Clinical Governance arrangements were in place throughout the year.

The State Hospital

CLINICAL GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

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

2 COMPOSITION

2.1 Membership

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

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

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

An ex-officio member is a member of a body who is part of it by virtue of holding another office. Such members shall have the power to vote in the Committee's decisions. Membership will be reviewed annually.

Members:

- M Whitehead
- N Johnston (Chair)
- D McConnell

Ex-officio Members

- Terry Currie, Chairperson

In Attendance

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

2.2 Appointment of Chair

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

2.3 Attendance

Members shall normally attend meetings and receive all relevant papers. All Board Members, the Chair of the Medical Advisory Committee and the Chair of the Research Committee, will have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

If attendance at the meeting is only required on a periodic basis, this should be agreed with the Committee Chair in advance. Apologies should be tendered to the Chair of the Committee via the minute secretary at least 2 working days prior to the meeting, unless an exceptional event prevents this level of notice.

Where a member who is due to present a paper is not able to attend they should ensure that another person is suitably briefed in order to deal with this item. The arrangement made should be discussed and approved by the Committee Chair.

To fulfil its remit, the group may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of hospital staff to attend meetings. If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

Others may attend the Committee on the approval of the Committee Chair.

3 MEETINGS

3.1 Frequency

The Clinical Governance Committee will meet quarterly to fulfil its remit and shall report to the Board following each meeting.
The Chair of the Committee may convene additional meetings as necessary.
The Accountable Officer of the Board may ask the Chair of the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least five working days in advance to allow time for consideration of issues.

The format of agendas and papers will be in line with corporate document standards. The lead Executive for co-ordinating agendas and papers is the Medical Director.

All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken. Cover papers should be prepared in the format set out in Corporate Document Standards, to draw out the main issues for the Committee. Annual Reports of reporting committees should follow the format set out in Corporate Document Standards.

Documents will be watermarked as Confidential or Draft as required. Documents which are watermarked as Confidential should not be shared outwith the Committee membership. Guidance on confidentiality and openness can be sought from the Records Services Manager.

The secretary for this Committee will maintain a master file of documents, in line with Policy for Management, Retention and Disposal of Administrative Records.

3.3 Quorum

In the event of the Committee making decisions, two members need to be in attendance to be quorate.

3.4 Minutes

Formal minutes will be kept of the proceedings and submitted for approval at the next Board meeting. The Board Secretary is responsible for minute taking arrangements. The draft minutes will be cleared by the Chair of the Committee and the nominated lead Executive (Medical Director) prior to approval by the Committee and notification to the Board.

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

4 REMIT

4.1 Objectives

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

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

4.2 Systems and Accountability

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

4.3 Safe and Effective Care

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

- Structures are in place to minimise potential problems such as effective risk assessment and management, incident reporting, critical incident reviews, and complaint procedures
- Lessons are being learned from adverse events and near misses
- Complaints are handled in accordance with national guidance and lessons will be learned from their investigation and resolution (including reports of the Scottish Public Services Ombudsman and the Mental Welfare Commission)
- Arrangements are in place to support child and adult protection obligations.

4.4 Health, Wellbeing and Care Experience

- To ensure that the environment supports delivery of high quality care with a culture and appropriate mechanism to allow staff and others to raise concerns on the service of care provided, including the performance of clinical colleagues, in the knowledge they will be addressed without detriment to themselves or prejudice to the principles of confidentiality.
- To ensure that arrangements are in place to embed Person Centred Improvement activities, including equality and diversity issues pertinent to clinical governance.
- To ensure that care is provided by appropriately trained and skilled professionals with the competencies required to deliver the required care.
- To ensure that clinical policies and procedures are developed, implemented and reviewed.
- To ensure that poor performance of clinical care will be identified and remedial action taken.

4.5 Control Assurance

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

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

5 AUTHORITY

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

6 PERFORMANCE OF THE COMMITTEE

The Committee shall annually review and report on:

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

7 REPORTING FORMAT AND FREQUENCY

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

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

8 COMMUNICATION AND LINKS

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

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

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

Subject to annual review.
Next revision: May 2020.

Paper No: 19/36

THE STATE HOSPITALS BOARD FOR SCOTLAND

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

1 SITUATION

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

2 BACKGROUND

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

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

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

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

3 ASSESSMENT

Staff Engagement Process

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

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

Reactions from staff groups to the Clinical Model Review

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

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

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

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

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

Options Appraisal Process

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

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

Next Steps

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

4 RECOMMENDATION

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

Paper No: 19/36

MONITORING FORM

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

Appendix 1

Clinical Model Options Appraisal

Options Appraisal Process

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

Benefits Criteria

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

Benefits Criteria

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

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

Weighting of benefits criteria

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

Scoring of options

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

Financial Analysis

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

Sensitivity Analysis (Risk, Reputation Workforce)

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

Decision Analysis

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

Paper No. 19/37

THE STATE HOSPITALS BOARD FOR SCOTLAND

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

1 SITUATION

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

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

2 BACKGROUND

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

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

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

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

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

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

3 ASSESSMENT

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

These principles are:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Duty to Follow the Common Staffing Method

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

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

The Common Staffing Method is set out in appendix 1.

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

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

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

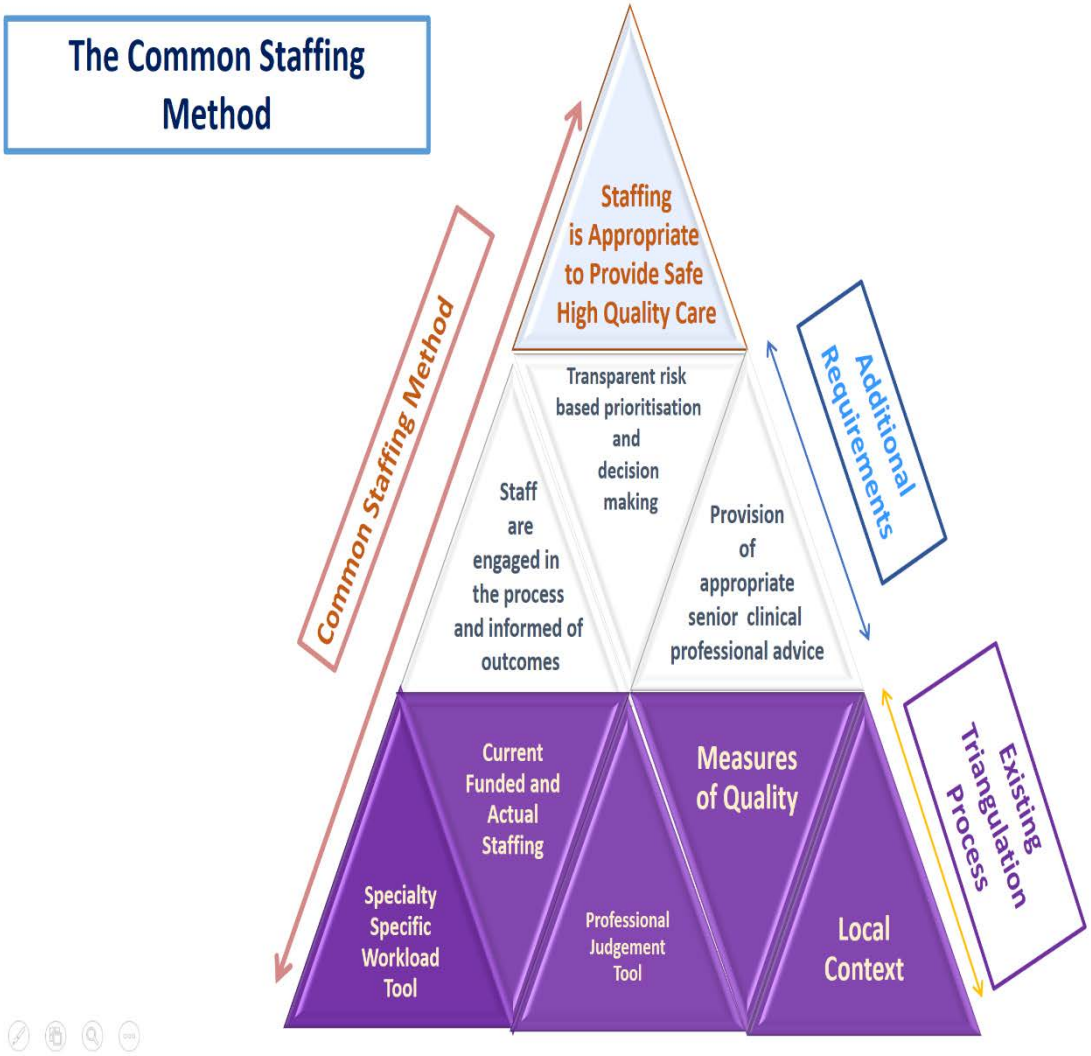
The workforce lead is working closely with Healthcare Improvement Scotland to prepare for meeting the requirements set out in the Bill, particularly the Common Staffing Method.

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

4 RECOMMENDATION

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

Appendix 1


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

MONITORING FORM

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

Paper No. 19/38

THE STATE HOSPITALS BOARD FOR SCOTLAND

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

1 SITUATION

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

2 BACKGROUND

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

3 ASSESSMENT

Key Pieces of Work Undertaken During the Year

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

Identified Issues and Potential Solutions

- Recruitment
- Sickness

4 RECOMMENDATION

Future Areas of Work and Potential Service Developments

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

Paper No. 19/38

MONITORING FORM

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

THE STATE HOSPITAL BOARD FOR SCOTLAND

SKYE CENTRE

12 MONTH UPDATE BOARD REPORT

1 June 2018 – 31 May 2019

Reference Number		Issue:
Lead Author	Jacqueline Garrity, Skye Centre Manager	
Contributing Authors	Tracy Tait, Skye Centre Secretary	
Approval Group	The State Hospital Board	
Effective Date	1 June 2018	
Review Date	31 May 2019	
Responsible Officer (e.g. SMT lead)	Mark Richards, Nursing & AHP Director	

Contents

Section 1 – Introduction

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

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

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

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

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

Recommendation Description	Achieved/Not Achieved	Comments
Evening Social Activities In response to feedback from our patient group via the What Matters To You events and the PPG a monthly programme of weekday evening social activities will be piloted during the summer months, starting in June 2018.	Achieved	Three social evening activities were planned commencing June '18. These were well attended and feedback from patients was very positive. The 'Events Committee' group, established during a TSH3030 project last year, has been introduced into the Skye Centre to offer patients across the hospital an opportunity to participate in a voluntary role as an events committee member.
Supporting Healthy Choices Skye Centre engagement with the Supporting Health Choices group is ongoing and the Shop staff and Sports & Fitness staff continue to demonstrate their support and deliver the agreed priorities for this plan of work. Both areas are actively involved in supporting the development of the Health and Well Being plans for our patients.	Achieved	Health & Wellbeing plans have been developed in consultation with all relevant disciplines. The Sports and Fitness and Shop staff have been trained in the completion of the relevant sections and are successfully completing these in line with the implementation programme.
Outcome Measures Further to discussions held at the Mental Health Practice Steering Group and the ongoing work related to Outcome Measures, The Research Manager has agreed to support the Skye Centre Leadership team to further define the existing measures to reflect the work carried out and support the service's governance arrangements. The Induction Pathway was reviewed and now includes joint working with the relevant OT and the completion of the OT assessment tools to inform the patient needs. The revised pathway was introduced in May 2018.	Achieved	Research Manager attended and supported the Skye Centre Leadership Group to discuss objectives related to the outcome measures report. The information related to our service has continued to be revised over the past year in order to best reflect the outcomes related to the service. A number of formal assessments are now included in the Induction process including a range underpinned by the Model of Human Occupation and others such as the Allen Cognitive Level Screen and the Peavy Social Comportment tool.
Patient Active Day Project Further evaluation of the Active Day Model is currently taking place in relation to the Iona Project taking into consideration feedback from patients and the wider clinical team members regarding this patient group engagement whilst at the Skye Centre and the potential impact on those patients remaining on ward.	Achieved	The Patient Day project was extended to include Arran 2 on 23rd August 2018, with this ward aiming to deliver the Patient Day model 2 sessions a week, however this was reduced to 1 session in November 2018. By December 2018 it was agreed that the Patient Day model would be implemented across the remaining 2 hubs (Mull & Iona) and Arran 2 session times would be reviewed to increase this back to 2 sessions as of January 2019. The extended project was successfully implemented the week

Recommendation Description	Achieved/Not Achieved	Comments
		commencing 7th January 2019 across all 4 hubs and has been maintained to present date.
Recruitment The recruitment is at various stages in order to fill vacancies. Discussions are ongoing to review the current workforce number and skill mix to ensure succession planning is built in to future service delivery to meet the needs of our patients.	Ongoing	Every effort has been made to address the ongoing vacancies across the service. The recruitment process for these posts is ongoing. The long standing Band 5 Gardens post has successfully been recruited to. Staffing contingencies continue to be put in place to minimise the disruption to this service until the vacancies are filled. The registered staff mix was reviewed and a band 6 Senior Occupational Therapist was also successfully appointed in February '19.
Patient Timetable A small sub group has been established with representation from the Skye Centre, AHP and Person Centred Improvement Team to identify the range of activities to be included and agree the most appropriate way for this to be presented. Our e-health department have also developed a draft form which will be completed on Rio. Work continues on the timetable and it is anticipated that this will be available within the coming months. This would enable the Skye Centre along with the other services to plan patient activity in a more efficient manner.	Partially Achieved	The development of the Patient timetable was commenced in December 2018. A multidisciplinary sub group was established with representation including Nursing, Psychology, Skye Centre, Medical, E-Health and AHP. Training on how to use the newly developed system was carried out in March 2018 and a pilot commenced in April 2019 within Lewis 2 and feedback has been received. The Sub group are meeting in June 2019 to discuss and make the necessary changes received from the Pilot prior to implementing across the site.

Overview

The Skye Centre service is defined by four Activity Centres (Patient Learning, Sport & Fitness, Craft & Design, and Gardens & Animal Assisted Therapy) and also includes the Atrium where the patients can access the activity group room, café, library, shop and bank. There are also a variety of other groups facilitated in this environment by the Person Centre Improvement Team (Patient Partnership Group - *PPG*, Christian Fellowship and Multi Faith Services), the Psychological Therapies Service and Allied Health Professions staff. The Advocacy service are also located within the building. It is also important to note that the Health Centre is an integral part of the service and operates closely with the wider activity centres and Atrium.

Service Delivery

Staff configuration
The Skye Centre service consists of a group of registered Nursing staff, supported by skilled technical staff and Health Care Support Workers, who are all dedicated to meeting the clinical, educational, health & wellbeing, vocational and recreational needs of our patient population. In February 2019 the service successfully appointed a Senior Occupational Therapist to join the team.

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

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

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

Delivery of Interventions

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

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

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

Section 2 - Governance & Management Arrangements

Governance Arrangements

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

Management Arrangements

The Skye Centre Manager is operationally responsible for the Skye Centre service and staff group. The Senior Charge Nurse is managerially responsible for the group of nursing staff, Senior Occupational Therapist and support staff group. There are 3 Charge Nurse posts across the service each with responsibility for the day to day supervision of discrete areas of the service.

Section 3 - Key Performance Indicators

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

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

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

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

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

Safe

The nursing staff within the Skye Centre service are offered the opportunity to receive individual clinical supervision in line with the nursing supervision model that has been agreed and approved within the organisation. Over the past 12 months all Skye Centre registered nursing staff received formal supervision – x6 individual sessions and 8 group sessions facilitated by a Clinical Nurse Specialist allocated from the Psychological Therapies Service. Our support staff participated in 7 group supervision sessions facilitated by a member of the Nurse Practice Development Team.

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

The delivery of activities continue to be risk assessed and modified to ensure that patients have access to the necessary resources, tools and equipment at a level appropriate to their needs.

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

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

Effective

The progress of individual patients is monitored in a number of ways. This can be achieved subjectively using non standardised methods such as observation of behaviours, interactions with peers/staff and the recording of staff clinical reasoning and judgement, documented using the electronic patient record (RIO). Our newly appointed Senior Occupational Therapist has also supported the use of standardised outcome measures within the induction process for new admission patients and also during OT treatment interventions.

There are presently a range of Patient Learning Outcomes and KPIs in place across the service and these are reported annually in a separate report to the Board. This report was received in February 2019 and detailed the progress made and the recommendations related to patient learning for the coming year. It is important to note that these outcomes related to patient learning are an integral part of the Activity Centres and support the selection and development of the patient timetable.

Skye Centre staff do not routinely attend weekly Clinical Team meetings and Annual CPA Review meetings however every effort is made to ensure staff input is available as and when the clinical need is indicated.

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

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

Figure 3 Skye Centre ICP DATA June 2018 – May 2019

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

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

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

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

Person – Centred

The Skye Centre service continues to comply with the principles outlined in the revised NHS Complaints & Feedback Procedure and staff are encouraged to act on all feedback effectively, resolving issues as early as we can and learning from them where we can so that we can improve our service.

There has been an increase in the number of complaints from patients regarding the Skye Centre within the last 12 months. Figure 4 below outlines the number of complaints received during the reporting period. A total of **15** complaints were received (8 upheld, 1 partially upheld, 4 not upheld, 2 withdrawn) in comparison to **11** during the previous year (4 upheld, 1 partially upheld, 4 not upheld, 2 withdrawn). Appendix 1 provides further detail for each complaint.

Figure 4

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

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

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

Figure 5

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

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

Figure 6 Reasons for non-attendance at planned sessions

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

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

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

Hub Induction
From the 35 patients admitted during this period, on the advice of the ward nursing staff, 3 patients currently remain too unwell to participate in a Hub Gym Induction. Unless informed otherwise, the Sports staff contact the ward every 14 days to review the patient's suitability to participate in the Induction process.

Of the 32 patients who have participated in the Sports Hub Induction, over the last 12 months it has taken on average around 21 days from admission for a patient to complete the initial stage of the Sports Pathway i.e. Hub Gym Induction, in comparison to 40 days in 2017/18. The reasons for this delay can be attributed to the patients' poor mental health and presenting challenging behaviours. As a consequence the other stages of the pathway are unable to be progressed. The Sports staff have maintained fortnightly contact with the ward nursing staff to ascertain all of the patients' suitability to attend. This information is recorded on the Sports Database.

Sports & Fitness Admission Assessment
From the 35 patients admitted, on the advice of the ward nursing staff, 3 patients currently remain too unwell to attend the Sports and Fitness Activity Centre to commence the physical fitness assessment and attend planned weekly Admission sessions. Unless informed otherwise, the ward are contacted every 14 days to review individual patient's suitability to engage in the Sports Induction programme.

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

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

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

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

Referrals

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

Figure 7 Number of Referrals:

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

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

Figure 8

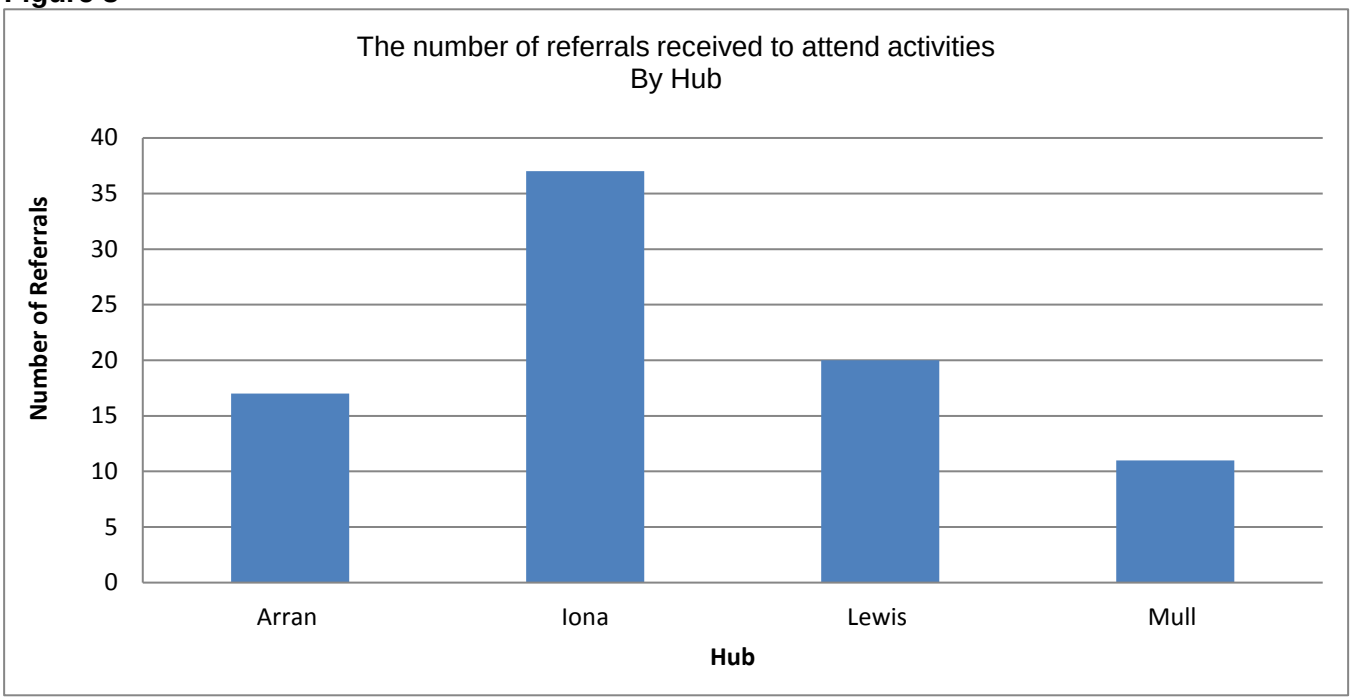
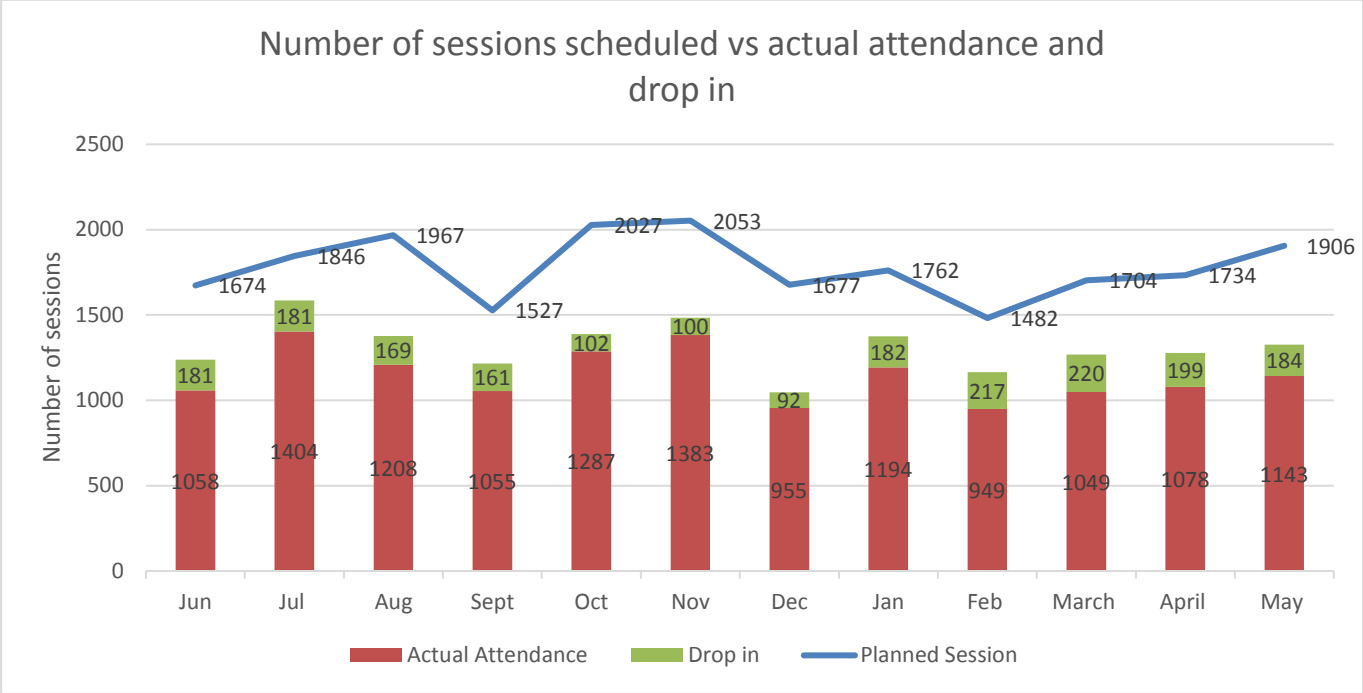


Figure 9 below details the number of activity sessions patients engaged in at the Skye Centre for the period June 2018 to May 2019.

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

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

Figure 9



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

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

Figure 10

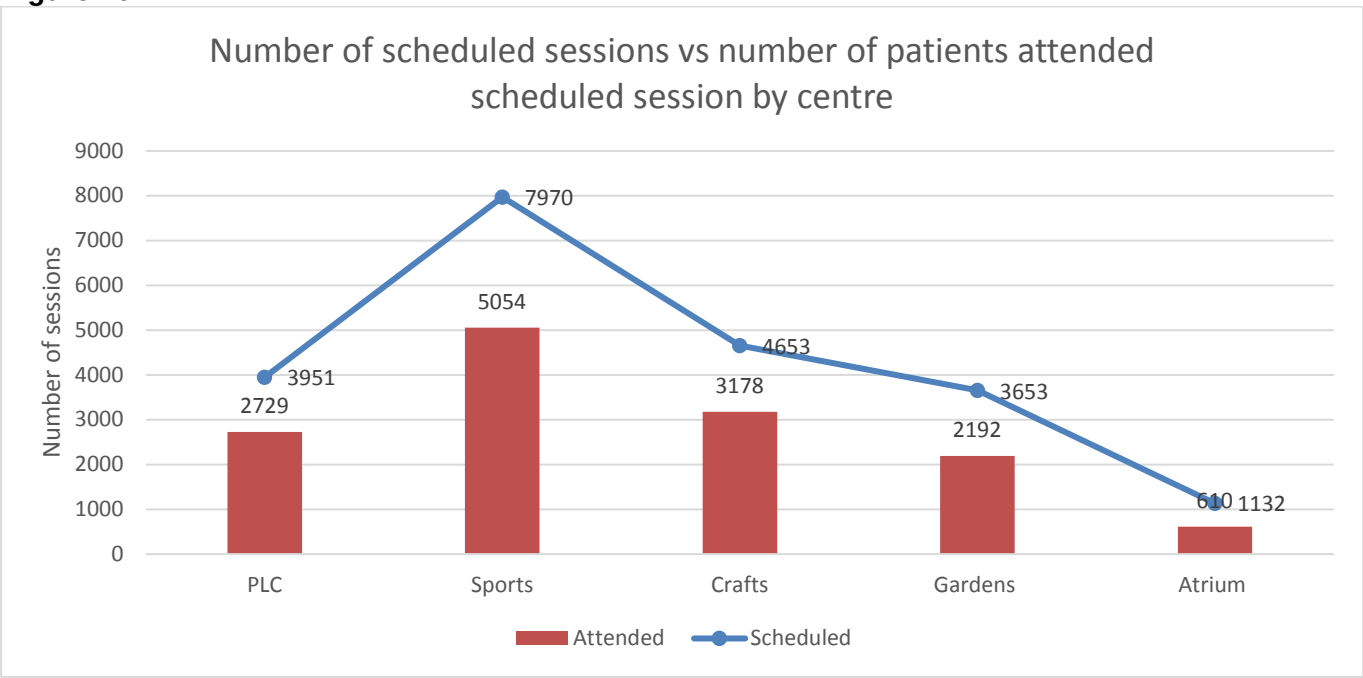


Figure 11 and Figure 12 provide information related to the caseload and waiting list for each activity centre. The 1 patient waiting for a placement in Gardens does have other placements within the PLC however due to the complex needs of this individual and requirement for increased staffing and tailored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

Figure 11

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

Figure 12

Number of patients on waiting list			
	2018/19	2017/18	2016/17
PLC	0	0	0
Sports	0	0	0
Crafts	0	0	0
Gardens	1	0	3
Atrium	0	0	0

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

The following Figure 13 demonstrates the number of sessions that individual patients are scheduled to attend (data related to week commencing 28th May 2019). It is evident that each hub varies in relation to individual patient engagement at the Skye Centre. The data presented is reflective of the patients' weekly Skye Centre timetable and does not include the time spent attending the Health Centre which varies or Patient Shop which the majority of patients attend one morning per week. It also does not include drop in activity or attendance at the Patient Day Project. The groups facilitated by the Person Centre Improvement Team are also recorded separately.

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

Figure 13 - Skye Centre Sessions

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

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

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

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

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

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

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

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

The group reflected on the two questions detailed below in relation to each activity area, from which a focused discussion took place to identify common themes, following which priority actions were developed.

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

Patients with significant barriers to communication were supported to share their views, eliciting some insightful comments.

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

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

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

Section 4 – Key Pieces of Work Undertaken During the Year

Patient Day Project

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

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

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

Performance Data

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

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

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

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

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

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

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

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

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

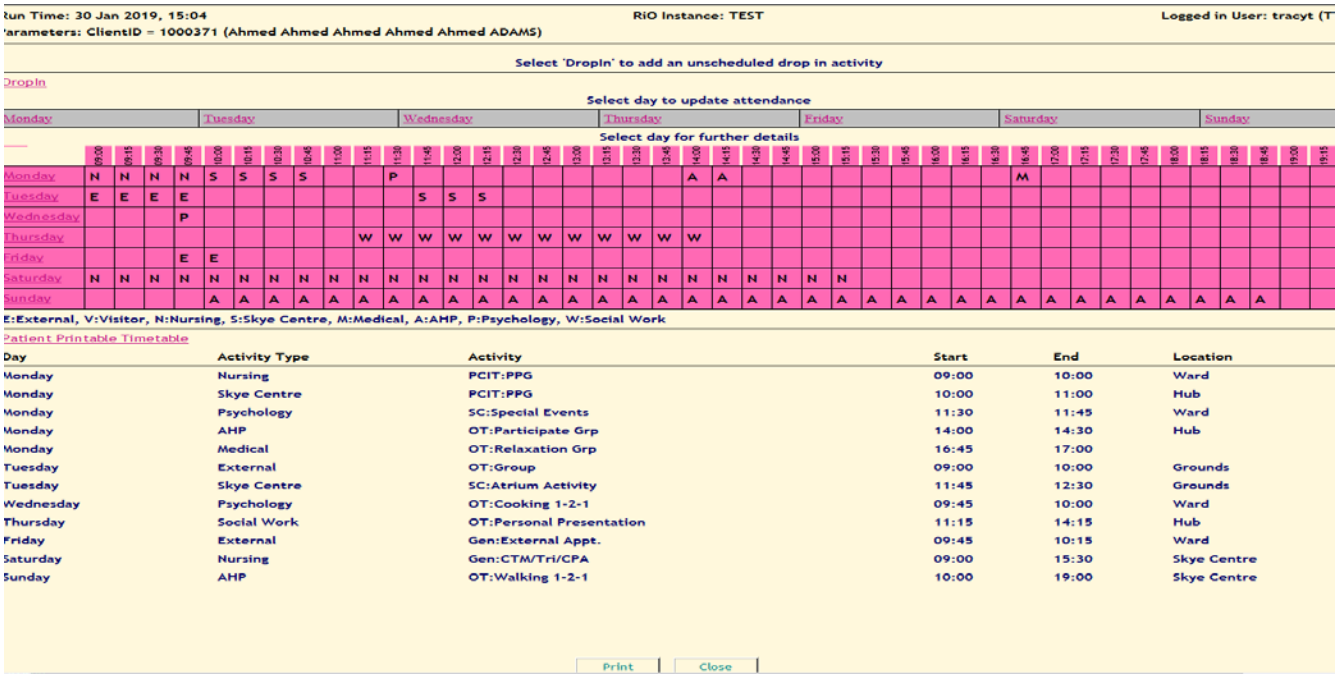
- Feedback has been provided on the Project feedback forms, Staff Feedback forms and verbally around the lack of space within the Atrium, especially on specific shop mornings i.e. Iona and Arran project days. When the Atrium Activity room is free this is noted to be beneficial to the project as it provides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

Patient Timetable

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

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

Figure 15 - Patient Timetable on Rio (activity scheduling)



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

Redesign of Woodwork Centre

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

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

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

Vocational Qualifications/Courses

Patient learning programmes are an integral part of the Skye Centre service with our Senior Rehabilitation Instructors and Education & Learning Officers responsible for the delivery of patient learning programmes. The objectives and progress made in this area over the past year has been outlined in more detail within the recent Patient Learning 12 month Update report to the Board received in February 2019.

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

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

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

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

Sickness

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

Events

The Skye Centre service continues to provide a series of planned events throughout the year. These included the Celebration of Success and Achievements Ceremony acknowledging our patients' engagement in the range of learning opportunities available to them and the Sportsman's Dinner, recognising the patients' achievements and progress. The Patient & Carer Christmas lunches and Christmas social and spiritual events were again delivered successfully and many positive responses were received from patients and carers regarding the enjoyment and quality of service they experienced. All of these events are accessed by patients and their carers. The success of these events can be attributed to the dedication and commitment of the Skye Centre team and Person Centre Improvement Team.

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

Figure 16 - Patient Attendance at Events

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

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

Outcome Measures

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

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

Section 5 – Identified Issues and Potential Solutions

Recruitment

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

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

Section 6 - Future Areas of Work and Potential Service Development

Vocational Activity Space

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

Patient Day Project

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

Patient Timetable

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

Outcome Measures

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

Provision of Activity out with 9 – 5

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

Efficiency Savings Targets

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

Section 7 – Financial Implications

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

Section 8 – Next Review Date

The next annual report will be provided to the Board in June 2020.

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

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

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

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

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

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

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

Appendix 2

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

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

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

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

Appendix 2 Patient Day Project - Data

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

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

CHAIR:	
Non Executive Director	Nicholas Johnston
PRESENT:	
Non Executive Director	David McConnell
Non Executive Director	Maire Whitehead
IN ATTENDANCE:	
Board Chair	Terry Currie
Chief Executive	Gary Jenkins
Chair of Medical Advisory Committee	Khuram Khan
Head of Corporate Planning and Business Support	Monica Merson
Research and Development Manager	Jamie Pitcairn [Item 7]
Director of Nursing and AHP	Mark Richards
Board Secretary	Margaret Smith
Clinical Effectiveness Team Leader	Sheila Smith
Medical Director	Lindsay Thomson

1 APOLOGIES AND INTRODUCTORY REMARKS

Mr Johnston welcomed everyone to the meeting. Apologies were received from Mr John Marshall and Mr Robin McNaught.

NOTED

2 CONFLICTS OF INTEREST

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

NOTED

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 14 February 2019 were approved as an accurate record.

APPROVED

4 PROGRESS ON ACTION NOTES

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

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

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

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

Action – Ms Merson

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

Action – Ms M Smith

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

Action – Ms M Smith

NOTED

5 MATTERS ARISING

There were no further matters arising.

NOTED

6 INFECTION CONTROL – 12 MONTHLY REPORT

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

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

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

Action – Mr Richards

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

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

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

Action – Mr Richards

NOTED

7 RESEARCH COMMITTEE/ RESEARCH GOVERNANCE AND FUNDING 12 MONTHLY REPORT

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

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

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

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

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

APPROVED

8 FITNESS TO PRACTICE

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

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

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

Action – Ms M Smith

NOTED

9 PATIENT MOVEMENT – STATISTICAL REPORT

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

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

NOTED

10 DUTY OF CANDOUR ANNUAL REPORT

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

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

NOTED

11 LEARNING FROM COMPLAINTS AND FEEDBACK - QUARTER 4 REPORT

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

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

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

Action – Ms M Smith

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

Action – Ms Merson/Mr Richards

NOTED

12 INCIDENTS AND PATIENT RESTRICTIONS

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

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

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

.

Action - Ms Merson

NOTED

13 CLINICAL GOVERNANCE STOCKTAKE

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

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

APPROVED

14 CLINICAL MODEL - UPDATE

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

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

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

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

Professor Thomson/ Mr Richards/ Ms Merson

NOTED

15 CATEGORY 1 REVIEW – 18.02

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

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

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

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

Action – Mr Richards

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

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

Action - Ms Merson

NOTED

16 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

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

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

17 WORKPLAN

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

18 ANY OTHER BUSINESS

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

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

19 DATE AND TIME OF NEXT MEETING

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

The meeting concluded at 12.15pm

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item: 11
Sponsoring Director:	Interim Human Resources Director
Author(s):	Interim Human Resources Director
Title of Report:	Annual Report of the Staff Governance Committee for the Year Ended 31 March 2019
Purpose of Report:	For approval

1 SITUATION

The attached Staff Governance Committee Annual report outlines the key achievements and key developments overseen by the Committee during 2018/19. The stock take also includes the Committee's Terms of Reference, Reporting Structures and Work Programme.

2 BACKGROUND

Staff Governance is defined as **'a system of corporate accountability for the fair and effective management of all staff.'**

The Staff Governance Standard (4th Edition) sets out what each NHS Scotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met, and that all policies and agreements are implemented. In addition to this, the Standard specifies that staff are entitled to be:

- well informed;
- appropriately trained and developed;
- involved in decisions;
- treated fairly and consistently; with dignity and respect, in an environment where diversity is valued;
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

3 ASSESSMENT

In the performance year 2018/19, The State Hospitals Board for Scotland's Staff Governance Committee continued to focus its monitoring activities in respect of the above. The Committee members recognised their obligations to support a culture within The State Hospitals Board for Scotland where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the organisation and is built upon the principles of partnership.

4 RECOMMENDATION

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

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE ANNUAL REPORT

1 April 2018 – 31 March 2019

1. INTRODUCTION

Staff Governance is defined as **'a system of corporate accountability for the fair and effective management of all staff.'** The Staff Governance Standard (4th Edition) sets out what each NHS Scotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met, and that all policies and agreements are implemented. In addition to this, the Standard specifies that staff are entitled to be:

- well informed;
- appropriately trained and developed;
- involved in decisions;
- treated fairly and consistently; with dignity and respect, in an environment where diversity is valued;
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

In the performance year 2018/19, The State Hospitals Board for Scotland's Staff Governance Committee continued to focus its monitoring activities in respect of the above. The Committee members recognised their obligations to support a culture within The State Hospitals Board for Scotland where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the organisation and is built upon the principles of partnership. Members of the Staff Governance Committee are appointed annually by the NHS Board. Membership details of the Committee during 2018/19 are detailed below.

2. COMMITTEE CHAIR MEMBERS AND ATTENDEES

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

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

Ex-officio members:
Terry Currie (Chairman)
Jim Crichton (Chief Executive)
John White / Kay Sandilands (Interim Human Resources Director)
Where required by the Chair or by other members of the Committee, appropriate members of staff were invited to be in attendance for the purposes of verbal updates, information sharing, presentations etc.

3. MEETINGS DURING 2018/19

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

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

4. REPORTS CONSIDERED BY THE COMMITTEE DURING THE YEAR

The Committee received reports and monitored areas as follows:

- Staff Governance Standard National Annual Monitoring Return 2017/18
- Monitoring of PDPR, Personal Development Plan Reporting performance
- Annual Submission to Scottish Government of mandatory workforce statistics.
- Monitoring of Attendance Management performance
- Monitoring HR Performance – Employee Relations Activity
- Implementation of the 2020 workforce vision
- Monitoring the content and actions relating to Audit Reports covering Staff Governance matters
- Monitor the implementation and consider the outcome of iMatter, the NHS Scotland Staff Engagement Tool

4.1 Annual Reports

Staff Governance Action Plan submission 2017/18

The Staff Governance Action Plan return for 2017/18 provided assurance that The State Hospitals Board for Scotland had met its obligations under the Staff Governance Standards. Feedback from Scottish Government contained the following comments:

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

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

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

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

To take these actions forward during 2018/19:

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

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

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

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

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

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

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

Occupational Health Service Annual Report

The annual report was presented by the Occupational Health Clinical Team from SALUS, current provider of the OHS service level agreement at the November 2018 meeting.

4.2 Progress Updates

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

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

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

PDPR, Personal Development Plan

Monitoring of the completion rates for Personal Development Plans for staff was kept under scrutiny all year and reported monthly to the Senior Management Team and Partnership Forum. The average monthly completion rate was 71.6%.

Attendance Management

The State Hospitals Board for Scotland did not achieve the absence management standard of 5% in 2018/19. The end of year average absence percentage was 8.52%.
The principal reasons for absence remained consistent with the previous year, with the two most common reasons for absence being anxiety/stress/depression and musculoskeletal conditions.

As previously stated the Committee paid particular attention and applied more scrutiny to this issue throughout the year and wished to be assured that all steps were being taken to reduce the level of absence being experienced by closely monitoring the action plan identified within the Attendance Management Improvement Working Group.

4.3 Standing Items Considered by the Committee During the Year

Workforce Plan

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

Fitness to Practise

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

Everyone Matters: 2020 Workforce Vision

The implementation plan for 2020 workforce vision generated much debate, and informed the planning process for the Staff Governance Action plan 2018/19.
The Committee received and noted minutes of the following committee meetings:

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

Values and Behaviours Group

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

Health Working Lives Group - HWL

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

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

Mandatory and Statutory Training

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

5. CONCLUSION

The performance year 2018/19 has underlined the continuing need to focus our attention on key Staff Governance issues.

The main priority area in terms of Staff Governance performance management continues to be the pursuit of the Attendance Management target of 5% absence. In addition another priority is the completion of Personal Development Plans. Performance in these two areas will continue to be monitored rigorously by the Committee in the coming year against the background of the new approaches which have been developed and are being adopted to address these priorities.

From the review of the performance of the Staff Governance Committee, it can be confirmed that the Committee has met in line with the Terms of Reference, and has fulfilled its remit. Based on assurances received and information presented to the Committee, adequate and effective Staff Governance arrangements were in place throughout the year.

I offer my thanks for the continuing support and encouragement of Committee members and also to those members of staff who have worked on the Committee's behalf during 2018/19**.**

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE COMMITTEE
TERMS OF REFERENCE

1 PURPOSE

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

2 COMPOSITION

2.1 Membership

The Staff Governance Committee is appointed by the Board and shall be composed of the Employee Director and three other Non-executive Board Members one of whom shall act as Chair.

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

There will be three lay representatives identified by the staff side organisations and nominated by the Partnership Forum. The lay representatives will not act in an ex officio capacity.

An ex-officio member is a member of a body who is part of it by virtue of holding another office. Such members shall have the power to vote in the Committee's decisions.

Membership will be reviewed annually.

The Staff Governance Committee will have the authority to co-opt other attendees from outwith the Board in order to carry out its remit.

2.2 Appointment of Chair

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

2.3 Attendance

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

Executive Directors of the Board are not eligible for membership of the Committee. The Accountable Officer (Chief Executive) and Human Resources Director shall be invited to attend meetings and receive all relevant papers. Other Directors and staff may also be invited by the Chair of the Committee to attend meetings as required.

3 MEETINGS

3.1 Frequency

The Staff Governance Committee will meet quarterly to fulfil its remit and shall report to the Board following each meeting.

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least five working days in advance of the meetings to allow time for members' due consideration of issues. All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken. The format of agendas and papers will be in line with corporate document standards. The lead Executive for co-ordinating agendas and papers is the Human Resources Director.

3.3 Quorum

Two members of the Committee will constitute a quorum.

3.4 Minutes

Formal minutes will be kept of the proceedings and submitted for approval at the next Board meeting. The Chief Executive's personal assistant is responsible for minute taking arrangements.

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

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

3.5 Other

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

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

4 REMIT

4.1 Objectives

The main objectives of the Staff Governance Committee are to provide the Board with the assurance that staff governance mechanisms are in place and effective within The State Hospital; and that the principles of the national Staff Governance Standards and The State Hospital's Staff Charter are applied equitably and fairly to all staff.

Existence and effective operation of this committee will be demonstrated in continuous improvement and compliance with staff governance standards, in delivery of improved working arrangements for

staff, and ultimately in achievement of outcome targets as evidenced through the staff related key performance indicators reported in the Local Delivery Plan.

4.2 Systems and accountability

4.2.1 To ensure that appropriate staff governance mechanisms are in place throughout the hospital in line with national standards.

4.2.2 To ensure that people management risks are managed in accordance with the corporate risk management strategy, policies and procedures.

4.2.3 To ensure that staff governance issues which impact on service delivery and quality of service are appropriately managed.

4.2.4 To review the Staff Governance Action Plan and ensure that the Partnership Forum is performance managing the action plan.

4.3 People management

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

4.3.1 Culture is maintained within the hospital where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the hospital and is built upon partnership and collaboration.

4.3.2 Structures are in place to monitor the outcome of strategies and implementation plans relating to people management.

4.3.3 Structures are in place to monitor the outcome of strategies and implementation plans relating to knowledge management.

4.3.4 Propose policy amendment, funding or resource submission to achieve the Staff Governance Standards.

4.3.5 Support is given for any policy amendment, funding or resource submission to achieve the Staff Governance Standards.

4.3.6 There is timely submission of all staff governance data required by the Scottish Executive Health Department and in respect of the Local Delivery Plan.

4.3.7 Pay modernisation processes are monitored and that the Boards Pay Benefits Realisation Plans are signed off.

4.3.8 Workforce planning and development is monitored and to sign off the Boards Workforce Plan and the Boards Development Plan and ensure they support the Local Delivery Plan.

4.3.9 Policies and procedures are developed, implemented and reviewed.

4.4 Controls assurance

To ensure that:

4.4.1 The information governance framework provides appropriate mechanisms for Codes of Practice on Data Protection and Freedom of Information to be applied to all staff.

4.4.2 The planning and delivery of services has fully involved partnership working.

4.4.3 Systems are in place to measure and monitor performance to foster a culture of quality and continuous improvement.

4.4.4 Staff governance information is provided to support the statement of internal control.

5 AUTHORITY

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

The Committee is authorised to establish a Remuneration Committee to cover staff under executive and senior manager pay arrangements and to validate the work of that committee. The Remuneration Committee must include, as a minimum, three non executive Directors of the Board. The Remuneration Committee will be a closed committee and shall sign off its own minutes. The Staff Governance Committee will require to be provided with assurance that systems and procedures are in place to appropriately manage the pay of this group of staff. This will not include detailed confidential employment issues that are considered by the

Remuneration Committee: these can only be considered by non executive Directors of the Board.

6 PERFORMANCE OF THE COMMITTEE

The Committee shall annually review and report on:

- Its own performance and effectiveness in meeting the terms of reference; including its running costs, and level of input of members relative to the added value achieved
- Proposed changes, if any, to the terms of reference.

7 REPORTING FORMAT AND FREQUENCY

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

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

8 COMMUNICATION AND LINKS

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

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item: 12
Sponsoring Director:	Interim Human Resources Director
Author(s):	Interim Human Resources Director
Title of Report:	Annual Report of the Remuneration Committee for the Year Ended 31 March 2019
Purpose of Report:	For approval

1 SITUATION

To provide a report containing a summary of the work overseen by the Remuneration Committee. The attached Remuneration Committee Annual report outlines the key achievements and key developments overseen by the Committee during 2018/19. The stock take also includes the Committee's Terms of Reference, Reporting Structures and Work Programme.

2 BACKGROUND

The Staff Governance Standard sets out what each NHS Scotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met and that all policies and agreements are implemented**.**

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

- A review of the committee's work programme for forthcoming years.
- A review of the committee's terms of reference. An annual report summarising the work of the remuneration committee.

3 ASSESSMENT

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

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

4 RECOMMENDATION

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

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

REMUNERATION COMMITTEE ANNUAL REPORT

1 April 2018 – 31 March 2019

1 INTRODUCTION

Staff Governance is defined as **'a system of corporate accountability for the fair and effective management of all staff.'**

The Staff Governance Standard (4th Edition) sets out what each NHSScotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met, and that all policies and agreements are implemented. In addition to this, the Standard specifies that staff are entitled to be:

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- treated fairly and consistently; with dignity and respect, in an environment where diversity is valued;
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

In the performance year 2018/19, The State Hospitals Board for Scotland's Remuneration Committee continued to focus its monitoring activities in respect of the above, with particular regard to the performance, pay and terms and conditions of Executive and Senior managers.

2 COMMITTEE CHAIR MEMBERS AND ATTENDEES

Committee Chair:
Terry Currie, NHS Board Chair

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

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

3 MEETINGS DURING 2018/19

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

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

4 REPORTS CONSIDERED BY THE COMMITTEE DURING THE YEAR

- Approval of the Performance Management arrangements and Performance Appraisals for Executive Directors for the performance year 2017-18.

- Agreement that the Appraisal outcomes for Executive Directors be submitted to the National Performance Management Committee. Also consideration of the National Performance Management Committee's appraisal analysis.
- Agreement of the Executive Directors Performance Planning and Review (Objectives) for the year 2018/19.
- Consultants discretionary points were reported on and approved.
- Endorsement of new post grading by National Evaluation Committee new Senior Management appointments.

5 CONCLUSION

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

I would like to thank the Committee members for their contribution to the meetings in 2018/19.

THE STATE HOSPITALS BOARD FOR SCOTLAND

REMUNERATION COMMITTEE

TERMS OF REFERENCE

TITLE

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

COMPOSITION

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

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

In addition there will be in attendance:

- Chief Executive
- Human Resources Director
- Board Secretary

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

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

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

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

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

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

FUNCTIONS

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

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

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

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

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

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

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

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

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

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

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

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

CONDUCT OF BUSINESS

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

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

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

REGULARITY OF MEETINGS

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

REPORTING ARRANGEMENTS

19 The Remuneration Committee will report to the Board.

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

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

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

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

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

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

1 SITUATION

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

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

However, absence still exceed the 5% target level.

2 BACKGROUND

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

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

3 ANALYSIS

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

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

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

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

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

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

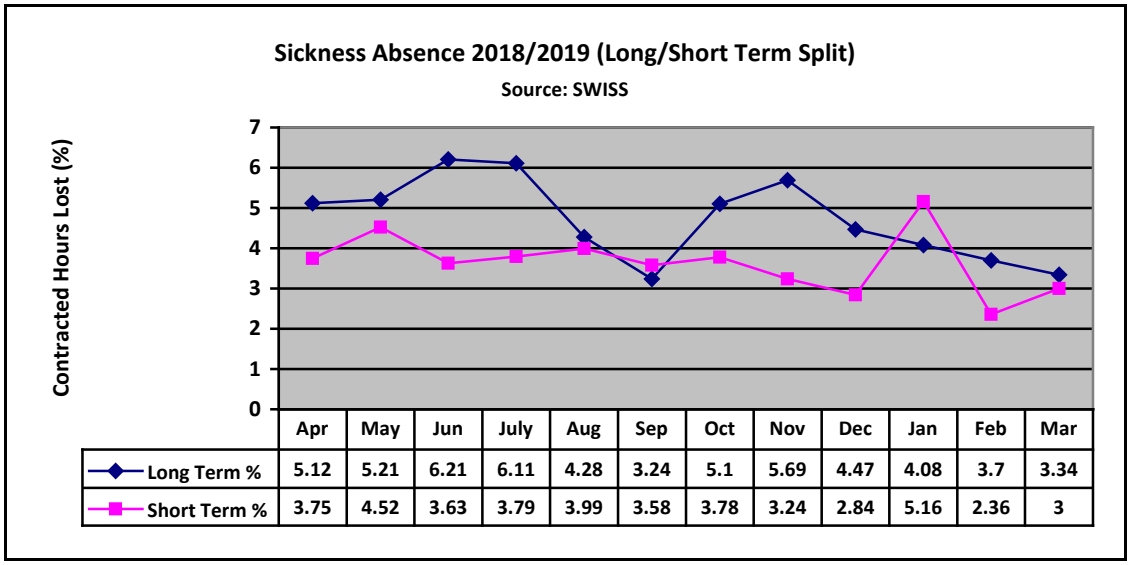
4 RECOMMENDATION

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

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

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

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

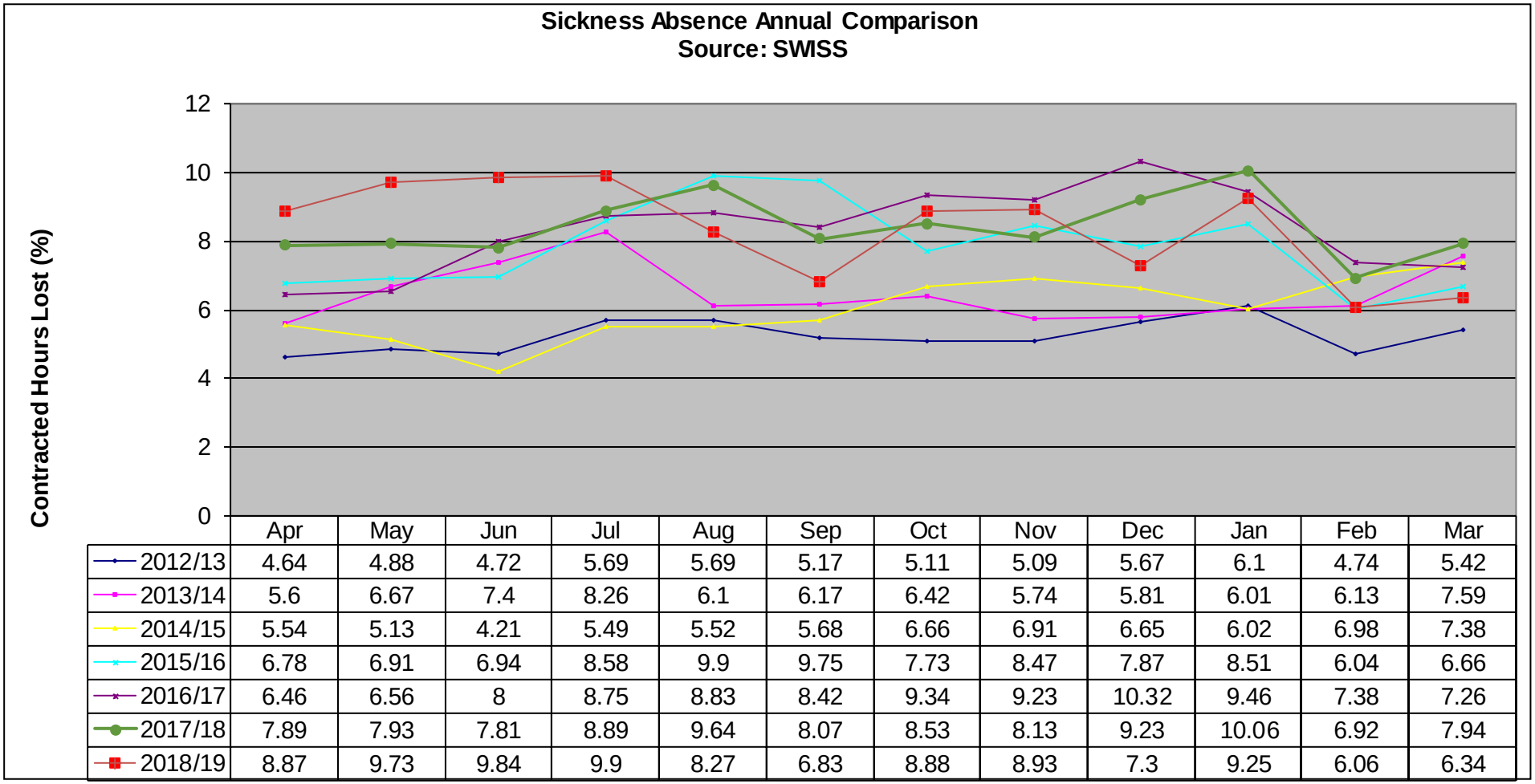


	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Long Term %	5.12	5.21	6.21	6.11	4.28	3.24	5.1	5.69	4.47	4.08	3.7	3.34
Short Term %	3.75	4.52	3.63	3.79	3.99	3.58	3.78	3.24	2.84	5.16	2.36	3

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

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

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



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

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

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

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item: 16
Sponsoring Director:	Director of Finance & Performance Management
Author(s):	Acting Head of Financial Accounts
Title of Report:	Annual Report of the Audit Committee
Purpose of Report:	For approval

1 SITUATION

The Report outlined in Appendix 1 is presented to the committee to meet the requirements within the Committee's Terms of Reference to submit an annual report of the work of the Committee to the Board. The report also supports the Governance Statement in providing periodic reports to the Board from the Committee in respect of Internal Control.

2 BACKGROUND

The establishment of an Annual Report by the Audit Committee is an important assurance process to the Board in considering the effectiveness of internal controls.

The report outlines the work of the Committee, including:

- Frequency of meetings
- The activities of the Committee
- Progress in Corporate Governance
- Update Terms of Reference

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

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

3 ASSESSMENT

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

4 RECOMMENDATION

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

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

AUDIT COMMITTEE ANNUAL REPORT

1 April 2018 – 31 March 2019

1 INTRODUCTION

The Report is submitted to meet the requirements within the Audit Committee's (the Committee's) Terms of Reference to submit an annual report of the work of the Committee. The report also seeks to satisfy the Governance Statement requirement for the Committee to provide periodic reports to the Board in respect of Internal Control.

2 MEMBERSHIP AND ROLE OF THE COMMITTEE

Audit Committee

Membership	**Role**
E Carmichael / D McConnell (Chair) W Brackenridge A Gillan M Whitehead	To oversee arrangements for external and internal audit of the Board's financial and management systems and to advise the Board on the strategic processes for risk, control & governance. It met 5 times during 2018/19.

3 AUDIT

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

The Internal Audit service was provided by RSM UK.

4 REVIEW OF THE WORK OF THE COMMITTEE

The Internal Audit Operational Plan from RSM for 2018/19 was approved by the Committee at its meeting on 28 June 2018. The plan was kept under review for the remainder of the year.

The plan was designed to target priority issues and structures to allow the Chief Internal Auditor to provide an opinion on the adequacy and effectiveness of internal controls to the Committee, the Chief Executive (as Accountable Officer) and the External Auditors.

During financial year 2018/19, the Committee met on FIVE occasions: 26 April 2018, 28 June 2018, 13 September 2018, 24 January 2019 and 28 March 2019

During the period from 31 March 2018 and up to the consideration of the Annual Financial Statements on 20 June 2019, the committee has:

- Received progress reports from the Chief Internal Auditors against the Internal Audit Plans approved by the Committee.
- Reviewed audit reports and action plans.
- Reviewed progress on action taken by management on action plans.
- Reviewed the final Annual Report for 2018/19 from the Chief Internal Auditor.
- Received the Annual Report and audit certificate for the 2018/19 audit from Scott Moncrieff.
- Reviewed the Standing Financial Instructions, Standing Orders and Scheme of Delegation, and recommended these for approval to the Board.
- Reviewed its Terms of Reference.
- Review the log of waivers of standing financial instructions.
- Considered the Fraud Incident Log.
- Reviewed Counter Fraud Service Alerts.

- Reviewed Fraud Action Plan.
- Reviewed progress made with the 2017/18 National Fraud Initiative.
- Reviewed and noted the Policy Management update.
- Received national Audit Scotland reports and performance audit studies, relating to the Health Service and to the wider public sector.
- Reviewed and noted the report and planned actions on the Security Audit.
- Reviewed and noted update of Efficiency / Productivity / Best Value.
- Met in private with Internal and External Auditors.
- Reviewed the recommendations received from National Services Scotland from their service audit reports.
- Reviewed the recommendations received from NHS Ayrshire & Arran from the service audit report on the National Single Instance (NSI) system.
- Reviewed the annual reports from the Governance Committees.
- Reviewed the annual report on Risk Management.
- Endorsed the Risk Management Strategy.
- Reviewed the summary of Losses and Special Payments.
- Reviewed and approved the Losses and Special Payment Policy.
- Reviewed and approved the Patients Funds Annual Accounts for submission to the Board.
- Reviewed and recommended approval of the statutory Annual Accounts to the Board.
- Reviewed and noted update on Business Continuity Resilience arrangements.
- Submitted minutes of meetings to the Board throughout the year.
- Received updates from the Human Resources Director in relation to the progress on the Sickness Absence audit report.
- Reviewed and noted the Procurement Annual Report.
- Reviewed and noted the Corporate Risk Register.
- Reviewed and approved the Annual Audit Committee Assurance Statement to the Board.
- Reviewed external Audit Plan.
- Review and agreed Audit Committee Work Plan 2019

5 CORPORATE GOVERNANCE

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

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

6 CONCLUSION

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

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

AUDIT COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

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

2 COMPOSITION

2.1 Membership

The Audit Committee is appointed by the Board and shall be composed of at least three Non-executive Board members, one of whom shall act as Chair. Membership will be reviewed annually and disclosed in the Annual Report.

2.2 Appointment of Chairperson

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

2.3 Attendance

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

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

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

3 MEETINGS

3.1 Frequency

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

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

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

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

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least five working days in advance of the meetings to allow time for members' due consideration of issues. All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken.

3.3 Quorum

Two members of the Committee will constitute a quorum.

3.4 Minutes

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

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

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

4 OTHER

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

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

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

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

5 REMIT

5.1 Objectives

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

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

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

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

5.2 Internal Control and Corporate Governance

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

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

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

The safeguarding of assets against unauthorised use and disposition;

- Maintenance of proper accounting records and

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

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

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

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

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

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

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

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

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

5.3 Internal Audit

5.3.1 To review and approve the Internal Audit Annual Plan.

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

5.3.3 To monitor audit progress and review audit reports.

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

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

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

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

5.4 External Audit

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

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

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

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

5.4.5 Annually appraise the performance of the External Auditors.

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

5.5 Standing Orders and Standing Financial Instructions

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

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

5.5.3 To review the Scheme of Delegation.

5.6 Annual Accounts

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

5.6.2 To review schedule of losses and compensation payments.

5.6.3 Review the reasonableness of accounting estimates.

5.6.4 Review the external auditors management letter.

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

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

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

6 AUTHORITY

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

7 PERFORMANCE OF THE COMMITTEE

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

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

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

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

THE STATE HOSPITAL BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item: 18
Sponsoring Director:	Director of Finance and Performance Management
Author(s):	Head of Management Accounts
Title of Report:	Financial Position as at 31 May 2019
Purpose of Report:	Update on current financial position

1 SITUATION

1.1 The Senior Team and the Board consider the Revenue and Capital plans, and financial monitoring. This report provides information on the financial performance to 31 May 2019, which is also included in the Partnership Forum agenda, and sent monthly to Scottish Government with the financial template.

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

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

2 BACKGROUND

2.1 Revenue Resource Limit Outturn

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

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

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

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

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

2.3 **Forecast Outturn**

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

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

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

3 ASSESSMENT

3.1 YEAR TO DATE POSITION – BOARD FUNCTIONS

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

Key Highlights

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

HR – Occupational Health backdated invoice for 18/19.

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

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

3.2 Further detail on Nursing & AHP's

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

Key Highlights

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

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

Further detail on Security and Facilities

3.3

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

Key Highlights

Facilities – Repairs spend, held back March 19.

Security – Overtime, acting post.

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

4 Savings

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

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

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

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

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

5 CAPITAL RESOURCE LIMIT

Capital allocation from Scottish Government is £0.269m.

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

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

6 RECOMMENDATION

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

Overtime in Nursing is still higher than budget.

Quarterly Financial Review meetings, over and above the monthly Management Accounts meetings, help eliminate any surprises in the accounts and aids forecasting the year-end outturn.

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

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

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

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

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

1 SITUATION

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

2 BACKGROUND

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

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

3 ASSESSMENT

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

3.1 Standing Financial Instructions

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

3.2 Scheme of Delegation

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

3.3 Standing Orders

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

4 RECOMMENDATION

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

MONITORING FORM

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

Paper No. 19/46

THE STATE HOSPITALS BOARD FOR SCOTLAND

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

1 SITUATION

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

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

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

2 BACKGROUND

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

3 ASSESSMENT

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

4 RECOMMENDATION

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

Paper No. 19/46

MONITORING FORM

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

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

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Scottish Government
Riaghaltas na h-Alba
gov.scot

James Crichton
Chief Executive
State Hospitals Board for Scotland

9 April 2019

Dear Colleague

State of NHSScotland's Infrastructure

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

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

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

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

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

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

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

The new programme and submission requirements are as follows:

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

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

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

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

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

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

Boards are thanked for their continued support with this programme.

Yours sincerely

Christine McLaughlin

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

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

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

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

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

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

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

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

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

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

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

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item: 21
Sponsoring Director:	Finance and Performance Management Director
Author:	Clinical Effectiveness Team Leader
Title of Report:	LDP Performance Report 2018/2019 and Comparative Annual Figures.
Purpose of Report:	To provide KPI data and information on performance management activities.

1 SITUATION

This report presents a high-level summary of organisational performance for the year from 1st April 2018 until 31st March 2019 and is based on the Local Delivery Plan (LDP) and its associated targets and measures. The data for Q1-Q4 are reported to present an overview of performance over the year (Appendix 1).

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

The figures from the previous three years have been included for comparison. The comparisons between the years have been made on the same periods – annual data against annual data, rolling figures against rolling figures etc (Appendix 2).

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

It should be noted that due to the low number of patients, natural variations in the population can have an effect on the sample and small changes in our Key Performance Indicators (KPI) figures can look more significant when presented as percentages. These limitations should be borne in mind when considering this comparative data.

2 BACKGROUND

Members receive quarterly updates on Key Performance Indicator (KPI) performance as well as an Annual Overview of performance and a Year-on-Year comparison each June.

3 ASSESSMENT

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

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

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

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

No 2 Patients will be engaged in psychological therapy.

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

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

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

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

The Health Centre consistently meets its targets. There was a slight dip in Q4 when invite letters were not sent for the month of March but this has been highlighted. The 48-hour access statistics are based on access to the appropriate healthcare professional, not solely the GP. Currently this would include the Practice Nurse, General Practitioners, Junior Doctors, Physiotherapist, Optician, Dental Team and NHS24.

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

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

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

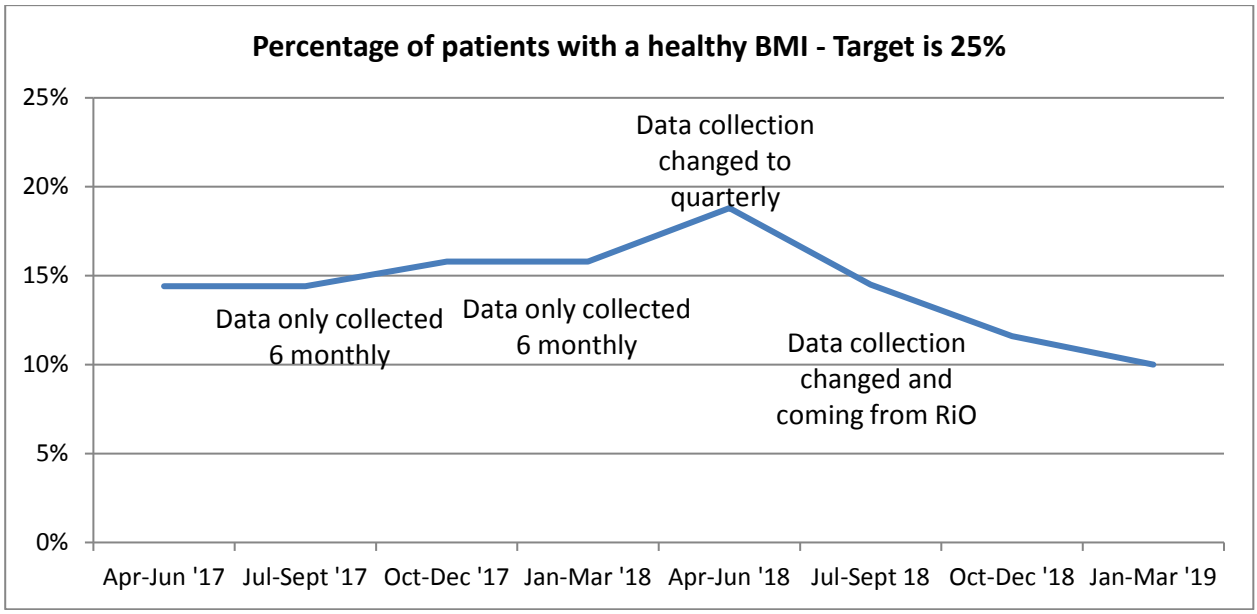
No 6 Healthier BMI.

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

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

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

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



No 7 Sickness absence.

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

The financial year 18/19 saw sustained pressure on staffing as a direct consequence of sickness absence that significantly exceeds the required standard.

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

An improvement plan led by the Human Resources Director was commissioned by the Staff Governance Committee.

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

- Improved Workforce Information to support managers identify trends and target interventions.
- Enhanced support for managers to ensure Policy Compliance.

- Enhanced Human Resource support for managers.
- OHS and EASY performance.
- Agreement on individual or collective actions.
- Employee engagement and responsibilities.
- Supplementary staffing alternatives.

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

No 8 Staff have an approved PDP.

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

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

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

No 9 Patients are transferred using CPA.

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

No 10 – refer to No 4.

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

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

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

Indicators 12 and 13 are to be replaced. A Performance Management Task Force has been set up to review all the current KPIs and suggest more appropriate KPIs. Four logical models are being worked on at present as part of this piece of work.

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

Performance has remained only slightly below the 100% target throughout the year. The figure for March 2019 is 100%. The system put in place from April 2017 has worked well over the past year and clinical risk assessments are now being completed timeously and in line with significant dates for each patient (e.g. date of renewal of detention or annual report). Monitoring and auditing of this system are ongoing.

No 15 Attendance by clinical staff at case reviews.

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

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

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

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

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

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

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

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

4 RECOMMENDATION

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

MONITORING FORM

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

APPENDIX 1

Key Performance Indicators

2018/19: Comparison across Q1-4

Item	Item	Principles	Performance Indicator	Target	Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan- Mar	LEAD
	1	8	Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	**100**	**94.9**	**96.9**	**96.1**	**LT**
	2	8	Patients will be engaged in psychological treatment	85%	**96.3**	**94**	**93**	**88**	**JM**
	3	8	Patients will be engaged in off-hub activity centres	90%	**81.7**	**79**	**84**	**82**	**MR**
	4	8	Patients will be offered an annual physical health review	90%	**100**	**100**	**100**	**71**	**LT**
	5	8	Patients will undertake 90 minutes of exercise each week	60%	**64.9**	**62.2**	**38.8**	**59.3**	**MR**
	6	8	Patients will have a healthier BMI (bi-annual audit)	25%	**18.8**	**14.5**	**11.6**	**10**	**LT**
	7	5	Sickness absence (National HEAT standard is 4%)	5%	**9.73**	**6.83**	**7.3**	**6.34**	**KS**
	8	5	Staff have an approved PDP	100%	**74.1**	**59.2**	**74.7**	**80.9**	**KS**
	9	1, 3	Patients transferred/discharged using CPA	100%	**100**	**87.5**	**100**	**100**	**LT**
	10	1, 3	Patients requiring primary care services will have access within 48 hours	100%	**100**	**100**	**100**	**100**	**LT**
	11	1, 3	Patients will commence psychological therapies <18 weeks from referral date	100%	**100**	**94**	**100**	**100**	**JM**
	12	1, 3	Patients will engage in meaningful activity on a daily basis	-	**New indicators to be agreed.**				**MR**
	13	2,6,7,9	Hubs have a monthly community meeting	-	**New indicators to be agreed.**				**MR**
	14	2, 6, 7, 9	Patients have their clinical risk assessment reviewed annually.	100%	**100**	**98.1**	**98.1**	**99**	**LT**
	15		Refer to next table.						**All Clinical Leads**

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

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

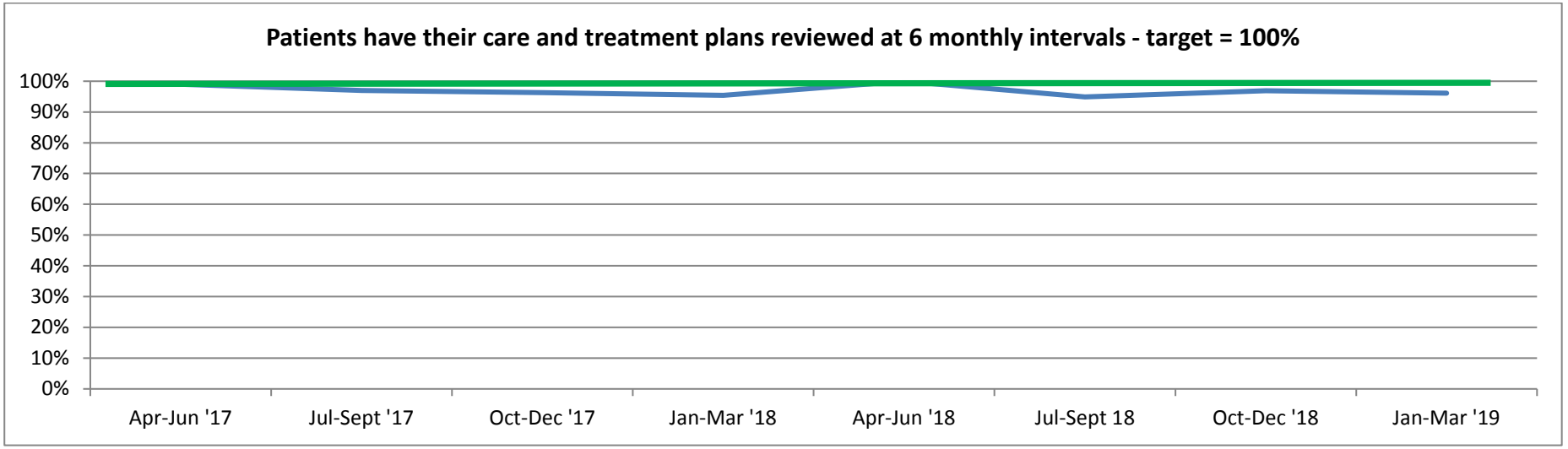
Item	Principles	Performance Indicator	Target	RAG	18/19	17/18	16/17	15/16		LEAD
1	8	Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	G	96.9%	95.4%	91%	98%	*Figure to March each year.*	LT
2	8	Patients will be engaged in psychological treatment	85%	G	92.8%	94.4%	96.4%	90.6%	*Figure to March each year.*	MS/ GM
3	8	Patients will be engaged in off-hub activity centres	90%	A	81.7%	78.7%	79.3%	81%	*Attendance averaged for the year.*	MR
4	8	Patients will be offered an annual physical health review.	90%	G	93%	100%	100%	100%	*Figure for Apr 2018 - Mar 2019.*	LT
5	8	Patients will undertake 90 minutes of exercise each week (Annual Audit)	60%	A	56.3%	Q4 only 48.7%	-	-	*Average figure for April 2018 – March 2019*	MR
6	8	Patients will have a healthier BMI	25%	R	13.7%	15.8%	13.6%	15%	*Average figure from April 2018 – March 2019*	LT
7	5	Sickness absence (National HEAT standard is 4%)	** 5%	R	8.26	8.52%	8.35%	8.03%	*Figure for April 2017-March 2018.*	JW
8	5	Staff have an approved PDP	*100%	R	80.9%	84.7%	73%	82.7%	*Figure to March 2019.*	JW
9	1, 3	Patients transferred/discharged using CPA	100%	G	97%	99%	100%	100%	*Figures for April 2018 - March 2019. 1 patient in year.*	KB
10	1, 3	Patients requiring primary care services will have access within 48 hours	*100%	G	100%	100%	100%	100%	*Figures for April 2017 - March 2018.*	LT
11	1, 3	Patients will commence psychological therapies <18 weeks from referral date	**100%	G	98.5%	100%	100%	100%	*Figure to March 2018.*	MS/ GM
12	1, 3	Patients will engage in meaningful activity on a daily basis	100%	-		-	-	-	*New indicators to be agreed.*	MR
13		Hubs have a monthly community meeting	100%	-		-	-	-	*New indicators to be agreed.*	MR
14	2, 6, 7, 9	Patients have their clinical risk assessment reviewed annually.	100%	G	99%	99.1%	97%	97.3%	*Figure to March 2019.*	LT
15	2, 6, 7, 9	Attendance by all clinical staff at case reviews	See above	-	56.6% overall	57.9% overall	59% overall	59% overall	*Figures for April 2018- Mar 2019.*	All Leads

Definitions for red, amber and green zone

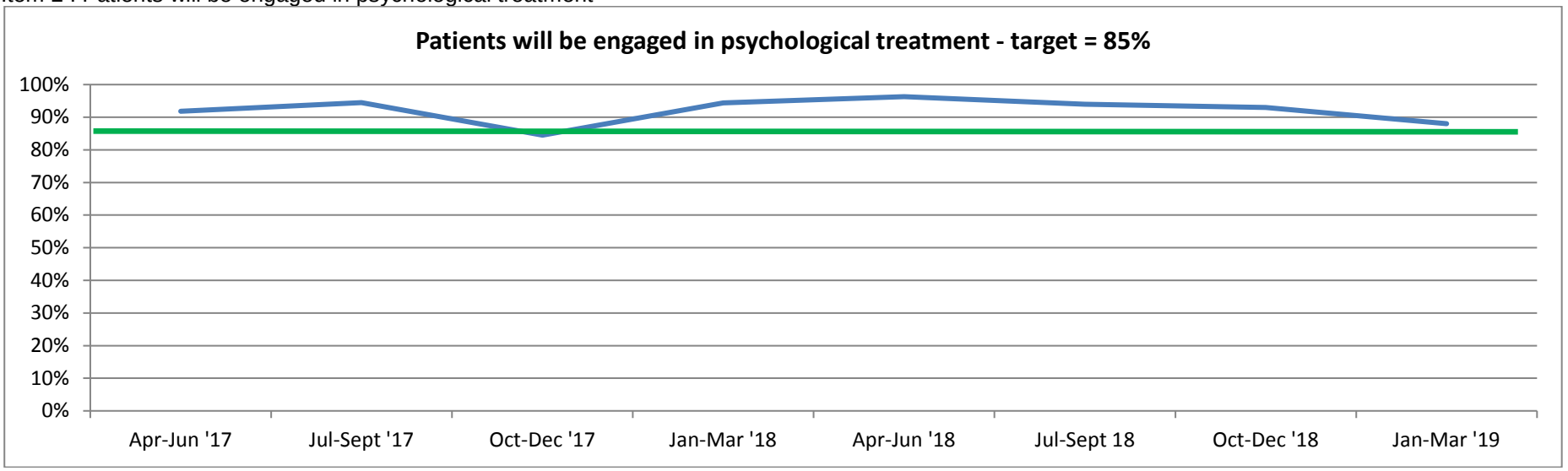
- For all but item 6 and 7 green is 5% or less away from target, amber is between 5.1% and 10% away from target and Red will mean we are over 10% away from target
- For item 6 'Patients have a healthier BMI' green will be 3% or less away from target, amber will be between 3.1% and 5% away from target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

Appendix 3 : Trend Graphs for Performance Management Data

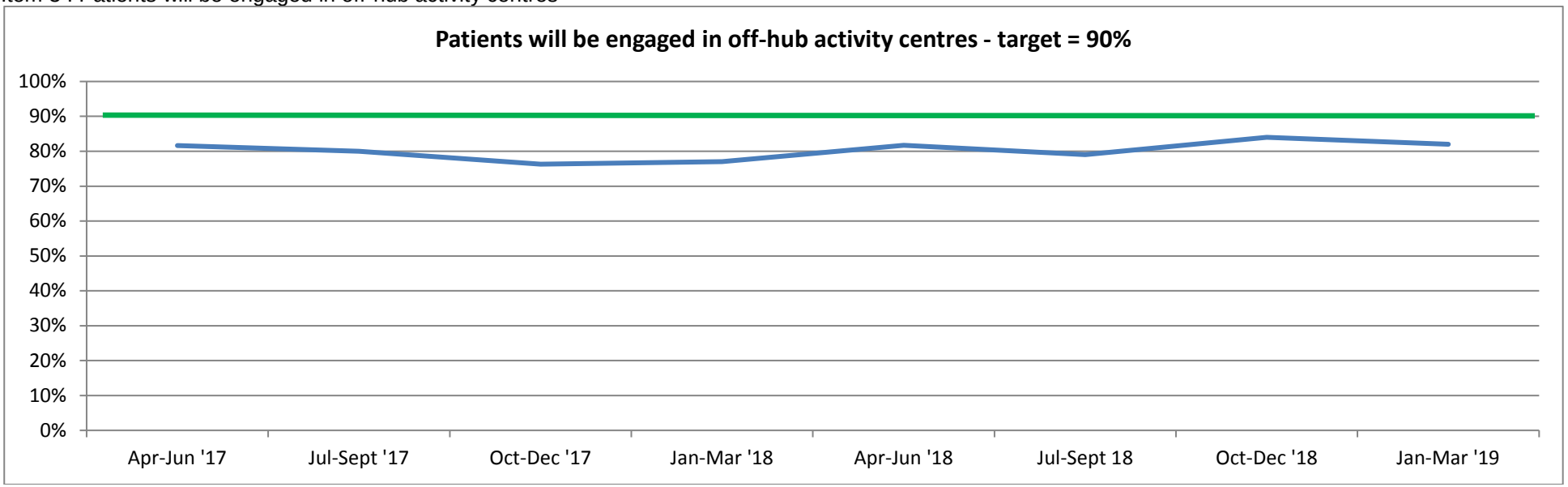
Item 1 : Patients have their care and treatment plans reviewed at 6 monthly intervals



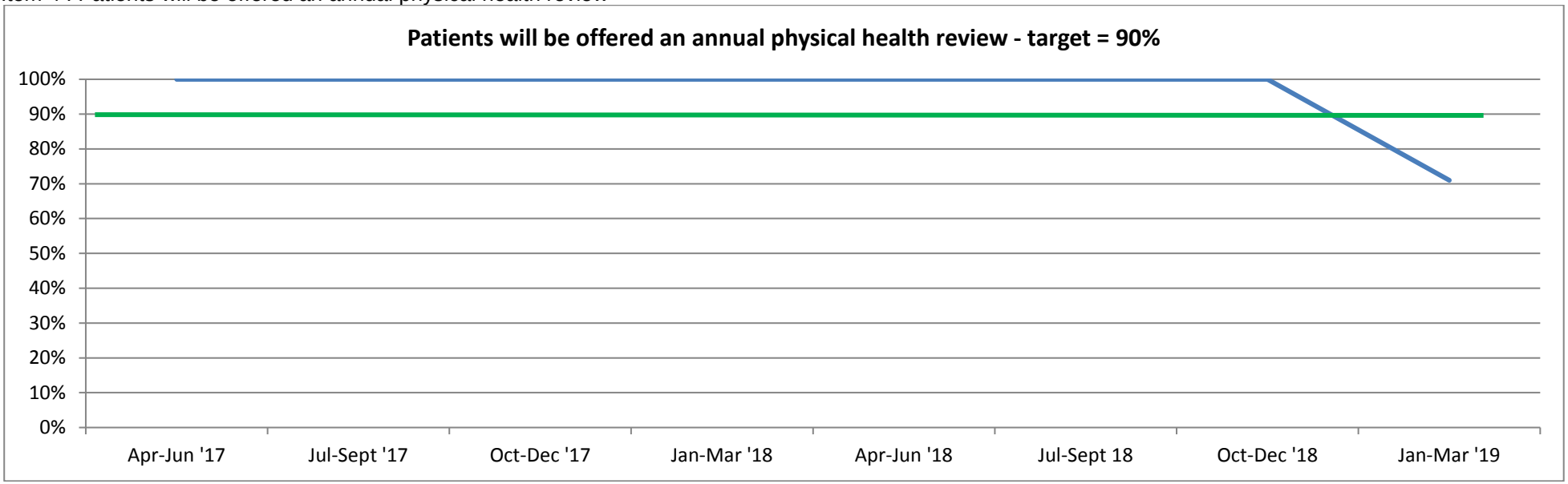
Item 2 : Patients will be engaged in psychological treatment



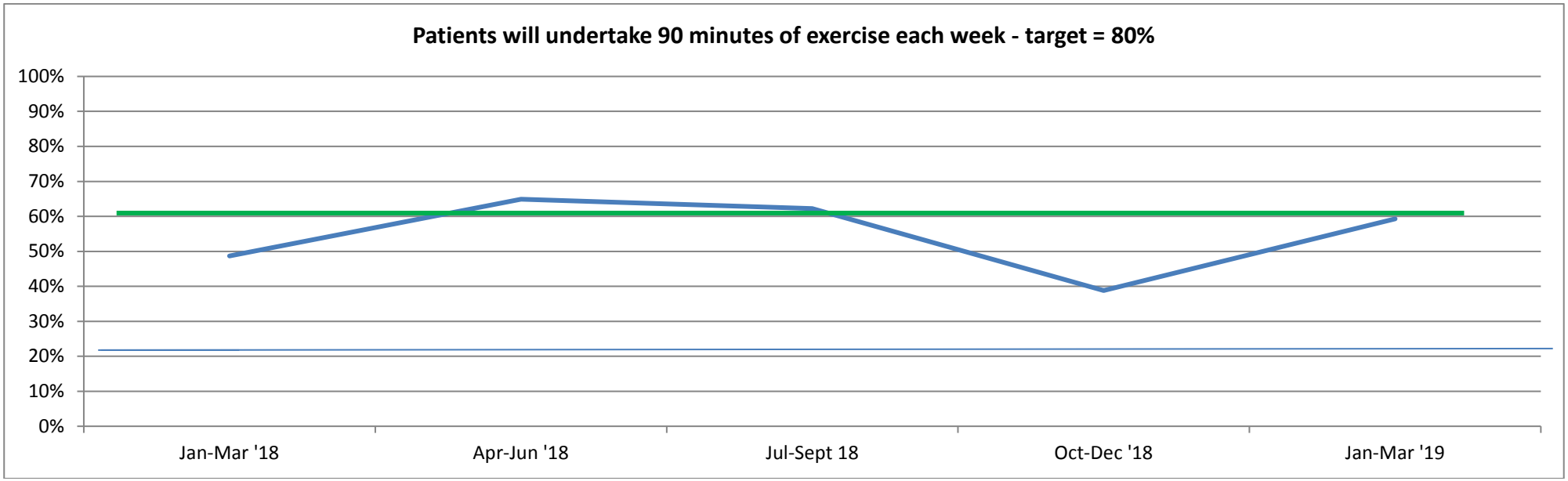
Item 3 : Patients will be engaged in off-hub activity centres



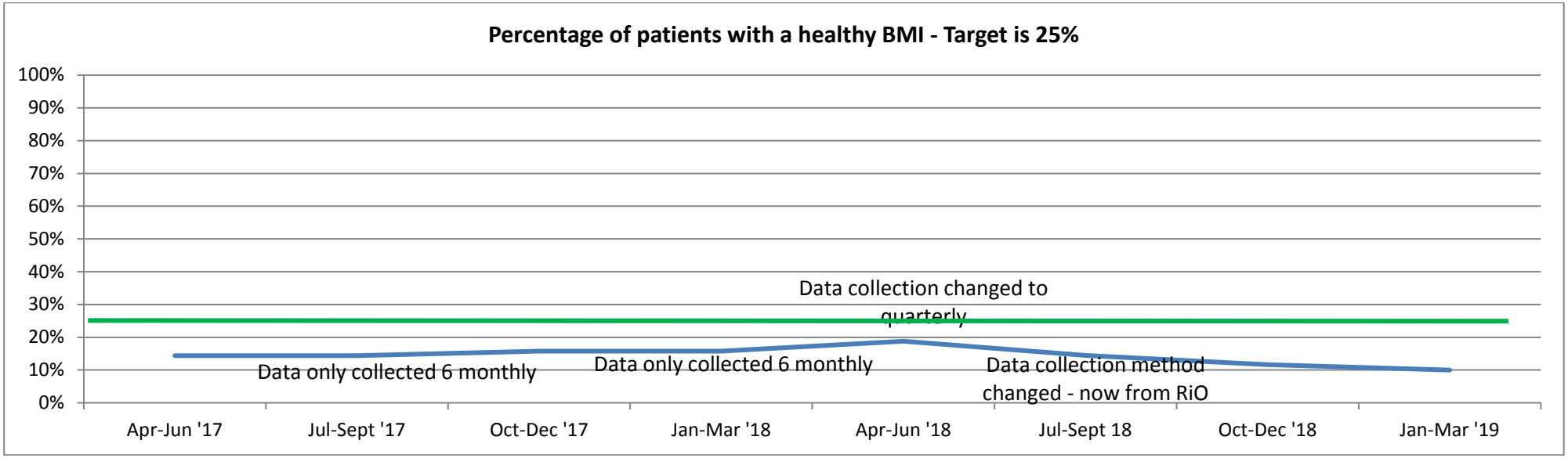
Item 4 : Patients will be offered an annual physical health review



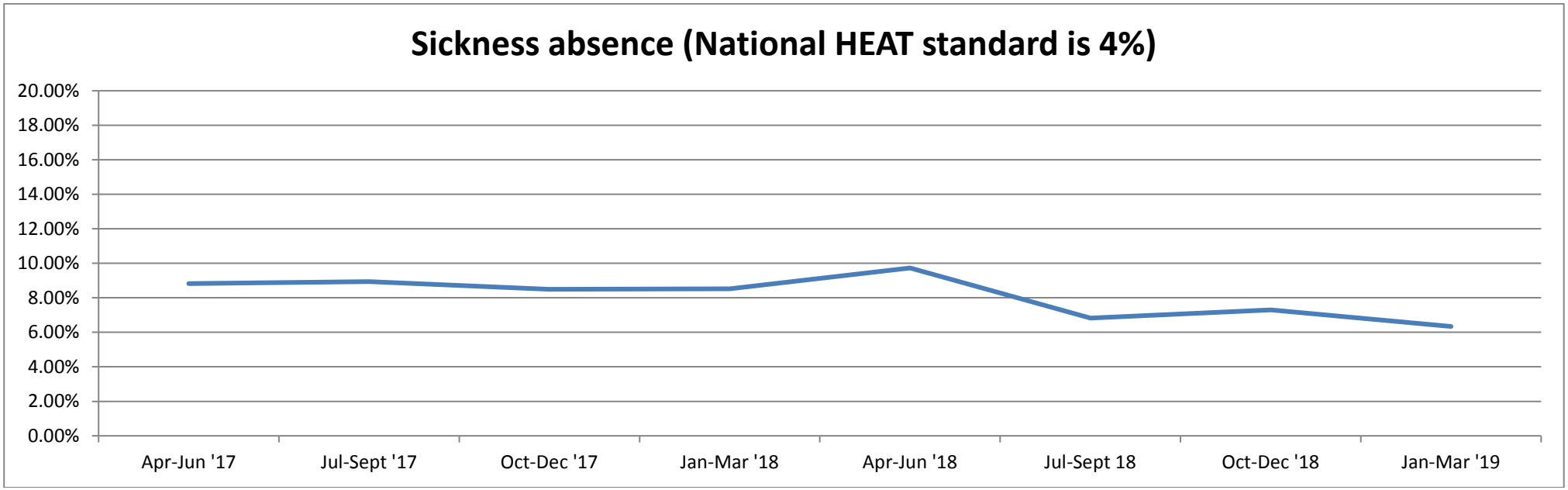
Item 5: Patients will undertake 90 minutes of exercise each week



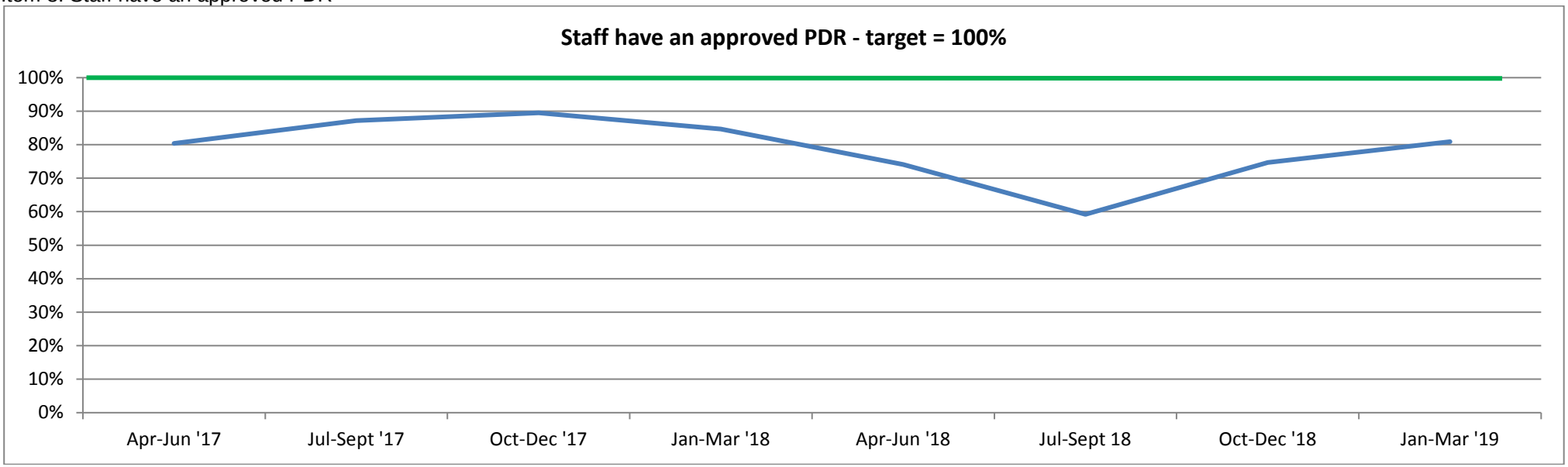
Item 6: Patients will have a healthier BMI



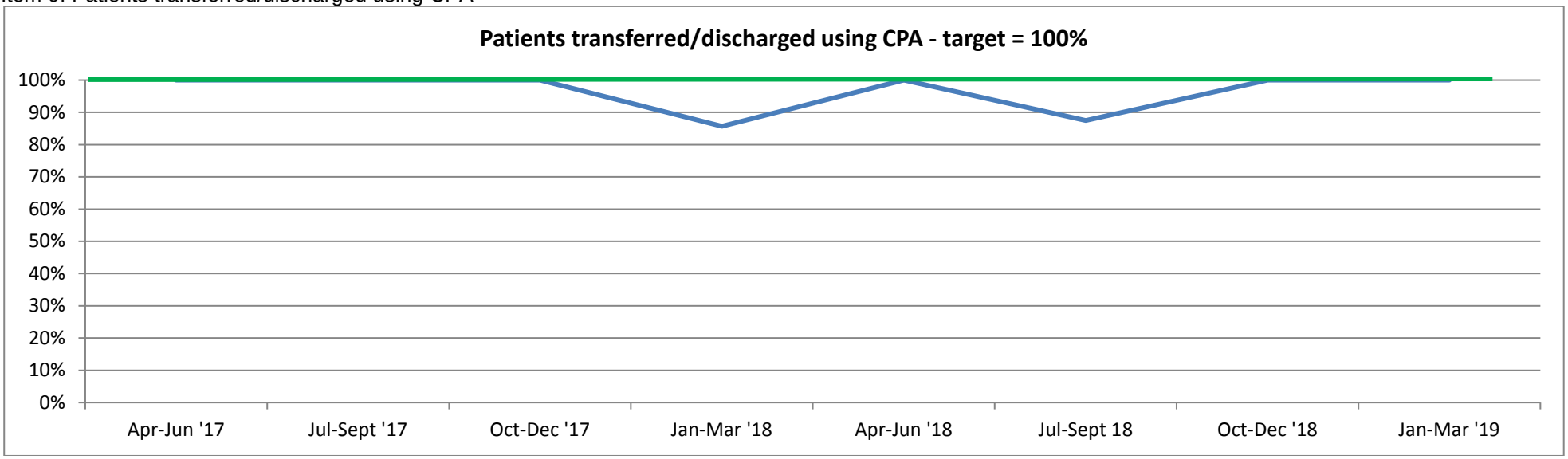
Item 7: Sickness Absence



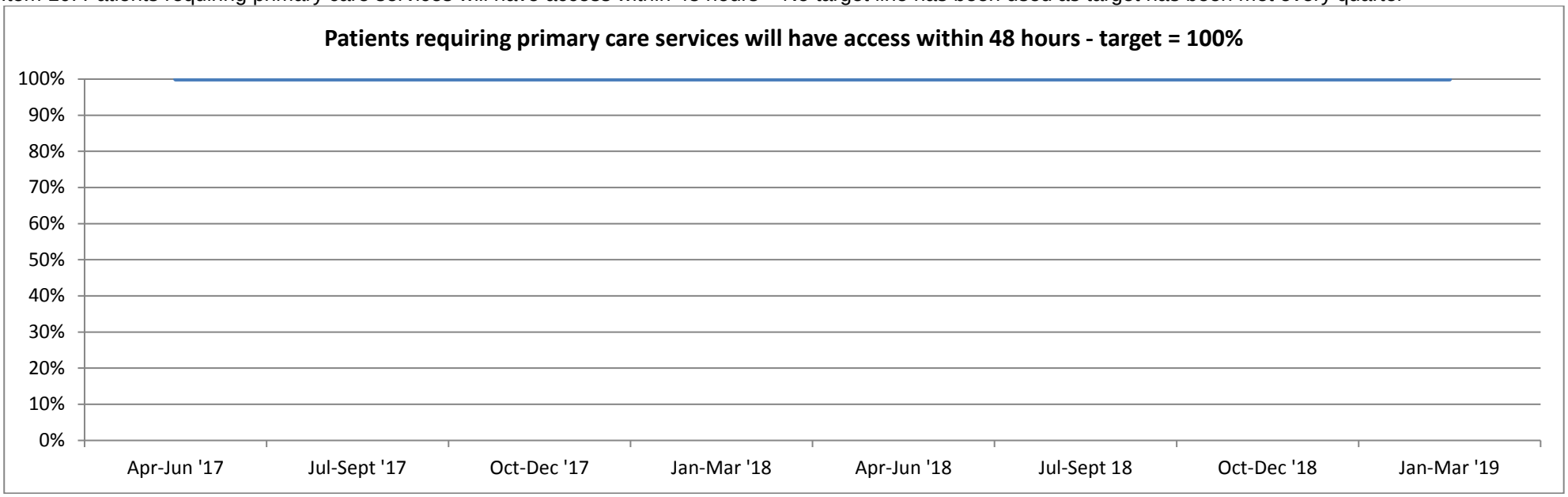
Item 8: Staff have an approved PDR



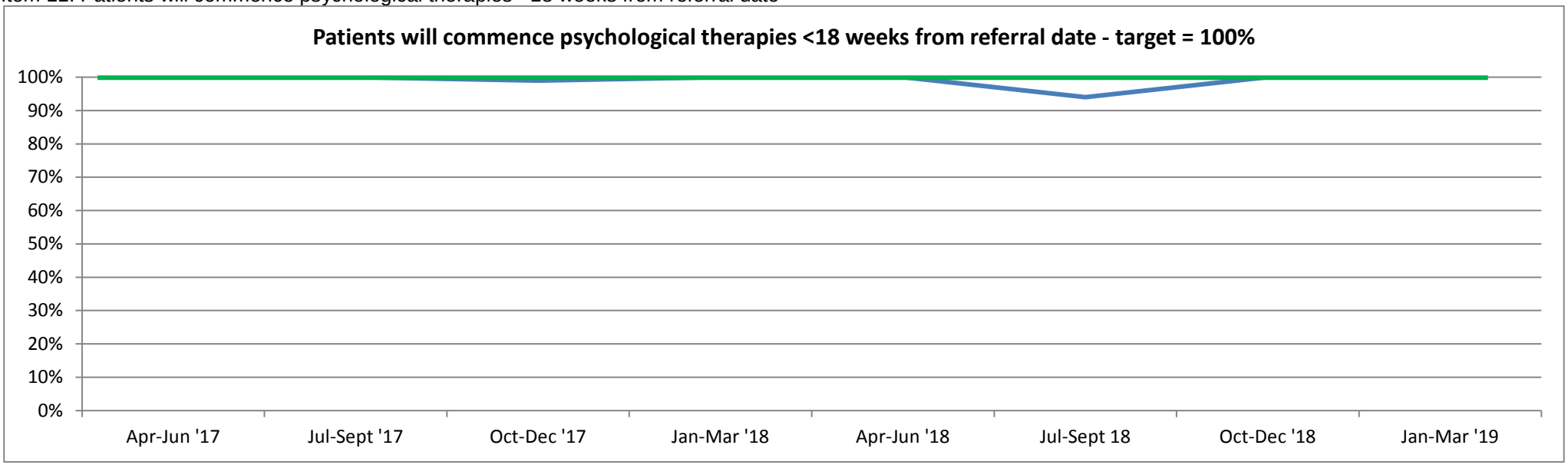
Item 9: Patients transferred/discharged using CPA



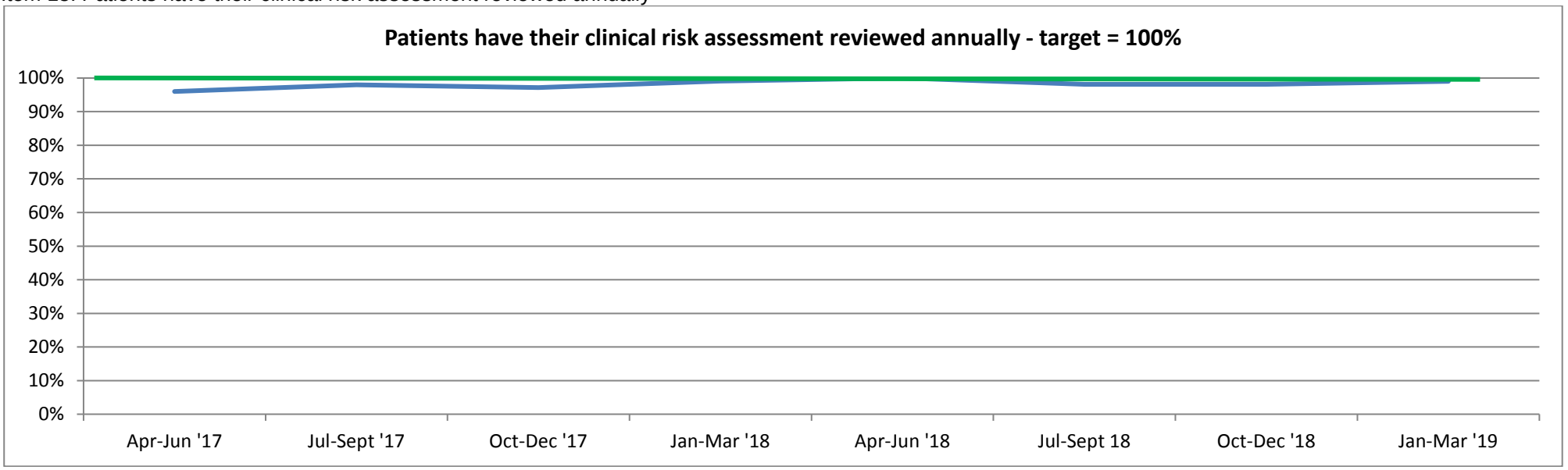
Item 10: Patients requiring primary care services will have access within 48 hours – No target line has been used as target has been met every quarter



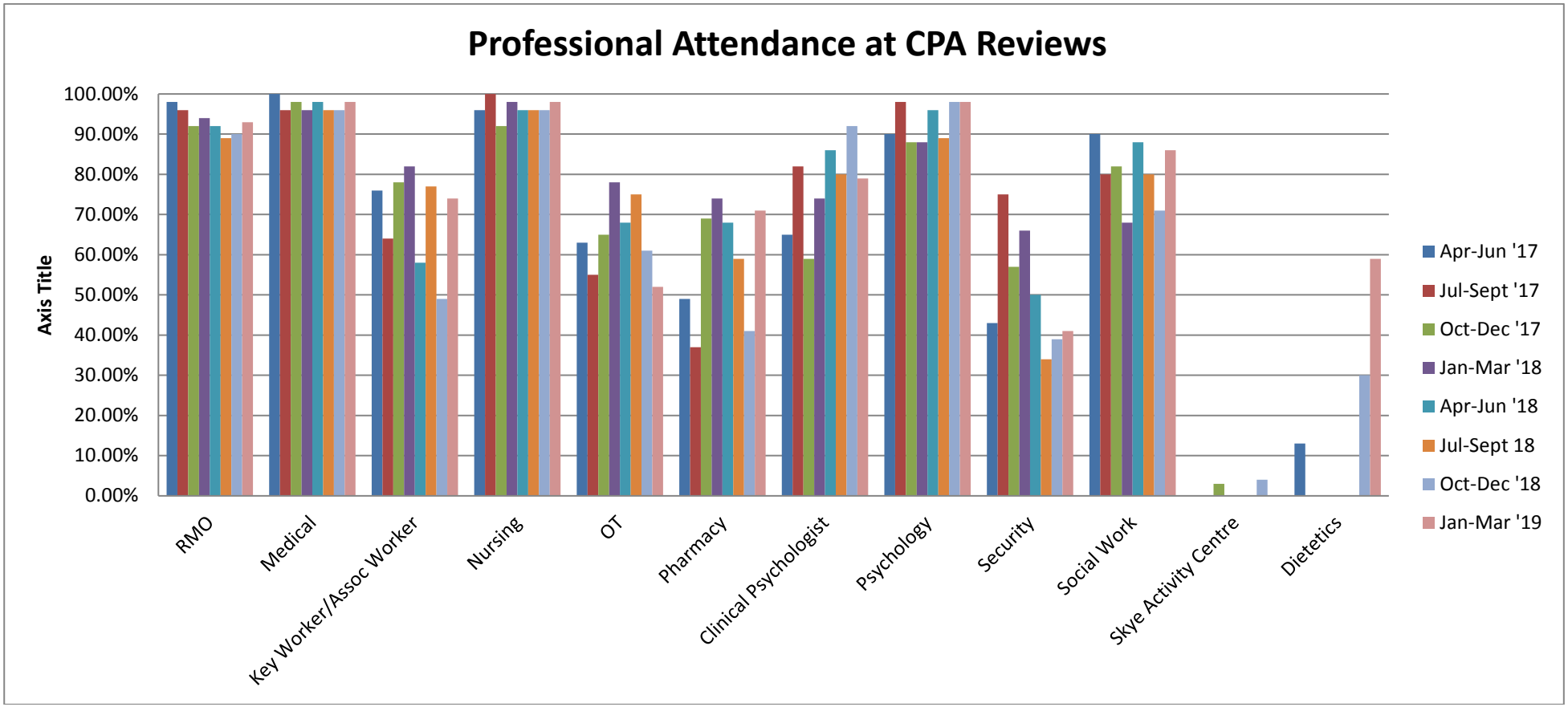
Item 11: Patients will commence psychological therapies <18 weeks from referral date



Item 13: Patients have their clinical risk assessment reviewed annually



Item 15: MDT Attendance at Case Review



Paper No: 19/48

THE STATE HOSPITALS BOARD FOR SCOTLAND

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

1 SITUATION

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

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

2 BACKGROUND

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

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

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

3 ASSESSMENT

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

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

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

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

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

4 RECOMMENDATION

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

Paper No: 19/48

MONITORING FORM

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

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

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

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

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

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

Appendix B

The State Hospital Strategy Map 2019 – 2020

NHS Scotland aims to:

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

The State Hospital mission:

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

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

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

The State Hospital Strategic objectives:

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

Key outcomes, by 2020 The State Hospital will have:

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

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

PRESENT:

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

IN ATTENDANCE:

Internal

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

External

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

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

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

NOTED

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted.

NOTED

3 MINUTES OF THE PREVIOUS MEETING

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

APPROVED

4 MATTERS ARISING AND ACTION NOTES UPDATE

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

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

Action - Mr McNaught

NOTED

5 ATTENDANCE MANAGEMENT REPORT

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

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

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

NOTED

6 LONG TERM SICKNESS ABSENCE TREND REPORT

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

NOTED

7 FRAUD UPDATE

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

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

NOTED

8 FRAUD ACTION PLAN

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

Action - Mr McNaught

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

Action - Mr McNaught

NOTED

9 CORPORATE RISK REGISTER UPDATE

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

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

NOTED

10 POLICY UPDATE

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

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

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

Action - Mr McNaught

NOTED

11 CATEGORY 1 AND 2 ADVERSE EVENT REVIEWS

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

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

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

NOTED

12 RESILIENCE COMMITTEE - UPDATED TERMS OF REFERENCE

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

NOTED

13 AUDIT PROGRESS REPORT 2018/19

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

The Committee noted this report.

NOTED

14 MANAGEMENT ACTION TRACKING REPORT

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

NOTED

15 DRAFT INTERNAL AUDIT PLAN 2019/20

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

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

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

Action - Mr McNaught/RSM

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

APPROVED

16 SICKNESS ABSENCE MANAGEMENT / POLICY AND PROCEDURE COMPLIANCE REPORT

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

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

NOTED

17 RISK MANAGEMENT AUDIT REPORT

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

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

NOTED

18 ANNUAL INTERNAL AUDIT REPORT 2018/19

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

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

Action - Mr McNaught

NOTED

19 INTERIM EXTERNAL AUDIT REPORT

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

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

The Committee were content to note this update.

NOTED

20 ANNUAL REVIEW OF STANDING DOCUMENTATION

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

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

APPROVED

21 AUDIT COMMITTEE - TERMS OF REFERENCE

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

Action - Mr McNaught

APPROVED

22 REVIEW OF ACCOUNTING POLICIES

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

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

The Committee approved these changes.

APPROVED

23 ANY OTHER BUSINESS

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

NOTED

24 DATE AND TIME OF NEXT MEETING

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

The meeting ended at 12 noon

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2019
Agenda Reference:	Item: 24
Sponsoring Director:	Chief Executive Officer
Author(s):	Board Secretary
Title of Report:	Chief Executive's Report
Purpose of Report:	For Information

1 BACKGROUND

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

2 GENERAL ISSUES OF NOTE

The Chief Executive will provide the Board with a verbal update.

3 PATIENT SAFETY UPDATE

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

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

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

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

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

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

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

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

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

- Safer Medicines Management

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

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

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

4 HEALTHCARE ASSOCIATED INFECTION (HAI)

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

Key Points:

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

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

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

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

Audit Activity:

Hand Hygiene

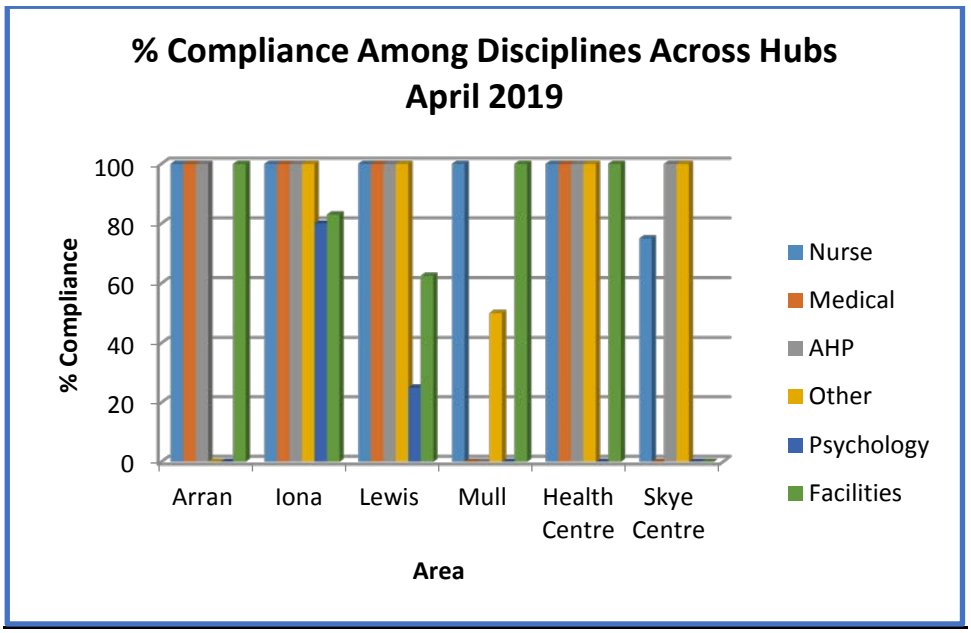
During this review period, there was a notable increase in the number of audits submitted.

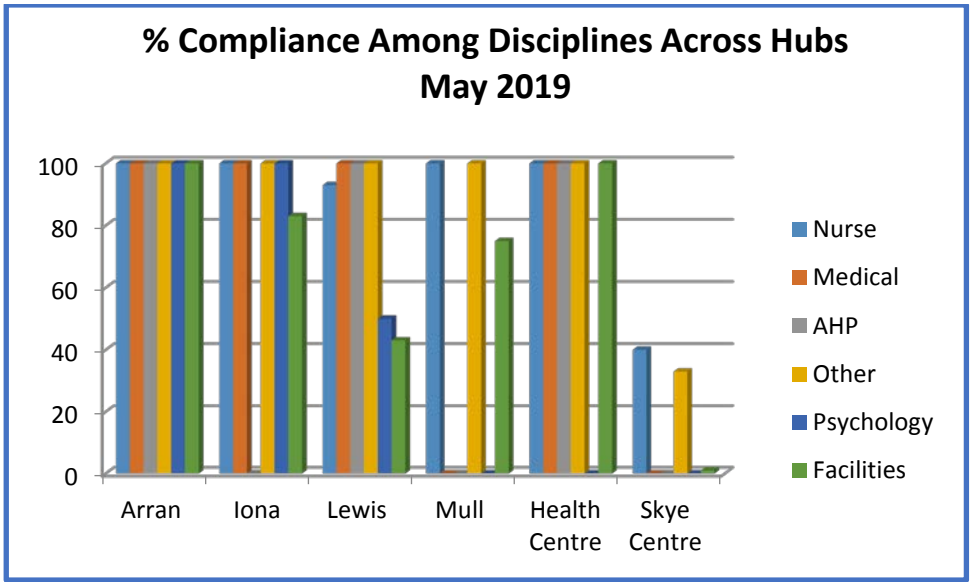
Reminders to submit and follow up of non compliance will continue to be carried out by the Senior Nurse for Infection Control.

April
12 out of a possible 12 were submitted.

May
12 out of a possible 12 were submitted.

The overall hand hygiene compliance within the hubs varies between 80-100%, with psychology continuing to be the discipline with the poorest compliance. The Skye Centre continues to remain low with significant variation 30-90% and the health centre consistently attaining 100%. The SNIC will undertake additional audits during the incoming months. The Charts below demonstrate the compliance among disciplines during the reporting period.





Following approval by the Senior Management Team both the product and the location of the hand gel within the Skye Centre was changed in September 2017. This was following feedback from those working in the Skye Centre. Unfortunately, these changes have not improved compliance within this area.

DATIX Incidents for Infection Control

There was a total of 12 incidents for the period under the Category of Infection Control, all of which relate to clinical waste (safe management of linen). This is being addressed by the SNIC, senior ward based nursing staff and Risk Management.

All Infection Control related DATIX incidents are investigated by the Senior Nursing Staff, clinical teams (as required) and reviewed by the SNIC to ascertain if there are learning outcomes identified. In addition, the Infection Control Committee is presented with this data quarterly.

Scotland's Infection Prevention and Control Education Pathway (SIPCEP) (previously Cleanliness Champions):

Following the launch of SIPCEP in September 2017 the ICC had advised that the four core modules should be completed within 6 months of implementation; however an extension was granted for three months but we have still not achieved the recommended target.

This will continue to be reviewed by the ICC quarterly.

Module	**Completions**		
	2017/18	**2018/19**	**Total (%)**
Why Infection Control Matters	301 (44.9% of target)	264 (39.3%)	**84.2**
Breaking the Chain of Infection	362 (54% of target)	233 (34.7%)	**88.7**
Hand hygiene	315 (new module) (47% of target)	266 (39.6%)	**86.6**
Respiratory and Cough hygiene	308 (45.9% of target)	263 (39.2%)	**85.1**

The remaining modules (allocated as per job requirement) are to be completed by 31st March 2020.

Module	**Completions**		
	2017/18	**2018/19**	**Total (%)**
Safe disposal of waste (inc Sharps)	*165 (35.9% of target)*	179 (37.4% of target)	**73.3**
PPE	*174 (38.9% of target)*	183 (38.2% of target)	**77.1**
Prevention and Management of Occupational Exposure (inc Sharps)	*166 (36.1% of target)*	182 (38% of target)	**74.1**
Blood and body fluid spillages	*201 (45.2% of target)*	176 (36.7% of target)	**81.9**
Safe Management of Care Environment	*120 (30.9% of target)*	155 (32.4% of target)	**63.3**
Safe Management of Care Equipment	*88 (26% of target)*	146 (30.5% of target)	**56.5**
Safe Management of Linen	*120 (30.9% of target)*	161 (33.6% of target)	**64.5**
Patient Placement/ Infection Risk	*92 (27.9% of target)*	140 (29.2% of target)	**57.1**

New staff will complete the priority modules within 6 months of employment with remainder of modules within 2 years of employment.

There is no data available for the reporting period as this is outwith the quarterly data reporting.

Hepatitis C Treatment

During this review period we have had 1 patient gain approval to commence a second attempt at treatment following his initial nil response. Funding is currently being sought from his home health board.

Queen Elizabeth University Hospital (QEUH)

Following a Healthcare Environment Inspectorate visit to the QEUH, all boards were asked to assess themselves against recommendations and requirements contained in report. The State Hospital completed this assessment and there are no areas of concern for the Infection Control Committee.

At a the Chief Nursing Officer's meeting with HCAI Executive Leads, it was suggested that Scottish Government host a workshop to reflect on lessons learned over the past year and to discuss the future landscape of HCAI. The SNIC will attend this workshop on 13th June and feedback to the Infection Control Committee.

Policies and Guidance

All infection control policies and procedures are being reviewed as per policy schedule and there are no outstanding policies.

5 PATIENT ADMISSION / DISCHARGES

A detailed report on admissions and discharges is provided to the Clinical Governance Committee on a 6 monthly basis. The following table outlines the high level position from 1 April to 31 May 2019.

	MMI	LD	Total
Bed Complement (as at 31/05/19)	126	14	140
Staffed Beds i.e. those actually available (as at 31/05/19)	118	14	132
Admissions (from 01/04/19 – 31/05/19)	4	1	5
Discharges / Transfers (from 01/04/19 – 31/05/19)	7	0	7
Average Bed Occupancy (April – May 2019)	-	-	107 81% of available beds 76% of all beds

6 RECOMMENDATION

The Board is invited to note the content of the Chief Executive's report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To provide the Board with specific updates on patient safety, infection control and patient admission and discharges as well as any other areas specified to be of interest to the Board.
Workforce Implications	As detailed within sections 3 and 4 of report
Financial Implications	No financial implications identified
Route To Board Which groups were involved in contributing to the paper and recommendations.	Update from CEO to Board
Risk Assessment (Outline any significant risks and associated mitigation)	Not identified for this report
Assessment of Impact on Stakeholder Experience	Not identified
Equality Impact Assessment	Not formally assessed
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not identified as relevant
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 22 AUGUST 2019
9.45am

The Boardroom, The State Hospital, Carstairs, ML11 8RP

A G E N D A

1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 20 June 2019	For Approval	TSH(M)19/06
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 19/53
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
	CLINICAL GOVERNANCE		
7.	**Patient Story:** **Emotional Touchpoint Story on What Matters to You?** Presentation by the Director of Nursing and AHPs	For Noting	Presentation
8.	**Review of the Clinical Service Delivery Model – Update** Report by the Medical Director	For Noting	Paper No. 19/54
9.	**Medical Education – Annual Report** Report by the Medical Director	For Noting	Paper No. 19/55
10.	**Implementation of Specified Persons Regulations – Annual Report** Report by the Director of Security, Estates and Facilities	For Approval	Paper No. 19/56
11.	**Patient Safety, Infection Control and Patient Flow Report** Report by the Director of Nursing and AHPs	For Noting	Paper No. 19/57
12.	**Clinical Governance Committee** Chair's Report of meeting held 15 August 2019	For Noting	Verbal
	STAFF GOVERNANCE		
13.	**TSH Action Plan – in response to the Sturrock Report** Report by the Chief Executive	For Discussion	Presentation

14.	**Attendance Management – Board Update** Report by the Interim Director of HR	For Noting	Paper No. 19/58
15.	**Staff Governance Committee** Draft Minutes of meeting held 23 May 2019	For Noting	SG(M)19/02

CORPORATE GOVERNANCE

16.	**Finance Report to 31 July 2019** Report by the Director of Finance & Performance Management	For Noting	Paper No. 19/59
17.	**Performance:** **a) Strategic Review of Performance** Report by the Director of Finance & Performance Management **b) Performance Report – Quarter 1 2019/20** Report by the Director of Finance & Performance Management	For Noting	Paper No. 19/60 Paper No. 19/61
18.	**eHealth Annual Report 2018/19** Report by the Director of Finance & Performance Management	For Noting	Paper No. 19/62
19.	**Network Information Systems Regulation (NIS) and the Information Security Policy Framework (ISPF) 2018** Report by the Director of Finance & Performance Management	For Noting	Paper No. 19/63
20.	**Communications Annual Report 2018/19** Report by the Head of Communications	For Noting	Paper No. 19/64
21.	**Corporate Governance – Improvement Plan Update** Report by the Board Secretary	For Noting	Paper No. 19/65
22.	**Annual Review – Actions 2018/19** Report by the Chief Executive	For Noting	Paper No. 19/66
23.	**Audit Committee** Approved Minutes of meeting held 28 March 2019 Draft Minutes of meeting held 20 June 2019	For Noting	A(M)19/02 A(M)19/03
24.	**Board and Committee Meeting Schedule 2020** Report by the Board Secretary	For Approval	Paper No. 19/67
25.	**Any Other Business**		
26.	**Date and Time of next meeting** 24 October 2019, 9.45am in the Boardroom At The State Hospital, Carstairs, ML11 8RP		

27. EXCLUSION OF PUBLIC AND PRESS

To consider whether to approve a motion to exclude the Public and press during consideration of the items listed as Part II of the Agenda in view of the confidential nature of the business to be transacted.

THE STATE HOSPITALS BOARD FOR SCOTLAND ***TSH(M)19/06***

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 20 June 2019 at 12.30pm in the Boardroom, The State Hospital, Carstairs.

Chair	Terry Currie
Present:	
Non-Executive Director	Bill Brackenridge
Employee Director	Tom Hair
Chief Executive	Gary Jenkins
Non-Executive Director	Nicholas Johnston
Non-Executive Director	David McConnell
Finance and Performance Management Director	Robin McNaught
Director of Nursing and AHPs	Mark Richards
Medical Director	Lindsay Thomson
Non- Executive Director	Maire Whitehead
In attendance:	
Head of Estates and Facilities	Kenny Andress [Item 20]
Skye Centre Manager	Jaqueline Garrity [Item 9]
Acting Social Work Manager	Peter Di Mascio
Head of Communications	Caroline McCarron
Head of Corporate Planning and Business Support	Monica Merson
Interim Human Resources Director	Kay Sandilands
Board Secretary	Margaret Smith
Director of Security, Estates and Facilities	David Walker

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Currie welcomed everyone to the meeting, and it was noted that there were no apologies for this meeting.

NOTED

2 CONFLICTS OF INTEREST

There were no declarations of conflicts of interests from Members in respect of the business to be discussed at this meeting.

NOTED

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 25 April 2019 were noted to be an accurate record of the meeting, subject to one minor amendment to the attendance.

APPROVED

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board noted progress on the action points from the last meeting - each action was completed or on today's agenda.

NOTED

5 CHAIR'S REPORT

Mr Currie thanked Mrs Whitehead for her attendance at the NHS Board Chair's meeting that had taken place on 20 May 2019.

He advised that there were a number of actions arising from this meeting, and Mr Currie outlined these for the Board. The Chairs were asked to make themselves familiar with the 'Hospital at Home' programme and consider implementing such a programme in their Board Area. Chairs were asked to create an aligned process for identifying and implementing exiting good practice across all Boards. Further, Chairs were asked to ensure that they are aware of performance reporting processes in their Boards and raise issues with Scottish Government as early as possible.

Chairs were asked to provide feedback on the Annual Review process, particularly on how to better incorporate integration. Mr Currie advised that the follow up letter to the Annual Review, which took place at The State Hospital (TSH) on 14 January 2019, had been received from the Minister of Mental Health. This would be circulated to the Board, and brought to the next Board Meeting for review.

Action – Ms Smith

Mr Currie advised that Chairs had been asked to set out what they will do within their Boards to help meet the Citizens' Jury recommendations, which were grouped into the following themes:

- Inform and educate patients to ask questions
- Create a culture of shared decision making
- The organization of appointments
- Training for professionals
- Advocacy
- Patient information and records.

He confirmed that the Realistic Medicine lead for TSH, Dr Gordon Skilling was progressing this work and planned to hold a forensic network event to discuss the recommendations and to develop an action plan on implementation. Mr Currie had asked that Dr Skilling report to the Board to allow Members an opportunity to discuss and review.

The NHS Chairs had also discussed the Scottish Government response to Sturrock Review into NHS Highland. Mr Currie emphasised that whilst the Review only examined matters in NHS Highland, there was important learning and reflection for all NHS Boards and the Scottish Government. He noted that that Cabinet Secretary for Health and Sport had written to all Boards on 20 May 2019 asking that they consider the Review and look again at the effectiveness of their own internal systems, leadership and governance. This response should be submitted by 28 June 2019.

Mr Currie noted that one of the actions contained in the Scottish Government response was the introduction of an Independent National Whistleblowing Officer for NHS Scotland and that this would

be the Scottish Public Services Ombudsman. In addition, it was the intention to recruit new Non-Executive Whistleblowing Champions for each health board and have these in post by the end of 2019. These champions would scrutinise the health board's application of whistleblowing processes and would have the authority to raise concerns directly with the Scottish Ministers where they feel that issues have not been appropriately addressed.

Mr Currie also made the Board aware that Mr Malcolm Wright had been confirmed in the post of Chief Executive Officer and Director General for NHS Scotland.

NOTED

6 CLINICAL GOVERNANCE COMMITTEE – ANNUAL REPORT 2018/19

A report was received from the Medical Director, outlining the activity overseen by the Clinical Governance Committee throughout 2018/19, and the Committee Chair, Mr Johnston provided an overview of this. The Board approved the report, subject to very minor amendment, which would be highlighted to the Clinical Effectiveness Lead.

Action – Ms Smith

APPROVED

7 REVIEW OF THE CLINICAL MODEL - UPDATE

The Board received a report from the Medical Director to provide an update on the review of the Clinical Model, and Professor Thomson led Members through the detail of the work progressed since the last Board meeting on 25 April 2019. She emphasised the breadth of work undertaken to engage with staff, patients and wider stakeholders.

Ms Merson then provided a summary of the progress made to date with a further feedback session held in May for Heads of Service and Senior Clinicians and on the emergent themes from staff engagement. Staff were eager to continue to engage in this way. She outlined the way forward through an options appraisal process, taken through development of a set of benefits criteria. Ms Merson outlined the involvement of the Clinical Forum with the establishment of a short life working group to give clarity on the meaning of each option. Ms Merson also underlined that financial analysis of each option was being progressed in tandem.

Professor Thomson emphasised the engagement through the Clinical Forum as a multi-disciplinary advisory committee, as well as operational nurse managers to ensure as wide engagement as possible through the options appraisal process. It was essential that all possible options were considered. As part of this engagement, the Clinical Forum were involved in nominating a wide cross-section of staff to participate in a visit to another high secure hospital in the U.K and provide feedback from this. The benefits criteria of each option would then be finalised in the next workshop, taking place in August 2019, with a formal options appraisal taking place in September 2019.

Board Members welcomed the progress made to date, particularly staff engagement, which had indicated a willingness to consider change carefully and in a pragmatic way. It was recognised that this was a huge project within TSH, and would require continued careful development. It would be important to continue to recognise the challenging financial backdrop, and to ensure that staff continued to feel invested in any structural organisational change.

It was noted that patient and staff safety were not specifically included in the benefits criteria, and Professor Thomson agreed that this should be the case; this had been recognised internally following submission of the paper to the Board and had been added.

It was agreed that a further update on progress should be brought to the Clinical Governance

Committee and to the Board in their meetings in August 2019, prior to submission of the finalised report on the result of the options appraisal to the Board at its meeting in October 2019.

Action – Professor Thomson/ Ms Merson

NOTED

8 HEALTH AND CARE STAFFING – UPDATE

A report was submitted by the Director of Nursing and AHPs, to update the Board on The Health and Care (Staffing) (Scotland) Bill which was passed by parliament on 2 May 2019 and was currently awaiting Royal Assent. Enactment of the legislation was expected in 2020.

In preparation for this, The State Hospital [TSH] was receiving funding until September 2020, to employ a part time workforce lead, working closely with Healthcare Improvement Scotland (HIS) to prepare to meet the requirements of the legislation, most particularly the Common Staffing Method.

Mr Jenkins added that this would be a significant change in focus for all NHS Boards, and it was essential to be able to describe what was needed within the organisation and plan accordingly. A further update would be brought to the Board at its October meeting.

Action – Mr Richards

9 SKYE CENTRE – 12 MONTHLY REPORT

A report was received from the Director of Nursing and AHPs, which provided an update to the Board on patient activity services within the Skye Centre for the period 1 June 2018 to 31 May 2019.

Ms Garrity was in attendance to lead Members through the detail of the report, emphasising the key pieces of work undertaken over the past 12 months, and the continued delivery of a quality service for patients. There was focus on the development of new activities for patients. She also asked the Board to consider the presentation of the information in the report, particularly tracking activity over time. Ms Garrity was pleased to advise the Board that the Skye Centre had recruited to the post of gardener, to ensure that this service could be provided to patients.

Mr Richards underlined the increase in the number of patients engaged in activity in the Skye Centre, and the positive direction of travel in this regard. Professor Thomson agreed that it was encouraging to see this improvement, and added that it was also essential to review the quality of the sessions undertaken. There was discussion around progress on the Patient Active Day, and Ms Garrity provided further background in terms of how this has been progressed including the work undertaken to consider patient feedback.

In response to a query on how to set a further target for improvement and monitor this, Ms Garrity confirmed that implementation of the electronic patient timetable will help to support this. The timetable would be used to capture both planned and ad hoc sessions. There was discussion around how patient attitudes to activities could impact on attendances as well as variance in clinical practice. Members were keen to support best clinical practice throughout the organisation, and Mr Jenkins confirmed that this would be taken forward to ensure equality of opportunity for all patients.

The Board welcomed this as a positive report, and thanked Ms Garrity and her team for the work undertaken throughout the year.

NOTED

10 CLINICAL GOVERNANCE COMMITTEE – CHAIR'S REPORT

The Board received the draft minutes of the meeting of the Clinical Governance Committee, which took place on the 9 May 2019. The Committee Chair, Mr Johnston, highlighted that the Research Committee had been noted as an area of good practice with reference to research study implementation as well as inclusion of patient feedback. An area of concern had been noted in relation to the Infection Control Committee in terms of hand hygiene practice in the Skye Centre and the downward trend in completion of infection control learning modules.

NOTED

11 STAFF GOVERNANCE COMMITTEE – ANNUAL REPORT 2018/19

The Board received a report from the Interim Director of Human Resources, outlining the key achievements and developments overseen by the Committee throughout 2018/19. The Committee Chair, Mr Brackenridge, provided an overview of the report, which was approved by the Board subject to one minor amendment. There had been five meetings throughout the year, but the meeting that took place on 5 April 2018 had been rescheduled from March 2018 due to very inclement weather.

APPROVED

12 REMUNERATION COMMITTEE – ANNUAL REPORT 2017/18

The Board received a report from the Interim Director of Human Resources, as a summary of the work undertaken by the Remuneration Committee throughout 2017/18. The Board approved this report subject to minor amendment on the date of the meetings, as well as noting that the Remuneration Committee will send reports to the Audit Committee, but does report directly to the Board.

APPROVED

13 RESPONSE TO THE CABINET SECRETARY FOR HEALTH AND SPORT – CULTURAL ISSUES RELATAED TO ALLEGATIONS OF BULLYING AND HARRASSMENT IN NHS HIGHLAND

Mr Jenkins introduced a discussion in relation to the Scottish Government Response to the Sturrock Review into Cultural Issues related to allegations of bullying and harassment in NHS Highland.

On 20 May 2019, the Cabinet Secretary for health and Sport had written to all NHS Board Chairs and Chief Executives requesting that they provide where appropriate:

- Details of immediate actions your Board have taken/ plan to take on the back of the recommendations made in the Sturrock report.
- What support your Board have put in place/ will put in place for any member of staff who has been affected by bullying and harassment.
- Details of your Board's plan for staff engagement to consider these recommendations and a timeline of when this will be carried out.

Mr Jenkins outlined the considerable progress made to date with discussions within the Partnership Forum the Senior Management Team, and the Staff Governance Committee. He had also engaged with a range of clinical groups within the hospital during this time and this had lent further opportunity to raise awareness of this engagement process.

At the Partnership Forum held in June, the Chief Executive and Interim HR Director had collated a list of themes and fed this back through the forum for discussion. Mr Jenkins went on to say that work was also being progressed to identify themes from previous iMatter reports, as well as from the engagement process underway on the review of the Clinical Model.

The emergent themes would be collated into a questionnaire for staff to complete during July 2019, weighting their views and priorities within the identified themes. In this way, the focus would be bottom up approach led by the whole staff group of the organisation. This would help inform the creation of an action plan for implementation thereafter.

Ms Sandilands added that the Executive Leadership would be participating in an Away Day session in July to lend additional focus to leadership within the Board.

It was noted that a response was due to the Cabinet Secretary for Health and Sport on the above points by 28 June 2018, and it was agreed that a copy of this would be circulated to Board Members thereafter.

The Board were content to note the progress made in, and the plan outlined, and that a further update would be brought back to the Board at its next meeting.

Actions - Ms Smith

AGREED

14 ATTENDANCE MANAGEMENT – BOARD UPDATE

A report was received from the Interim Director of Human Resources, to provide the Board with an update on attendance management within TSH, particularly sickness absence rates. It was noted from the report that sickness absence had reduced further to a rate of 6.34% in March 2019, and Ms Sandilands provided a further verbal update that this had been reduced further to 5.55% in April 2019. She highlighted that future focus should be particularly on longer term absences, in order to help support staff and bring further improvement.

The Board welcomed this report, and Ms Sandilands's further update, and noted the need to sustain focus in this area.

NOTED

15 STAFF GOVERNANCE COMMITTEE

The Committee Chair, Mr Brackenridge, provided a verbal report on the meeting that took place on 23 May 2019, which had focused on attendance management, compliance on personal development plans and statutory and mandatory training, as well as the Sturrock report. The minutes of this meeting would be presented to the Board at its August meeting.

NOTED

16 AUDIT COMMITTEE – ANNUAL REPORT 2018/19

A report was received from the Director of Finance and Performance Management, to summarise the work of the Committee as well as to support the Governance Statement to the Board as part of the Annual Accounts, in respect of internal controls.

The Committee Chair provided an overview of the report, and the Board were content to approve its

contents.

APPROVED

17 ANNUAL ACCOUNTS FOR YEAR ENDED 31 March 2019

A report was received from the Director of Finance and Performance Management, noting that the annual accounts had an unqualified audit opinion from the external auditors, Scott Moncrieff, and were approved by the Audit Committee at their meeting on the morning of 20 June to be adopted by the Board.

Mr McNaught asked Members to note that the paper referred to the Governance Statement and the Statement of Health Board Members' Responsibilities; as well as summarising the Audit Committee's responsibility in reporting to the Board that the accounts should be adopted. Further, that the authority to sign as required was given to the Chief Executive and the Finance and Performance Management Director.

The Board provided approval for the following:

- Chief Executive to sign the Performance report
- Chief Executive to sign the Accountability Report
- Chief Executive and Director of Finance and Performance Management to sign the Statement of Financial Position.

It was also noted (in relation to Patient Funds) that the full background report was presented to the Audit Committee which recommended approval by the Board. The Board provided approval on this basis.

The Board noted the positive feedback from the external auditors on the presentation of background papers to support their audit, from the Finance Department, and that this would be fed back to the team.

APPROVED

18 FINANCE REPORT AS AT 31 MAY 2019

A report was received from the Director of Finance and Performance Management, to present the financial results to 31 May 2019 [Month 2].

Mr McNaught advised that TSH was reporting an overspend at 31 May of £67k, compared to a £58k overspend at the same point last year, but that was much reduced at the time due to the actions taken just before the 2018 year end resulting in almost nil overtime in March 2018 impacting on the April 2018 payroll. He highlighted the need to continue to focus on the short-term nursing overtime position to ensure operational steps move forward towards lower long-term sustainable levels.

Mr McNaught highlighted a significant issue for TSH to address as the currently unidentified savings for the year, the next step being to engage with all budget holders in second-stage line-by-line budget reviews at the end of quarter 3. The unidentified balance was reduced so far by confirmation from Scottish Government that the 6% pensions uplift was being funded for 2019/20.

In addition, the capital project facilitation costs (such as escorting) would be included in the final project funding. With reference to the National Boards' collaborative discussions, TSH did not expect to be in a position to contribute anything over the currently recognised £220k consistent with 2018/19. Both of these factors would reduce unidentified savings, but there would still be a strong requirement for focus on all directorate savings opportunities. He noted that Finance were also evaluating the level of benefit to be received from the agreed application of 5% VAT on utilities in

place of 20%.The capital resource budget was anticipated to be fully utilised in 2018/19.

Members noted the report, and placed this within the context of the report to the Audit Committee by the external auditors in relation to the risk presented from attendance management as well as overspend on nurse overtime. Mr Jenkins advised that work was in progress through the Senior Management Team in relation to managing the nurse resource to deliver the service within core hours.

Mr McNaught confirmed that, as discussed at the last Board meeting, and with the year end accounts process now complete, there would be a review of the presentation of this finance paper to the Board.

NOTED

19 ANNUAL REVIEW OF STANDING DOCUMENTATION

The Board received a report from the Director of Finance and Performance Management to submit proposed changes to Standing Documentation. He also noted the work of the Corporate Governance Steering Group led by the NHS Chairs to provide national guidelines in relation to Standing Orders, and that an update on this was expected later in the year.

The Board approved the recommended changes as outlines within the report.

APPROVED

20 PROPERTY AND ASSET MANAGEMENT STRATEGY (PAMS)

A report was received from the Director of Security, Estates and Facilities to provide a local interim update for PAMS as required by Scottish Government.

Mr Andress was in attendance and provided Members with a high level summary of the paper, and noted that TSH along with other National Boards were tasked with producing a National PAMS by the end of 2019.

The Board approved the report to be submitted to the Scottish Government Health, Finance, Corporate Governance and Value Directorate.

APPROVED

21 PERFROMANCE REPORT 2018/19

A report was received from the Director of Finance and Performance Management, to provide a high level summary of organisational performance for the 2018/19. He advised that a review was underway led by the Head of Corporate Planning and Business Support to reframe and update the individual KPIs and the quality of the available information for each measure.This would tie in with the work being undertaken on Tableau data warehousing options and systems support that would improve the reporting and sharing of relevant information.

Members discussed the presentation of data to give more sophisticated data e.g. changes in patient BMI over time. Ms Merson advised that the Business Tableau project was aimed at providing these additional layers of data to help present the organisational performance report.

Board Members noted the content of the report.

NOTED

22 CORPORATE GOVERNANCE - IMPROVEMENT PLAN UPDATE

A report was received from the Chief Executive, and Ms Smith provided Members with an overview of the key details, noting that this improvement plan had been added to the Board Workplan and that an update would be brought to each meeting.

The improvement action plan had been updated to include a section to detail progress against each item. Work was progressing to develop a strapline for all corporate documents through engagement with the wide staff group who had been asked for their suggestions. This would be finalised and a strapline chosen at the end of the month. Ms Smith noted that a wide range of staff were actively participating in this project.

Ms Smith also advised that review of the Strategy Map would form part of the Executive Lead Away Day taking place in July in line with review of the Board's Corporate Objectives.

In response to a query on point 4 – compliance with national guidelines in management of Executive Pay, Ms Sandilands clarified that this was intended to note the new guidelines in place this year and a commitment to take this forward. The plan would be amended to indicate this.

Action – Ms Smith

In reference to the review of the nurse rostering system, Mr Richards clarified that this was being taken forward in conjunction with the national work on eRostering. However, it was acknowledged that TSH had internal work to progress internally in terms of any anomalies or hot spots in shift rostering.

The Board noted the report, as a helpful summary of the work being progressed across the organisation.

NOTED

23 AUDIT COMMITTEE

The Board noted that the minutes of the Audit Committee that took place on 28 March 2019 were approved at this morning's Audit Committee meeting and would be submitted to the next Board Meeting in August.

NOTED

24 CHIEF EXECUTIVE'S REPORT

A paper was submitted to the Board by the Chief Executive, which highlighted and provided an update to Members on issues that did not feature elsewhere on the Board's formal agenda, including updates on Patient Safety, Infection Control and Patient Admissions and Discharge data.

Mr Jenkins provided an additional verbal update on his activities since the date of the last Board Meeting. He noted the work undertaken in response to the Sturrock Review as had been discussed during this meeting of the Board.

Mr Jenkins advised that he had a helpful and productive meeting with colleagues at the Mental Health Directorate within Scottish Government, with focus on the TSH Annual Operational Plan for 2019/20.

He also noted the two reviews currently underway, of the Mental Health Forensic Estate as well as

of the Mental Health Act, and noted that Mr Derek Barron would be visiting TSH in his role as Chair of the Review of the Mental Health Forensic Estate.

Mr Jenkins had also attended the Scottish Leadership Forum, on behalf of the Board and would continue to do so as the meeting would take place twice a year. He had also approached the Head of Integration at Scottish Government to schedule a meeting at TSH in the near future.

NOTED

25 ANY OTHER BUSINESS

There were no other items of competent business for discussion at this meeting.

NOTED

26 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 22 August 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

NOTED

27 EXCLUSION OF PUBLIC AND PRESS

Members approved a motion to exclude the public and press during consideration of the items listed at Part II of the agenda in view of the confidential nature of the business to be transacted.

AGREED

ADOPTED BY THE BOARD

CHAIR _____
(Signed Mr Terry Currie)

DATE 20 June 2019

MINUTE ACTION POINTS
THE STATE HOSPITALS BOARD FOR SCOTLAND
(From June 2019)

ACTION NO	AGENDA ITEM NO	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	5	Chair's Report	Circulate Annual Review Letter and add to Board Agenda	M Smith	Immediate	**On Agenda**
2	6	Clinical Governance Annual Report	Amendment to report.	S Smith	Immediate	**Completed**
3	7	Review of Clinical Model	Update on progress	Prof. Thomson/ M Merson	August 2019	**On Agenda**
4	13	Sturrock Review	Update on TSH Response	K Sandilands	August 2019	**On Agenda**
5	22	Corporate Governance – Improvement Plan	Amendment to wording in place to clarify the action (point 4)	M Smith	Immediate	**On Agenda**

Board Paper 19/54

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 8
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Business Support
Title of Report:	Review of Clinical Model
Purpose of Report:	Update the Board on progress

1 SITUATION

This report provides and update to The Board on a review and options appraisal process on The Clinical Model. The requirement to review the Clinical Model arose from a presentation to the Board on 28th June 2018 by the Service Transformation and Sustainability Group where comments were expressed by staff on the current structure for the delivery of care.

2 BACKGROUND

The clinical care model describes the way The State Hospital provides high secure services to patients with a mental disorder many of whom have offended. The need to review the Clinical Care Model arose from issues raised through a staff engagement exercise which focused on readiness to change. As part of the Service Transformation and Sustainability projects, this stream of work has focused on the review of the clinical care model. This work is split into three parts:

1. Review of the clinical model principles
2. Review of safety factors
3. Review of the clinical service delivery model.

The Board received an update in October 2018 on point 2 - review of the safety factors; and a further update in December 2018 on point 1 - review of the Clinical Model Principles and point 3 - review of the clinical service delivery model, which consisted of staff consultation activities via an online questionnaire in December and January 2019 and staff, stakeholder and patient workshops in February 2019 and engagement activity March – June.

3 ASSESSMENT

Options for change were identified through staff consultation and engagement. Following extensive engagement on these options there is now a need to move into a process of options appraisal to provide a robust approach to considering options and their potential impacts on the delivery of care.

The Clinical Forum have supported the options appraisal process in detailing each option for consideration to ensure that there is clarity on the meaning of each, consistency in the use of language and an exploration of what each option means for the delivery of care.

There are currently 6 options being considered including the status quo. 2 options are based on the 3 Hub 3 ward model, 3 options are based on Hubs operating with different functions and either 1 or 2 ID wards. These are detailed below:

Option 1: Status Quo

Option 2: 3 Hubs with 3 wards (Ward 1- Admission & Assessment, Ward 2- Treatment & Recovery, Ward 3- Transition) and 1 ID ward in separate hub

Option 3: 3 Hubs with 3 wards (Ward 1- Admission & Assessment, Ward 2- Treatment & Recovery, Ward 3- Transition) and 2 ID wards in separate hub

Option 4: 3 Hubs with different functions (Hub 1- 2 Admission & Assessment wards, Hub 2- 3 Treatment & Recovery wards, Hub 3- 2 Treatment & Recovery wards, Hub 4- 2 Transition wards and 1 ID ward

Option 5a: 3 Hubs with different functions (Hub 1- 2 Admission & Assessment wards, Hub 2- 3 Treatment & Recovery wards, Hub 3- 2 Treatment & Recovery wards and 1 ID ward, Hub 4- 2 Transition wards and 1 ID ward

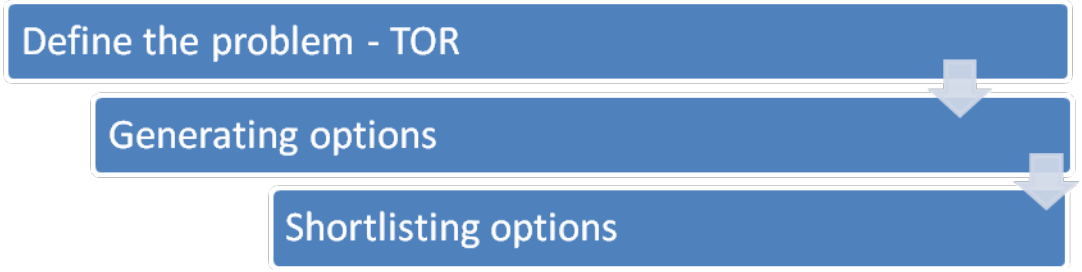
Option 5b: 3 Hubs with different functions (Hub 1- 2 Admission & Assessment wards and 1 Transition ward, Hub 2- 3 Treatment & Recovery wards, Hub 3- 2 Treatment & Recovery wards, Hub 4- 2 Transition wards and 1 ID ward

The Clinical Forum have identified the following terms to apply to all options

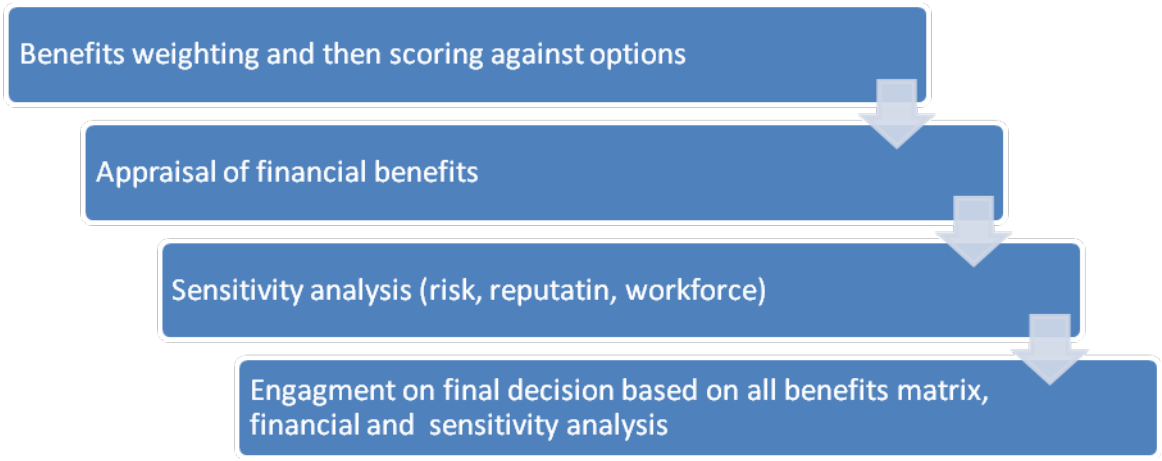
- Admission and Assessment wards: Agreed purpose of these should be about assessment. Restrictions should be standardised but based on the team's working understanding of the patient's risk..
- Treatment and Recovery wards: these wards need to be able to meet the needs of complex patients. Patients who are high risk, but where the risk is well understood and the management of their risk is clearly articulated with a defined care package, should be placed here.
- Transition wards: These wards are suited to patients whose risks and needs are well understood and articulated, and the level of care and management required is lower and less intense. They may have been identified as being ready to move onto less secure

Options appraisal Process

Steps in the Options Appraisal process



The above stages are complete. The next steps in Options Appraisal Process are:



Benefits Criteria
Draft benefits criteria have been developed and will be scored at workshop on 21st August
It is important that the benefits criteria are clearly defined to ensure that the scoring of each for the models is accurate and informed.

Weighting of benefits criteria
Following agreement of the benefits criteria, the benefits matrix will be completed. To do this, each benefit will be compared against one another and ranked (weighted) . This weighting will be developed through individuals identifying the respective priorities of each of the benefits criteria against the others , producing an overall weighting.

Scoring of options
The proposed options will then be assessed against each benefits criteria, which will be weighted to provide an order of importance and priority. This will produce an overall position for the clinical assessment of what option best suits future needs of the hospital. This will be carried out at workshop on 16th September and any preferred options will be considered together with the Financial and Situational analysis to produce a final Decision Analysis and the identification of a preferred option.

Financial Analysis
This will involve capturing the projected costs of the option proposed.

Sensitivity Analysis (Risk, Reputation Workforce)
This will involve mapping out the risks, assumptions and workforce requirements for each model to fully understand the implication of each option. It will also consider any uncertainty in the proposed models and the impact this could have on the hospital

Decision Analysis / Engagement
Data on costs and benefits are brought together with the risks and uncertainty analysis and summarised using marginal analysis. The **emerging preferred option** should then be identified with clarity of the range of strategic analysis carried out to support the preferred option.

Engagement
Staff, stakeholders, partnership and patient engagement will take place to share the outcome of the options appraisal process and gain feedback on this. The Board will be offered the preferred option to consider, alongside the process used to reach this. Following acceptance from the board an implementation plan will be developed which will take account of the magnitude of change and the processes required to implement this.

4 RECOMMENDATION

The Board is invited to note the progress made on the Clinical Model Review

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Corporate objectives of high quality clinical care and staff experience
Workforce Implications	Workforce implications that may arise from the review of the Clinical Model will be formally assessed at options appraisal stage
Financial Implications	Financial implications that may arise from the review of the Clinical Model will be formally assessed at options appraisal stage
Route To Board Which groups were involved in contributing to the paper and recommendations.	SMT
Risk Assessment (Outline any significant risks and associated mitigation)	Risks that may arise from the review of the Clinical Model will be formally assessed at options appraisal stage
Assessment of Impact on Stakeholder Experience	Through stakeholder workshop
Equality Impact Assessment	Not formally assessed
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not relevant at this point
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One □x There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 9
Sponsoring Director:	Prof. Lindsay Thomson, Medical Director
Authors:	Dr Callum A MacCall, Dr Natasha Billcliff
Title of Report:	Annual Medical Education Report
Purpose of Report:	For Noting

1 SITUATION

The General Medical Council (GMC) Quality Improvement Framework for Undergraduate and Postgraduate Medical Education in the UK sets out expectations for the governance of medical education and training. GMC standards specifically refer to Board governance and it is within this context that this report is being presented to the Board. This report covers the period 1 August 2018 to 31 July 2019.

2 BACKGROUND

Dr Callum A MacCall is Educational Supervisor at The State Hospital. He is responsible for postgraduate medical training while Dr Natasha Billcliff leads on issues relating to medical undergraduates.

The medical staff group within The State Hospital hold a 3 monthly training committee meeting which is chaired by Dr Callum A MacCall. This committee reviews training issues of relevance to the Hospital. The Educational Supervisor reports within The State Hospital to Professor Lindsay Thomson, Medical Director. He reports externally to the Training Programme Director for Forensic Psychiatry Higher Training in Scotland, Dr John Crichton, and to local Training Programme Directors for Core Training.

3 ASSESSMENT

3.1 UNDERGRADUATE TRAINING

Teaching Programme for Edinburgh Undergraduate Medical Students

Day Visit

The State Hospital continued to deliver training to medical students in their 5th year during the academic year 2018/19 in the form of a one day visit incorporating clinical teaching in the morning and formal lectures in the afternoon. The lectures cover the civil mental health act and the more

specialised area of forensic psychiatry. There are six visits per academic year each comprising of approximately 50 students.

Feedback is sought from the students on the day for both parts of the teaching. The clinical teaching is mostly in the "excellent" domain, with a choice of "poor, average, good or excellent". The formal lectures feedback is very positive, with the amalgamated feedback from the lectures detailed below.

Did you find the lecture useful?

1 not useful	40 quite useful	86 very useful	----------

How was the presentation?

0 poor	6 okay	121 good	----------

Feedback from the small group teaching

0 poor	3 average	53 good	88 excellent

Clinical Attachment

In 2018/2019 there was a change in the arrangements for attachments of 4th year students. Previously the hospital had facilitated a two week clinical attachment for four groups of two students per year which was well attended and well received by students. Instead, the students had their six week attachments to a General Adult Psychiatry team organised ad hoc when they met with their tutor. Clinical attachments to specialties such as forensic and addictions are no longer part of the formal programme and are required to be arranged individually, on request. To try and pre-empt a decrease in students attached to TSH, the local tutors were contacted and offered a four day forensic programme during their attachment. There have been no requests for placements at TSH during this academic year.

The new system has caused issues all around. The specialties are no longer receiving students for attachments and general adult colleagues have found the system difficult to navigate. At the 2019 clinical tutors meeting it was unanimously agreed that there should be a return to the previous system. The two week attachment to TSH will restart when the programme reverts to its previous format.

Ad Hoc Attachments

Individual students from other medical schools in Scotland and from further afield contact the State Hospital directly on occasion for day visits or seeking elective placements for several months. We have the capacity to accommodate these requests. Students from Glasgow, Aberdeen, Dundee and Nottingham medical schools have visited this year.

Feedback

A report is provided to the Medical Advisory Committee yearly which gives the opportunity to discuss improvements to the teaching. Medical staff also have the option of requesting individual assessment of their teaching skills as part of the Clinical Educator Programme. To date, two staff have taken this up with positive results.

As undergraduate teaching lead Dr Billcliff attends the Edinburgh University Undergraduate Sub-Committee Meeting annually where feedback from each psychiatry placement is discussed. This year's meeting was focused on the unproductive changes to the teaching programme and the support for a return to the previous system that worked well for exposing students to high secure care.

3.2 POST GRADUATE TRAINING

Core Training

The past year has been a very positive one for our post graduate training, especially for our Core Trainee group. Normally we receive two Core Trainees from the West of Scotland Training Scheme and one from the East. This has been the case during each of the two six month blocks over the past year. In the first six months all of our Core Trainees were full time whereas in the second six month block one of our Core Trainees was less than full time (LTFT, 80%). Alongside our two non-training grade Specialty Doctors this meant that we had five Doctors on our first tier medical on call rota during the first six months, necessitating internal locum cover for the remaining slot in our one in six first on call rota. During the second six months we were fortunate in having a Specialty Trainee ST4 who elected to join our on call rota, thus enabling it to run on a one in six basis.

The recruitment climate for Core Trainees in Psychiatry remains challenging nationally and there is the continuing possibility we may not receive three Core Trainees from the West and East of Scotland Training Schemes as a result of vacancies there, thus leaving our first medical on call rota exposed. I understand that consideration is being given to recruiting an additional Specialty Doctor to bring our complement up to three. If it is possible to do so, this would put our first tier on call rota on a more secure footing.

The highlight of our Core Training over the past year has been the award of a Good Practice Recognition from the NES Mental Health Quality Management Group, not only for the current training year but also for the consistency of high quality feedback over a consecutive three year period. The Scotland Deanery Mental Health Quality Review Panel held on 11 September 2018 wrote to congratulate the Hospital on its achievements in relation to training in Core Psychiatry. It recognised the important, positive feedback from Doctors in Training about the quality of training and the training environment provided. In the National Training Survey for 2018 the State Hospital achieved 4 or more green flags (denoting top quartile) and the absence of any red flags. Green flags were achieved for clinical supervision out of hours, reporting systems, supportive environment, workload, team work and educational environment. Additionally, triple green flags in consecutive yearly data were noted for clinical supervision out of hours, supportive environment and workload. The good practice recognition letter is attached in Appendix 1.

Higher Specialty Trainees

Over the past year we have had seven Specialty Trainees attached to the State Hospital for periods varying from one week to six months, on either a full time or LTFT basis. Our Specialty Trainees work under the supervision of Consultant trainers, of which we have nine employed by the State Hospital, one of whom is currently working with the Scottish Government - see Appendix 2.

Specialty Trainees spend part of their weekly timetable undertaking research and special interest activities and overall generally spend less time at the State Hospital than Core Trainees and Speciality Doctors. Their role is distinct, represents a progression from Core Training and maintaining appropriate distinction in their role from those of other non-Consultant grade Doctors is important as they progress towards readiness for Consultanthood.

Senior Specialty Trainees in their final year of training can act up as a Consultant for a maximum period of three months. This has not occurred within the State Hospital during the last year.

In terms of the quality of training for our Specialty Trainees, the State Hospital has once again performed strongly. In the GMC National Trainee Survey the State Hospital has been in the top quartile nationally for workload, feedback and rota design. The results for the Scottish Training Survey and the GMC National Training Survey are attached in Appendix 3.

Teaching Programme

A series of six lectures is delivered by Consultant Psychiatrists to Trainee Doctors during the first three months of their placement at The State Hospital. The current programme encompasses six lecture topics which broadly cover the fundamentals of Forensic Psychiatry and related practice.

State Hospital Visits

Occasional requests for "taster visits" by Foundation Grade Doctors / Core Trainees / non-forensic Specialty Trainees continue to be received on a fairly regular basis. Generally speaking these Doctors are curious to find out more about Forensic Psychiatry and in some cases they have an interest in pursuing Forensic Psychiatry as a career. Over the past year one such request was facilitated in May 2019 from a Core Trainee working in NHS Lanarkshire.

Psychotherapy Training

We have part-time input from a Consultant in Forensic Psychotherapy, Dr Adam Polnay. He provides Balint / Reflective Practice sessions for non-Consultant Grade Doctors. Such work forms part of the Core psychotherapy training requirements and feedback for same has been positive. A summary of feedback from the Balint Group is included in Appendix 4.

GMC Recognition and Approval of Trainers (RoT)

Implementation of the GMC led recognition of secondary care trainers is now properly embedded and allows formal recognition of trainer status via the annual appraisal process of Doctors who have one or more of the following roles:

a) Named Clinical Supervisor in postgraduate training
b) Named Educational Supervisor in postgraduate training
c) Lead Co-Ordinators of undergraduate training at each local education provider
d) Doctors responsible for overseeing student's educational progress for each medical school

As shown in Appendix 2, the State Hospital is currently in a strong position with regard to recognition of trainers. Two of our Consultants have become Higher Specialty Trainers within the past year and we are well positioned with regard to our capability for providing training for Doctors in Forensic Psychiatry, Intellectual Disabilities and Psychotherapy.

NES Deanery Quality Management Visit

On 19 June 2019, the State Hospital received its first NHS Education for Scotland (NES) Quality Management Visit, chaired by Dr Amjad Khan, Lead Dean Director for Mental Health. I think it is fair to say that this visit was very positive, recognising many areas of good practice, including Trainee involvement in multi-professional learning, reflective practice, patient safety and quality improvement activities. Areas for improvement included two IT related items (delays in accessing IT systems at the start of placements and limitations on access to the internet / certain websites) and a suggestion that greater use could be made of handovers as learning opportunities. These issues have already been considered by the Training Committee on 22 July 2019 and will remain on these minutes to ensure progress is monitored. There was only one formal requirement from the visit, namely that colour coded badges should be introduced to enable the level of competence of Trainees to be evident to those that they come into contact with. This requirement was immediately implemented and was in place for the cohort of Trainee Doctors who joined us on 7 August 2019.

The NES visit also noted comments from trainee doctors expressing concern about the potential impact of forthcoming changes to Consultant's job plans resulting from the loss of the contracts to provide psychiatric input to a number of prisons in Forth Valley. This may have an impact on the availability of suitable training opportunities for postgraduate Doctors and could lead to a reduction

in the duration of placements of Specialty Trainees from other areas. It was however acknowledged this is an evolving situation and one which will require monitoring.

The feedback report from the NES Deanery Quality Management Visit is attached as Appendix 5.

Representation at External Committees Relevant to Medical Education

Dr Callum A MacCall represents The State Hospital and / or the National Forensic Psychiatry Training Programme at the following:

- West of Scotland Committee in Psychiatry
- National Forensic Psychiatry Specialty Training Committee
- Royal College of Psychiatrists Forensic Specialty Advisory Committee
- Royal College of Psychiatrists Curriculum Review Committee
- NHS Education for Scotland Annual Review of Competence Progression (ARCPs) for Forensic Higher Specialty Trainees
- Taskforce for the Improvement of Medical Education (TIQME)

4 RECOMMENDATION

The Board is invited to note the following:

i) The continuing high standard of undergraduate and postgraduate medical training provided within the State Hospital. Within the past year particular achievements have been the award of a Good Practice Recognition from NHS Education for Scotland and the very positive first Scotland Deanery Quality Management visit.

ii) The Hospital has a well trained and experienced Consultant workforce which has been strengthened this year with the addition of two new Higher Specialty Trainers. We are well positioned to continue to provide high quality training for medical students and postgraduate trainees in forensic psychiatry, intellectual disability and psychotherapy.

iii) The past year has shown improvements with regard to our overall levels of non-Consultant grade medical cover (Core Trainees and Specialty Doctors) however there have been points where our first tier medical on call rota has required internal locum cover. It is hoped that the possible recruitment of an additional Specialty Doctor (to bring our complement up to three) may put our first tier rota on a stronger footing going forward.

iv) The loss of contracts for the provision of prison mental healthcare in Forth Valley may have an impact on the availability of suitable training opportunities for postgraduate Doctors and could lead to a reduction in the duration of placements of Specialty Trainees from other areas. Hence the availability of opportunities for offsite working by our medical staff should be monitored.

Dr Callum A MacCall

Dr Callum A MacCall
Consultant Forensic Psychiatrist
Educational Supervisor

6 August 2019

Date of next annual report – August 2020
Date of next Board report – October 2020

Appendix 1

Professor Lindsay
Thomson Medical Director
National Facility

Date: 1st November 2018

Dear Professor Thomson

Recognition of important, positive feedback from doctors in training about the quality of training and the training environment in Core Psychiatry at the State Hospital, Carstairs

Following the Scotland Deanery Mental Health Quality Review Panel that was held on 11th September 2018, I write on behalf of the Mental Health Group to congratulate you and the trainers associated with training in Core Psychiatry at the State Hospital on the very positive feedback that trainees have provided on their experience of training.

The feedback that we have been particularly impressed with relates to:

NTS 2018 - 4 or more green or light green flags in a single year and absence of red flags. Green - Clinical Supervision Out of Hours, Reporting Systems, Supportive Environment, Workload, Teamwork and Educational Environment.

NTS 2018 - Triple green in consecutive yearly data - Clinical Supervision Out of Hours, Supportive Environment and Workload.

We appreciate your leadership of training for your Health Board, but also recognise the valuable contribution made by your trainers, and we are delighted to be able share our awareness of the positive feedback that we have received about the training you provide.

Yours sincerely

Professor Ronald MacVicar Lead Dean Director
Mental Health Quality Management Group

cc: Dr Claire Langridge; Associate Dean

Appendix 2

	NES Clinical Supervisor Course or equivalent	NES Educational Supervisor Course or equivalent	Named Medical Trainer Role	Forensic, Intellectual Disabilities+ or Psychotherapy++ Higher Specialty Trainer	Self-declared Recognition of Trainers (RoT) section of appraisal (or do you intend to do so at next appraisal)?
Duncan Alcock	Yes				Yes
Prathima Apurva	Yes				Yes
Natasha Billcliff	Yes		Undergraduate Supervisor	Yes	Yes
Ian Dewar	Yes			Yes	Yes
Jana De Villiers	Yes			Yes+	Yes
Sheila Howitt	CEP* Level 2		Undergraduate Supervisor		Yes
Khuram Khan	Yes	Yes		Yes	Yes
Callum MacCall	Yes	Yes	Postgraduate Supervisor	Yes	Yes
Jon Patrick	CEP* Level 2				Yes
Adam Polnay	CEP* Level 3			Yes++	Yes
Gordon Skilling	Yes			Yes	Yes
Nicola Swinson	Yes	Yes		Yes	Yes
Lindsay Thomson	Fellow HEA**	Yes		Yes	Yes

*CEP = Clinical Educator Program **HEA = Higher Educational Academy

Scotland Deanery
Director of Medical Education Report

Postgraduate Medical Education: Quality Report
Key to survey results

Scottish Training Survey (STS)

Key	
R	Low Outlier - well below the national benchmark group average
G	High Outlier – performing well for this indicator
P	Potential Low Outlier - slightly below the national benchmark group average
L	Potential High Outlier - slightly above the national benchmark group average
W	Near Average
▲	Significantly better result than last year**
▼	Significantly worse result than last year**
—	No significant change from last year*
	No data available
	No Data

** A significant change in the mean score is indicated by these arrows rather than a change in outcome.

GMC National Training Survey (NTS)

Key	
R	Result is below the national mean and in the bottom quartile nationally
G	Result is above the national mean and in the top quartile nationally
P	Result is in the bottom quartile but not outside 95% confidence limits of the mean
L	Result is in the top quartile but not outside 95% confidence limits of the mean
W	Results is in the inter-quartile range
▲	Better result than last year
▼	Worse result than last year
—	Same result as last year
	No flag / no result available for last year

Aggregated results have been provided where there are fewer than 3 responses in the current year's NTS survey and therefore no data is available. The aggregated RAG outcomes have been **generated by NES** using the 2017-2019 NTS data. They are not attributable to the GMC.

Site: State Hospital, Specialty: Forensic Psychiatry

GMC NTS (Trainee)

Level	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Handover	Induction	Adequate Experience	Supportive environment	Work Load	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave	Reporting Systems	Teamwork	Curriculum Coverage	Educational Governance	Rota Design	N
ST	W	W			W	W	W	L	W	G	W	W	W	W	W	W	W	G	4

Scottish Training Survey

Group	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Work Load	N
Core - Psychiatry								3
Core - Psychiatry (aggregated)	G —	W —	W —	G —	G —	L —	G —	8
Higher - Psychiatry								4
Higher - Psychiatry (aggregated)	W —	W —	W —	W —	W —	W —	W —	13

GMC Trainer Survey

Specialty	Overall Satisfaction	Work Load	Handover	Supportive environment	Curriculum Coverage	Educational Governance	Time for Training	Rota Design	Resources for Trainers	Support for Trainers	Trainer Development	Response rate
Forensic psychiatry												29%

Site: State Hospital, Specialty: Core Psychiatry Training

GMC NTS (Trainee)

Level	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Handover	Induction	Adequate Experience	Supportive environment	Work Load	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave	Reporting Systems	Teamwork	Curriculum Coverage	Educational Governance	Rota Design	N
Core	W -	W -	G -		W -	W -	W ▼	G -	W -		W -	G ▲	W -	W ▼	L -	W -	W ▼	G ▲	3

Balint Group for Junior Doctors – Summary of Feedback.

Description of Intervention

I facilitate a Balint group for junior doctors (trainees and specialty doctors) twice a month. The purpose is to provide a regular, safe and reflective space for doctors to reflect on staff-patient interactions, and to discuss and apply psychodynamic ideas into everyday work. This sort of reflective activity is recognized as being essential for the safe and sustainable running of forensic hospitals (Forensic Matrix Papers on Reflective Practice and Structured Clinical Care, 2018). Applied to the State Hospital, a related aim of the group is to make the State Hospital an attractive and supportive place for trainees and specialty doctors to work in. The group counts for Core and higher Trainees as part of their psychotherapy training requirements.

Background

A previous evaluation of doctors' experience of these groups in July 2016 was very positive. In order to see how the groups are currently perceived, the survey was repeated.

Method

In the last month of the 6 month placement a short questionnaire given to all doctors taking part in the Balint groups for two cohorts:

- Trainees or specialty doctors whose attachment was between August 2017 and January 2018 ('Cohort 1)
- Trainees or specialty doctors whose attachment was between August 2018 and January 2019 ('Cohort 2')

The questionnaire consisted of 7 questions scored on a 5-point Likert scale (1 = 'disagree strongly'; 5 = 'agree strongly') (see table 1). Higher scores indicate more positive responses. There is a final free-text question asking for 'any other comments'

Table 1 – questionnaire used

Disagree strongly	Disagree	Neutral	Agree	Agree strongly
1	2	3	4	5

1. The groups started and ended on time with no unexpected cancellations
2. I found the group to be a non-judgmental setting
3. I had the opportunity to contribute from my own experiences
4. The groups helped my understanding of interactions between patients and staff
5. The groups helped my understanding about the workings of teams and the institution as a whole
6. The groups have helped to process and manage my responses to situations
7. Please give an overall appraisal of the groups (for this question the options range from 1 'very unhelpful' to 5 'very helpful')

The option was given to either return anonymously via the medical secretary, or to return to me directly.

Results

All doctors on placements took part in the Balint sessions. 5 doctors were in Cohort 1 and 5 in Cohort 2. 1 doctor was in both cohorts. 1 doctor in the cohort 2 finished the placement before the questionnaires were given out. Therefore a total of 9 questionnaires were administered.

7 questionnaires were returned out of 9 administered. 4 were returned anonymously and 3 by email directly to me.

All questionnaire items were rated as 'agree strongly' by all 7 respondents, indicating consensus positive responses about the Balint groups. In addition, all respondents indicated they found the group 'very helpful' as an overall appraisal.

Free text comments were given by all respondents (Box 1). These were largely positive, describing the group as helping with understanding situations and processing feelings. One respondent mentioned the timing of the group was not ideal.

Box 1 – free text comments

'I have found the Balint group very useful, working at TSH is different to other settings I have worked for a number of reasons – patient group, offending histories, staff dynamics and politics. Having a confidential space to talk through experiences and better understand situations and dynamics has been extremely helpful!'

'I really value Balint Group, a high secure setting would be a difficult place to work at times if there was no outlet to discuss challenging feelings. Realising that colleagues have shared similar emotions or had similar experiences helps significantly.'

'I feel I didn't get along to as many of the groups as I would have liked due to other commitments/on-calls/leave etc. although I do appreciate that Mondays are the best day to have the group due to most people being in the hospital that day.'

'An excellent Balint group – one of the best I've experienced. Thank you very much.'

'Very helpful! Provides valuable insights. Dr Polnay is an excellent facilitator.'

'I've found it very useful being new to forensics.'

'I enjoyed having a mixture of core trainees and higher trainees. Always felt comfortable to speak openly and raise any issues I had.'

Conclusions

The feedback from the questionnaire suggests that participants in the junior doctors' Balint group continue to find the groups very helpful in terms of supporting understanding of patient-staff interactions they are part of, and in providing opportunities to process emotional responses associated with clinical work.

In terms of limitations, this is a basic questionnaire measure only. Whilst the highly positive score are encouraging, I also note the possibility of responder bias as the doctors knew the questionnaires would be analysed by the group facilitator. In addition, to make it easy for questionnaires to be returned, there was the option to return questionnaires directly to me. Finally, clearly a more in-depth method of assessment (e.g. the Reflective Functioning Scale (Fonagy et. al. 1998) or other paper based methods could add to the robustness of the method. However these would take up considerable time, and the purpose of the current evaluation was by contrast for a simple and achievable way of evaluating routine practice.

In summary, the junior doctor Balint group is well valued by its participants and appears to be helpful. Accordingly I will continue to run Balint groups for Specialty Doctors, and for Core and Higher Trainees as part of their training placements at the State Hospital.

Dr Adam Polnay
January 2019.

Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	19th June 2019	**Level(s)**	Core/Higher
Type of visit	Scheduled	**Hospital**	The State Hospital
Specialty(s)	Mental Health	**Board**	The National Facility

Visit panel	
Amjad Khan	Visit Chair – Lead Dean Director Mental health
Claire Langridge	Associate Postgraduate Dean – Quality
Daniel Bennett	Regional Associate Postgraduate Dean
Les Scott	Lay Representative
Dawn Mann	Quality Improvement Manager
In attendance	
Patriche McGuire	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Mental Health	
Lead Dean/Director	Amjad Khan	
Quality Lead(s)	Claire Langridge and Alastair Campbell	
Quality Improvement Manager(s)	Dawn Mann	
Unit/Site Information		
Non-medical staff in attendance	9	
Trainers in attendance	4	Inc Medical Director and Educational Supervisor
Trainees in attendance	6 (All trainees)	Core/Higher
Feedback session: Managers in attendance	Medical Director, Chief Executive and Educational Supervisor	

Date report approved by Lead Visitor	10th July 2019

1. Principal issues arising from pre-visit review

This is a scheduled visit as part of the Deanery's five-year plan to visit each unit delivering training within the quality cycle. The visit team will take the opportunity to gain a broad picture of how training is carried out within the department and to identify any areas of innovation or good practice for sharing more widely. The visit provides an opportunity for trainees and staff within the unit/department to tell the Deanery what is working well in relation to training; and also, to highlight any challenges or issues, the resolution of which could be supported by the Deanery.

The 2018 NTS data was positive for the State Hospital with the site receiving a letter of good practice from the Mental Health Specialty Quality Management Groups (SQMGs).

2.

2.1 Induction (R1.13)

Trainers: The panel were advised that due to the high security nature of the environment they provide a thorough induction programme for trainees which runs over the first 5 days of their placement. A variety of topics are covered including sessions on security, breakaway training, on call duties, systems training and PANNSS training. There are also sessions run by multi professional colleagues including introductory sessions from pharmacy, learning and development, research and clinical effectiveness. The trainees also get a tour of the site and health centre and an opportunity to attend the hub they will be based at and meet staff based there. We were advised trainees are also provided with a comprehensive induction manual at the start of placement. Trainees are asked for feedback following the induction and improvements are made accordingly.

Trainees: Trainees advised they had received a thorough induction to the site which included a tour and time on the ward. We were told they had faced delays in receiving their IT log ins, they have raised these concerns with the educational supervisor who advised this will be corrected for the next intake of trainees. It was also felt that due to the nature of the site there are a lot of forms to complete but there is some repetition of these and the same form is requested several times.

Non-Medical Staff: It was felt the induction was comprehensive and different areas were involved in delivering sessions at induction including staff from pharmacy, the clinical effectiveness team, nursing and the library.

2.2 Formal Teaching (R1.12, 1.16, 1.20)

Trainers: The panel were advised there is a 6-lecture local teaching programme in place which runs at the start of placement covering a range of topics relating to the functioning of a high security unit and different psychiatric conditions. We were advised attendance at local teaching is good and there is a lot of planning in place to ensure it is run at a time that is suitable for maximum attendance including for the next session a doodle poll. There is also a weekly journal club and case discussion meetings on a Monday which are multi-disciplinary and have internal and external speakers. Trainees have access to additional courses and learning for example the New to Forensic programme. All trainees are supported to attend regional training relevant to their training programme which is bleep free.

Trainees: Trainees confirmed they all had the ability to attend the local six-part lecture programme, weekly journal club and case discussions which they found useful. Trainees advised they have protected time to attend the appropriate regional training.

Non-Medical Staff: The panel were advised all staff attend journal club and it has a good level of attendance from trainees.

2.3 Study Leave (R3.12)

Trainers: The panel were informed there are no issues with trainees accessing study leave.

Trainees: Trainees advised they had no problems gaining study leave.

2.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6)

Trainers: We were advised Dr MacCall is the educational supervisor for all higher trainees and core trainees will have an educational supervisor in their home area. We were informed trainees will be allocated an appropriate clinical supervisor depending on their hub location and placement, normally trainees work with the same two or three consultants and one of these will be their clinical supervisor. Normally the site would be informed by the trainee's home area if there are trainees coming where there are known concerns. All trainers at the site have had RoT training and have time in their job plans for their educational role. There are known issues with systems showing incorrect RoT information for trainers at the site and they would appreciate guidance on how to correct this.

Trainees: Trainees advised they had all met with their local supervisor approximately 3 times a year.

Non-Medical Staff: It was felt trainees always have access to support both during the day and out of hours. We were informed there are various policies and procedures in place to maintain safety and this could lead to trainees being over protected at times.

2.5 Adequate Experience (opportunities) (R1.15, 1.19, 5.9)

Trainers: Trainers advised they are aware of the curricula requirements for trainees and Dr MacCall is currently involved with the changes to the Forensic curriculum. The panel were advised that trainees work with two consultants and are able to attend clinics with these consultants for example prison clinics and community based forensic clinics. Due to the nature of the work trainees would not be running their own clinics and are there for experience only. The trainers felt the trainees get a good range of educational experience and have access to research opportunities and Balint group and as there is a health centre on site trainees are not expected to carry out routine tasks such as bloods and ECGs. We were told there are no known issues with trainees achieving their competencies. Trainees attend psychotherapy long and short cases in their home location and timetables are arranged to facilitate these, it would be beneficial if these were at the start or end of the day due to travel but accommodations are made.

Trainees: Trainees felt they would have no trouble achieving their competencies. Trainees appreciated the opportunity to attend prison-based clinics with consultants. It was raised that there were no opportunities to see emergency cases, but this was not viewed as a problem as these could be met whilst at other placements. It was felt there is a good balance between time spent developing as a doctor and activity with little educational benefit especially as there is a health centre on site.

Non-Medical Staff: Senior nursing staff advised nursing staff were involved in the trainee's induction program and they delivered a session in the teaching program.

2.6 Adequate Experience (assessment) (R1.18, 5.9, 5.10, 5.11)

Trainers: It was felt it is easy for trainees to achieve their assessments within the placement. We were advised that trainers had not formally benchmarked assessments against other trainers however due to the size of the site consultants have discussions regarding assessments and trainees normally get assessed by two different consultants.

Trainees: Trainees felt it was easy to complete their assessments and felt these were fair and consistent.

Non-Medical Staff: The panel were informed nursing staff were asked by trainees to contribute 360-degree feedback and are involved in patient/trainee simulation.

2.7 Adequate Experience (multi-professional learning) (R1.17)

Trainers: The panel were told the trainees have access to modules run by the School of Forensic Mental Health which are open to multi-professional learners. The weekly journal club is open to all staff and there are internal and external multi professional speakers.

Trainees: Trainees felt there were ample opportunities for multi professional learning including Balint group, Journal club and a hub based reflection group.

Non-Medical Staff: It was felt there are numerous opportunities for joint learning among trainees and non-medical staff including journal club, case base discussions, discharge planning, monthly hub based reflective practice sessions and quality initiatives like TSH 3030.

2.8 Adequate Experience (quality improvement) (R1.22)

Trainers: We were informed the site has a very engaged clinical effectiveness department who run a session during induction and encourage trainees to take part in projects and audits. We were given details of the recent TSH 3030 programme that encouraged teams to spend 30 minutes a day for 30 days thinking about quality improvement, this was all staff across the site and trainees were involved. There are also monthly quality improvement clinics.

Trainees: Trainees felt there were lots of opportunities to get involved in quality improvement projects and audit. We were told there is a very engaged and approachable clinical effectiveness team on site who run regular events to encourage staff engagement including quality improvement cafes and a monthly event webinar. We were told the clinical effectiveness team run a session at induction.

2.9 Clinical supervision (day to day) (R1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 2.14, 4.1, 4.6)

Trainers: The panel were advised there is no formal way for staff to differentiate between the different doctors, but details of the trainees will be given to staff at the start of placements. We were told there is a duty rota in place, so trainees are aware of who to contact for support both during the day and out of hours. Most consultants work at other sites as well as The State Hospital, but admin staff have access to their electronic diaries and they are contactable by phone. Trainers were not aware of any instances where trainees had to cope with problems out with their competence. Trainers felt that due to the nature of the site it was a very paternalistic organisation and there could be a risk of the trainees being overly protected. Trainers try to encourage staff to go to trainees and not straight to the consultants. It was also mentioned that the trainers value the trainees 'fresh eyes' and are open to them making change suggestions as it prevents institutionalisation.

Trainees: Trainees advised they always have access to clinical supervision and know who to contact both during the day and out of hours. Trainees advised they have never felt they had to cope with problems out with their experience. It was felt that due to the nature of the site there is a potential for them to not getting enough exposure or responsibility but felt the consultants were conscious of this and ensured they still had access to experience. Trainees felt senior colleagues and non-medical staff at the site were approachable and supportive.

Non-Medical Staff: Non-medical staff advised they are introduced to staff at the beginning of placement and told if they are core or higher trainees. They were not aware of any instances where a trainee had to cope with problems out with their competence level apart from an occasion a trainee was called whilst on call for a medical issue, but this was raised and addresses.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: The panel were informed that due to the small size of the site trainees work closely with the consultants which it was felt allows for regular informal feedback and trainees receive structured feedback at weekly supervision sessions.

Trainees: Trainees advised they receive formal feedback at weekly supervision sessions and due to the small team receive informal feedback on a daily basis. They find the feedback constructive and meaningful.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: We were advised that **t**rainees are encouraged to provide feedback to their clinical supervisor or educational supervisor. The panel were informed there are 3 - monthly training committee meetings which all trainees attend which has a standard agenda item for trainees to provide feedback. We were given a recent example where a trainee had raised whether it would be possible to work from home due to the travel commitments of attending regional training.

Trainees: Trainees felt they have opportunities to provide feedback to trainers on the experience of their training through their clinical and educational supervisors and at 3 - monthly training committee meetings.

2.12 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: Trainers advised core trainees work on the State Hospital rota currently on a 1 in 6 rotation. There have been several occasions recently where there have been rota gaps, but a locum is employed to fill these. The trainers advised it is a relatively quiet rota and trainees are not required to be on site as travel time is worked into calls. Higher trainees are not part of the site rota but occasionally ask to be added for experience and this is accommodated. The panel were told there are no known issues with the rota which impact training or patient safety, rota monitoring has recently taken place and the rota was compliant.

Trainees: Trainees felt the rota was manageable and had no implication on patient safety or their education. It was confirmed the rota is 1 in 6 and it's rare to get called on site after midnight.

Non- Medical Staff: Non-medical staff were not aware of any concerns relating to the rota and thought it was easy to interpret who was on call.

2.13 Handover (R1.14)

Trainers: Trainers advised there is a 24-hour security report in place at the site allowing everyone access to information regarding patients. On a Friday there is a weekend safety report meeting which all levels of staff attend and includes handover information for the weekend. A written report is generated from this meeting which all can access. We were advised there is a Monday morning pathway meeting where the weekend is discussed. It was felt by trainers that there are informal opportunities for learning from handovers.

Trainees: The panel were advised there is no formal day to day handover due to the nature of the work but as there is a small cohort they are confident anything important would be handed over. Trainees confirmed there is a pre-weekend safety meeting which all levels of staff attend to convey information. It was felt there are no formal opportunities for learning from the handovers.

Non-Medical Staff: The panel were informed there is a pre-weekend safety meeting that all staff levels would attend and has an element of handover involved. We were told there are morning MDT meetings on each ward Monday to Friday and nursing staff have an evening handover where the nurse in charge would provide a personal handover to the duty trainee if appropriate. It was not felt that handovers were used as learning opportunities.

2.14 Educational Resources (R1.19)

Trainers: Trainers advised there are ample computers for the trainees to access and a library in the learning centre with an experienced librarian.

Trainees: Trainees advised they have limited internet access at the site due to a combination of security and capability issues, this can prevent them from accessing Royal College information or booking onto courses.

2.15 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12)

Trainers: We were advised there is a 3 - monthly training committee meeting which all trainees attend and are able to feedback any concerns about their experience at The State Hospital. Trainers informed us there are regular consultant and specialty doctor's meetings where patient safety is a standard agenda point, medical advisory meetings with trainee representatives and patient related care would be discussed at Monday morning meetings which are attended by all levels of staff. The educational supervisor advised he would be made aware of any cases where a student is struggling and would link in with local educational supervisors, clinical supervisors and the specialty training committee (STC). We were told that if a trainee were struggling senior staff would link in with the occupational health team if appropriate or the PSU team within the Deanery.

Trainees: The panel were advised some trainees worked less than fulltime and the site had been accommodating regarding this. It was felt support would be available for those struggling with the job in any way and they would have no hesitation in seeking support.

Non-Medical Staff: The panel were advised staff would raise any concerns regarding a trainee with the appropriate consultant or supervisor.

2.16 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1)

Trainers: We were informed the State Hospital as a specialty NHS board have a requirement to produce an annual report which is reviewed by the Board to ensure the quality of training within the site. The report includes information on GMC results from the National Trainee Survey and local feedback garnered from trainees on local teaching etc.

Trainees: Trainees advised they would raise quality concerns through Dr MacCall who would feed into the Board. The panel were advised there are trainee representatives at various meetings where the quality of education at the site was discussed.

2.17 Raising concerns (R1.1, 2.7)

Trainers: The panel were informed trainees are encouraged to raise concerns regarding patient safety either immediately to the nurse in charge or through their clinical supervisor at weekly sessions. If trainees had concerns regarding their education, it was felt these would be raised to the educational supervisor or at the training committee meeting.

Trainees: Trainees advised they would raise concerns regarding patient safety with their supervisor or through Datix. We were informed there is a policy in place where any staff member can call a clinical pause if they have patient safety concerns and the concern will be discussed by all staff in the hub.

Non-Medical Staff: It was felt there are a number of ways for staff to raise patient safety concerns including handovers, staff business meetings, patient safety meetings, whistle blower policy, debriefs and clinical pauses.

2.18 Patient safety (R1.2)

Trainers: Trainers advised that the safety of patients, staff and the public was integral to the function of the State Hospital. We were told there are routine systems in place to ensure the safety of patients including a morning safety briefing which includes clinical and security updates. Trainees are not involved in this briefing however there is a hub meeting attended by trainees following the huddle each morning and relevant info would be shared. Trainees receive a session on health and safety as part of their induction.

Trainees: Trainees advised they would have no concerns if a friend or family member were admitted.

Non-Medical Staff: Staff provided details of the sites safety report which holds details of the last 5 years' worth of adverse incidents including details of the category assigned, review outcomes and learning points. Staff can access this report online.

2.19 Adverse incidents (R1.3)

Trainers: The panel were advised that due to the nature of the site there are numerous systems in place to report adverse incidents including Datix. We were told there is a formal process in place were every Datix is reviewed in a timely manner by a member of the risk team who will identify any immediate learning outcomes and decide if a full review is required. The results of the review will be shared with the team however due to timescales of the review this can sometimes be after trainees have moved on. There would be a briefing immediately after an incident though and trainees would receive feedback on reported issues. All learning outcomes are also reviewed by management and published on the site's website, so all staff can learn from adverse incidents.

Trainees: Trainees advised they would raise adverse incidents through Daitx or a clinical pause. Trainees advised there would be a debrief following the event and depending on the incident a significant event review providing feedback.

Non-Medical Staff: It was confirmed there is a review following every Datix and a quarterly report is discussed at the clinical governance meeting. There will be a debrief following an event which will include relevant trainees and learning points are published for all to view once resolved.

2.20 Duty of candour (R1.4)

Trainers: The panel were informed there has recently been a site wide review of the duty of candour policy and this is published on their website, these will be updated in the induction pack for future trainees. We were told there is a weekly acute candour group which is multidisciplinary and a monthly review meeting to encourage an open and honest culture when things go wrong and the importance of apologising.

Trainees: The panel were advised there had been an occasion where a trainee was involved in a possible duty of candour concern, we were told it was thoroughly discussed among the team and an agreed response circulated when it was decided the issue fell out with the formal scope of the Duty of Candour process.

Non-Medical Staff: It was felt that as all clinical decisions about patients are made at a multi professional level this fosters close working relationships and a team culture. We were told there are site wide surveys carried out including questions on culture and behaviours and it was felt a significant amount of work is undertaken by senior staff to encourage a good environment and culture.

2.21 Culture & undermining (R3.3)

Trainers: It was felt that the small size of the site encourages a positive team culture as all staff were known by name and trainees work closely with consultants and multi-professional staff. We were informed there are

policies in place to prevent bullying and undermining including feedback from imatter surveys, training modules and a non-executive member of the board who can be confidentially contacted by any level of staff to report inappropriate behaviour. Trainers were unaware of any cases of trainees having received comments that were felt to be less than supportive.

Trainees: Trainees reported they had not witnessed undermining or bullying behaviour at any level during their placement. The panel were advised there are bullying and undermining processes in place and felt the senior staff at the site were very supportive.

Non-Medical Staff: Staff were unaware of any incidences of undermining or bullying behaviour and felt there is a positive team culture at the site.

2.22 Other

Trainees raised concerns regarding the cessation of prison clinics by the State Hospital following changes in the service provision back to certain health boards. It was felt that attending prison clinics with consultants was a valuable learning experience and trainees highlighted concerns regarding the implication on experience and workload for future trainees.

Trainees were asked to score their training experience from 0-10, the average score was 8 with a range from 7 to 9.

3. Summary

Is a revisit required?	**Yes**	**No**	**Highly Likely**	**Highly unlikely**

We would like to thank the site for their assistance in organising the visit and good attendance on the day. The panel were left with the impression of a supportive and approachable senior team with a focus on safety and training.

Please find below a list of positive and less positive aspects from the visit:

- Comprehensive induction including the extensive written manual
- Supportive and approachable consultants and senior team
- Strong focus on training for trainees including access to additional forensic courses
- Day to day opportunities for multi professional working and learning and trainee involvement in the MDT reflective hub group meetings
- Shared learning from adverse incidents including access to all incidents over 5 years with learning outcomes
- Emphasis on quality improvement and the visibility of the clinical effectiveness team including trainee involvement in initiatives such as the QI café and TSH 3030
- Focus on patient safety including the ability for any staff member within a hub to request a clinical pause where all staff will discuss the concern.

Less than positive:

- Trainees advised there were delays in accessing IT systems at the start of placement due to no system access.
- The panel recognised the high security nature of the site but there were limitations on internet leading to problems accessing educational sites i.e. Royal college sites and booking onto courses.

- The GMC have suggested the implementation of a colour coded badge system and posters to ensure all staff can identify the level of trainee and are aware of their competencies and supervision requirements.
- Handover could be used as a learning opportunity.
- Due to the nature of the work there could be a risk of trainees being overly protected and not having enough exposure or responsibility. The site seems aware of this concern and we would encourage them to continue this awareness.
- There is a period of change approaching where the prison clinics will cease. This could lead to uncertainty for trainees regarding experience and workload and we would encourage an open dialogue with trainees regarding this change.

4. Areas of Good Practice

Ref	Item	Action
5.1	Day to day opportunities for multi professional working and learning including trainee involvement in the MDT reflective hub group meetings and 9am MDT hub meetings.	
5.2	Focus on patient safety including the ability for any staff member within a hub to request a clinical pause where all staff will discuss the concern.	
5.3	Emphasis on quality improvement and the visibility of the clinical effectiveness team including trainee involvement in initiatives such as the QI café and TSH 3030.	

5. Areas for Improvement

Ref	Item	Action
6.1	Trainees advised there were delays in accessing IT systems at the start of placement due to no system access. We were advised this had been raised and taken on board.	
6.2	Handover could be used as a learning opportunity.	
6.3	Limitations on internet access leading to problems accessing educational sites i.e. Royal college sites and booking onto courses.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	The level of competence of trainees must be evident to those that they come in contact with. The use and promotion of colour coded badges as part of this must be introduced.	9 Months	All

8. DME Action Plan: to be returned to QIM on 15th August 2019

Ref	Issue	By when	Owner	Action(s)
8.1	The level of competence of trainees must be evident to those that they come in contact with. The use and promotion of colour coded badges as part of this must be introduced.	20th April 2019	The State Hospital	

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 10
Sponsoring Director:	Security Director
Author(s):	Security Director
Title of Report:	Annual Report to Scottish Government on the Implementation of Specified Persons Legislation
Purpose of Report:	For Approval

1 SITUATION

The Mental Health (Care & Treatment) (Scotland) Act 2003, Section 286, makes provision for regulations (the regulations) relating to safety & security, use of telephones and correspondence. The Safety & Security Regulations place a duty on The State Hospital to furnish Scottish Government with an annual report on the implementation of the regulations. In the interests of openness and transparency, the annual report to the Scottish Government also includes information on the implementation of the regulations relating to correspondence and telephones.

The draft report for 2018 – 2019 is attached at Appendix 1.

2 BACKGROUND

The regulations are:

- The Mental Health (Safety & Security) (Scotland) Regulations 2005
- The Mental Health (Use of Telephone) (Scotland) Regulations 2005
- The Mental Health (Definition of Specified Persons) (Scotland) Regulations 2005

The regulations allow restrictions to be made relating to “Specified Persons”. The purpose of the specified person designation and related restrictions are to ensure the safety and welfare of the patient and others by allowing the Clinical Team to introduce managed and proportionate controls in defined areas. A system of reviews, reporting and appeals is also in place to safeguard the patient from excessive or disproportionate use of the specified person designation.

The specified person designation relates to:

- Correspondence
- Telephone calls
- Property and visitors
- Searching of patients and their property
- Searching of visitors and their property
- The taking of samples

- Surveillance of patients and visitors

Outside of the State Hospital the specified person designation is applied by the Responsible Medical Officer. The Act states that all patients at The State Hospital are automatically deemed to be Specified Persons due to their detention in The State Hospital.

3 ASSESSMENT

The report attached at appendix 1 is in the same format as previous years. It meets our obligation for an annual report. The data included in the report is regularly reported in more detail to the Board's Clinical governance Committee.

4 RECOMMENDATION

The Board is invited to **approve** the report for submission to the Scottish Government.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Meets obligation for annual report to Scottish Government
Workforce Implications	None
Financial Implications	None
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	SMT
Risk Assessment (Outline any significant risks and associated mitigation)	None
Assessment of Impact on Stakeholder Experience	None
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not applicable
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One □ There are no privacy implications. X There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Appendix 1

Annual Report to the Scottish Government Health Department on the Implementation of:

- **The Mental Health (Safety and Security)(Scotland) Regulations**
- **The Mental Health (Use of Telephones)(Scotland) Regulations 2005**
- **The Mental Health (Definition of Specified Person: Correspondence)(Scotland) Regulations 2005**

by The State Hospitals Board for Scotland for the period 1 August 2018 to 17 July 2018

1 THE HOSPITAL'S CURRENT POLICY ON SAFETY AND SECURITY

The State Hospital has 140 beds and is currently operating with 120. According to the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Act) all patients at The State Hospital are automatically deemed to be Specified Persons due to their detention in The State Hospital.

The State Hospital does not have a single "Safety and Security" Policy. Due to the intrinsic nature of security within a high security hospital, safety and security are a part of all policies and procedures. Areas in which policy exists that implement or are affected by the above regulations include:

- Patient mail and telephones
- Searching Patients
- Restricted and excluded items
- Restrictions on visitors
- Taking of samples
- Surveillance

Detail on these areas is provided below.

2 PATIENTS' MAIL AND TELEPHONES

Mail

The State Hospital Policy allows mail to or from the patient to be inspected and read by staff if individually prescribed by the Clinical Team. Mail can then be withheld from the patient or from being sent if it satisfies criteria related to safety or distress. As at July 2019 the patient numbers in the differing categories and instances of withheld mail were as below:

Incoming Mail Scrutiny	**13-14**	**14-15**	**15-16**	**16-17**	**17-18**	**18-19**
Opened in the presence of staff	39	48	35	31	28	23
Opened then inspected by staff	27	25	22	22	22	21
Opened, then inspected and read by staff	61	50	61	60	57	60

Outgoing Mail Scrutiny	**13-14**	**14-15**	**15-16**	**16-17**	**17-18**	**18-19**
Sealed by patient and handed to staff	25	34	24	22	19	17
Inspected by staff	33	35	27	24	24	22
Inspected and read by staff	69	54	67	67	64	65

Withheld Mail	13-14	14-15	15-16	16-17	17-18	18-19
Being sent by patient	1	2	0	0	0	2
Being sent to patient	1	0	0	3	7	0

Telephones

The State Hospital Policy allows outgoing calls from patients to persons approved by the Clinical Team. Under normal circumstances patients cannot take incoming calls.

Patients are either directly supervised by a member of staff who listens to the patient during the call, or indirectly supervised by a member of staff in the vicinity of the telephone. Technology and a new policy has been introduced which allows staff to hear both sides of the call and will allow recording of calls if deemed appropriate when the required technology has been introduced.

As at July 2019 the patient numbers in the differing categories were as below:

Telephone Call Supervision	13-14	14-15	15-16	16-17	17-18	18-19
All Supervised	53	45	59	57	49	52
All Unsupervised	53	56	34	30	22	20
Some Supervised	21	22	25	26	36	30

Calls to Advocacy, The Mental Welfare Commission, Legal Representatives and other persons listed in the Act are not to be supervised and do not require Clinical Team approval.

3 SEARCHING AND RESTRICTED OR EXCLUDED ITEMS

The State Hospital Policy allows the regular searching of:

- Patients
- Patients' rooms
- Patients' Lockers
- Patients' Visitors

Planned search frequencies are as follows:

Patient	Weekly
Locker	Weekly
Room	Monthly

Patients are also randomly searched when moving between areas, or if leaving an area where risk items are present that have not all been accounted for. An example of this would be when a patient needs to leave the dining room before cutlery has been counted.

In addition to these measures, to which every patient is subject, searches can be individually directed at a patient, his room or his locker based on information or presentation.

Policy also details those items that a patient is allowed in his room or is able to access. Items are excluded or restricted for a number of reasons, particularly the potential to cause harm or communicate with other devices and the internet. There are also overall restrictions on the quantity and volume of items to ensure rooms can be quickly and safely searched.

4 RESTRICTIONS ON VISITORS

The State Hospital Policy restricts patient visitors to those authorised by the patient's Clinical Team and restricts the items that can be brought into the Hospital by visitors. Policy also allows for Restricted Visits, in which 1:1 close supervision of the patient takes place.

The policy relating to Child Protection makes special arrangements to protect children who may visit patients or be present during Leave of Absence. Child contact requires special approval arrangements.

All visitors may be requested to submit to a search following entry through airport style security; all bags and other carried items are X-rayed and then searched if necessary.

5 TAKING OF SAMPLES

The State Hospital Policy allows the taking of oral fluid or urine samples to test for drugs of abuse. The majority of patients opt for an oral fluid test. The frequency of testing is between two weekly and annually as determined by the Clinical Team. The numbers of patients subject to each frequency as July 2019 is as follows:

Sampling Frequency	**13-14**	**14-15**	**15-16**	**16-17**	**17-18**	**18-19**
2 Weekly	21	24	23	29	15	15
1 Monthly	14	12	13	5	14	7
3 Monthly	20	13	18	17	17	16
6 Monthly	29	25	22	19	19	23
Annually	43	49	42	43	42	43

6 SURVEILLANCE

The Hospital operates a CCTV system around the perimeter, grounds and reception building of the Hospital, including areas of reception used by patient visitors.

CCTV is not currently used in clinical areas or to observe patients meeting visitors, though a business case has been approved that includes the introduction of CCTV to clinical areas.

7 POLICY REVIEW

The Hospital's policies and procedures are reviewed on a regular basis and as required.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item: 11
Sponsoring Director:	Director of Nursing and AHPs
Author(s):	Board Secretary
Title of Report:	Patient Safety, Infection Control and Patient Flow Report
Purpose of Report:	For Noting

1 BACKGROUND

This report is presented to the Board to provide an update in relation to patient safety, healthcare associated infection and patient flow.

2 PATIENT SAFETY UPDATE

The last patient safety meeting was held on 6 August 2019. The Patient Safety rolling 12 month report was presented to Clinical Governance Group on 7 August 2019 and will now be an agenda item at the August Clinical Governance Committee.

A brief summary of SPSP activity across the Hospital in the last two months includes:

Improving Observation Practice (IOP) Workstream

- Awareness raising is ongoing within clinical teams
- Ongoing delivery of participatory learning sessions for nursing staff
- National observation policy template issued in June 2019
- GAP analysis completed for policy rewrite
- Short Life Working Group (SLWG) established to deliver policy rewrite by end of September
- Healthcare Improvement Scotland attending SLWG on 29 August
- Collaboration with Lead OT re hard to reach patients
- Case studies completed and shared following specific interventions from IOP lead
- Individual meetings with SCN's ongoing
- IOP now part of multi professional induction.

Communication at Transition

Patient Support Plans continue to be implemented for those on increased levels of observations, and for all new admissions. This is an individually tailored summary that highlights risk factors and interventions, and promotes person centred care. The key/associate worker is responsible for compiling the plan with patient input. This is reviewed and updated with the patient during their key worker 1-1 in advance of the weekly review.

Safer Medicines Management
The electronic PRN (as required medicine) form has been implemented across all wards. This remains subject to weekly checks. Site wide improvements have been observed with the completion of the e-form. This is now well embedded, and continues to be monitored by the Patient Safety Group. Iona 2 &3 have 100% completion of PRN recorded on RiO for the month of July.

Least Restrictive Practice
All Hubs have now had a formal introductory session with Dr Skilling and the Clinical Pause process is now live on RiO. All four Hubs have now held Clinical Pauses. It is anticipated that the process will continue to improve with ongoing PDSA cycles and feedback.

Dr Skilling has also presented Clinical Pause work at the National SPSP MH IOP leads meeting, and at the IHI/BMJ Annual Quality and Safety Forum (poster). Contact has been received from the three medium secure units in Scotland to request information on the Clinical Pause process. Information has also been shared with Broadmoor Hospital in the context of clinical model discussions here.

Leadership and Culture
Five walkrounds have taken place so far in 2019. Areas visited are Human Resources, Lewis 3, Mull 2, Mull 1 and Lewis 1. Actions and owners are discussed monthly at the Chief Executive Business meeting and the Patient Safety group.

Nationally, SPSP MH have launched new safety principles:

- Communication
- Leadership and Culture
- Least Restrictive Practice
- Physical Health
- Enablers

Work is ongoing to align our SPSP existing work with these new principles. For example, the Physical Health gap analysis has been shared with the Physical Health Steering Group to ensure a cohesive approach, and to avoid duplication of effort. The new safety principles, along with the existing policy review following the publication of From Observation to Intervention, are the focus of the group's priorities at the moment.

A presentation on tableau has been re-organised for the next Patient Safety Group to identify how this business management tool could be used to utilise the data collected at ward/hub level.

The Patient Safety group are keen to continue with Quality Improvement projects and maintain links with other groups in the hospital such as PMVA, and the QI Forum. TSH presented the TSH3030 project at two recent national Patient Safety events in Glasgow and Edinburgh and have received requests for further information following this.

3 HEALTHCARE ASSOCIATED INFECTION (HAI)

This is a summary of the Infection Control activity from 1st June – 31st July (unless otherwise stated).

Key Points:

- The submission of the hand hygiene audits continues to be a key priority which is monitored and reported both to this Board, Infection Control Committee and Senior Ward staff routinely. The Senior Nurse for Infection Control (SNIC) will continue to contact individual wards which are non-compliant to allow a late submission.

- The compliance within the Skye Centre continues to be of concern and the Infection Control Committee is working alongside Security and Estates to see if physical improvements to the location of hand gel dispensers can improve compliance.

- DATIX incidents continue to be monitored by the SNIC and Clinical Teams, with no trends or areas identified for concern with the exception of the Safe Management of Linen.

- The antimicrobial prescribing is minimal in comparison to other NHS Boards; however the prescribing that occurs within The State Hospital is being monitored by the antimicrobial pharmacist for compliance with NHS Lanarkshire Antimicrobial Prescribing Formulary. The Infection Control Committee review antimicrobial prescribing quarterly with no trends or areas identified for concern. The biennial audit is due to commence in November 2019. The Senior Nurse for Infection Control is now a member of the Hospitals Medicines Committee & Medication Incident Review Group.

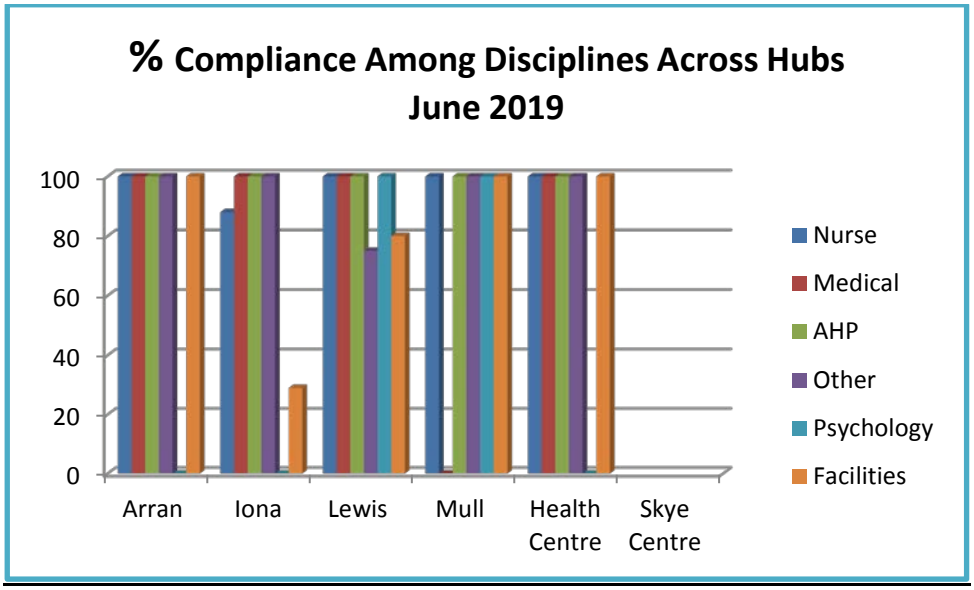
Audit Activity:

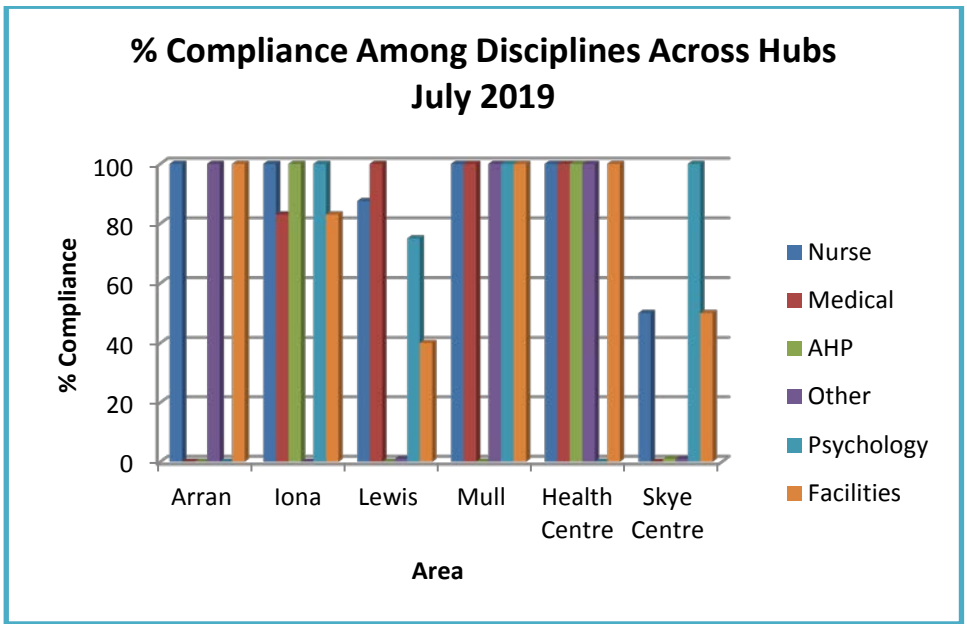
Hand Hygiene
During this review period, there was a drop in the number of audits submitted. Investigation shows that those responsible for undertaking the audits were on annual leave. Reminders to submit and follow up of non-compliance will continue to be carried out by the Senior Nurse for Infection Control.

June
11 out of a possible 12 were submitted

July
10 out of a possible 12 were submitted

The overall hand hygiene compliance within the hubs varies between 80-100%, with psychology continuing to be the discipline with the poorest compliance. The Skye Centre continues to remain low with significant variation 4% and health centre consistently attaining 100%. The Senior Nurse for Infection Control will undertake additional audits during the incoming months. The Charts below demonstrate the compliance among disciplines during the reporting period.





In order to improve the compliance rate within the Skye Centre the location of the Alcohol Based Hand Rub (ABHR) has been moved next to the screens. This seems to be a natural flow for staff exiting the building. The existing ABHR will remain in situ to provide staff with the option of using either dispenser. Skye Centre staff who are on 'door duty' will encourage staff to use the ABHR on entry and exit to the building and ensure that when possible this area is kept clear to aid compliance.

DATIX Incidents for Infection Control

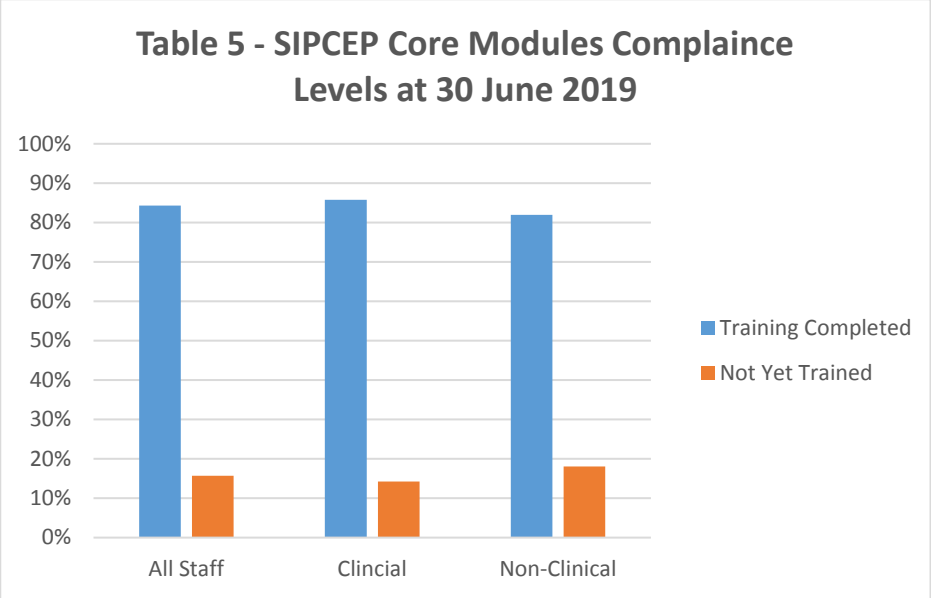
There were a total of 12 incidents for the period under the Category of Infection Control, all of which relate to clinical waste (safe management of linen). Staff are reporting that the laundry tags are falling off in the laundry cage; however this would not account for the misplacing of the red bags in the white hampers. These laundry tags are used by other NHS Boards. This is being investigated by the Senior Nurse for Infection Control, senior ward based nursing staff, and Risk Management.

There were 4 incidents recorded within the secondary category of Infection Control, 3 of which all related to 1 patient. This is being reviewed by the clinical team.

All Infection Control related DATIX incidents are investigated by the Senior Nursing Staff, clinical teams (as required) and reviewed by the Senior Nurse for Infection Control to ascertain if there are learning outcomes identified. In addition the Infection Control Committee is presented with this data quarterly.

Scotland's Infection Prevention and Control Education Pathway (SIPCEP) (previously Cleanliness Champions):

The SIPCEP implementation pathway was approved by the Infection Control Committee in August and by the SMT in September 2017. This has been added to the mandatory modules and is monitored by the Learning Development.



Core Modules	Advocacy	AHP	Arran 1	Arran 2	CE&R	Estates	Finance	F Network	Hotel Ser	House K
Target	6	15	29	29	9	25	8	5	18	58
Completed	5	13	23	22	8	16	8	4	18	52

Core Modules	Hub Adm	HR	I&E	Iona 1	Iona 2	Iona 3	eHealth	L&D	Lewis 1	Lewis 2
Target	20	6	2	29	27	29	12	10	32	33
Completed	15	5	2	25	25	24	9	10	28	30

Core Modules	Lewis 3	Mgt Cent	Medical	Med Rec	Mull 1	Mull 2	Nurse Dir	Nurse Pool	NPD	Ops Mgr
Target	28	13	14	3	27	28	5	10	4	5
Completed	24	10	13	3	25	24	5	7	4	4

Core Modules	OHS	Pharmacy	Procure	Psychology	Security	Skye	Social Work			
Target	4	7	7	24	44	33	10			
Completed	1	7	4	22	39	25	4			

Total	**Clinical**	**Non-Clinincal**
668	**408**	**260**
563	**350**	**213**
105	**58**	**47**
84.3 %	**85.8%**	**81.9 %**

Hepatitis C Treatment

1 patient is currently waiting on a second round of treatment. This has been outstanding for several months and is being progressed by our Finance Director in terms of funding for this treatment.

This will be discussed at the Medicines Committee and fed back to the Infection Control Committee in due course.

Policies and Guidance

All infection control policies and procedures are being reviewed as per policy schedule and there are no outstanding policies.

4 PATIENT ADMISSION / DISCHARGES

A detailed report on admissions and discharges is provided to the Clinical Governance Committee on a 6 monthly basis.

The following table outlines the high level position from 1 June to 31 July 2019.

	MMI	**LD**	**Total**
Bed Complement (as at 31/07/19)	126	14	140
Staffed Beds (ie those actually available) (as at 31/07/19)	108	12	120
Admissions (from 01/06/19 – 31/0/19)	5	0	5
Discharges / Transfers (from 01/06/19 – 31/07/19)	10	0	10
Average Bed Occupancy June - July 2019	-	-	104 86.3% of available beds 74.2% of all beds

5 RECOMMENDATION

The Board is invited to note the content of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To provide the Board with specific updates on patient safety, infection control and patient admission and discharges as well as any other areas specified to be of interest to the Board.
Workforce Implications	As detailed within sections 2 and 3 of report
Financial Implications	No financial implications identified
Route To Board Which groups were involved in contributing to the paper and recommendations.	Nursing and AHP Directorate/ Health Records – Board requested information
Risk Assessment (Outline any significant risks and associated mitigation)	Not identified for this report
Assessment of Impact on Stakeholder Experience	Not identified
Equality Impact Assessment	Not formally assessed
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not identified as relevant
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Board Paper 19/58

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 14
Sponsoring Director:	Interim HR Director
Author(s):	Interim HR Director
Title of Report:	Attendance Management Report
Purpose of Report:	To update the Board on attendance across the site

1 SITUATION

The State Hospital (TSH) sickness absence level in-month figure for May 2019 was 5.34%; with an average rolling 12 month figure of 7.52% for June 2018 to May 2019.

This is the lowest monthly level of absence in TSH in the last 5 years. The Board should note the local target level is 5%..

2 BACKGROUND

Over the last 3years, TSH monthly absence levels have frequently been between 8% and 10%. Consequently absence management and monitoring have been areas of particular focus.

Absence data reported is extracted from both the SWISS, the national source and SSTS local information system to provide this report.

3. ANALYSIS

The March 2019 sickness level of 5.34% is the lowest in-month level recorded by TSH in the last 5 years. However, this does exceed the 5.0% target and the NHS Scotland level of 5.17% for the same period (Appendix IV).

Long/short term absence split is 4.38% and 0.96% respectively. These figures were recently recalibrated and therefore make comparison with historic data irrelevant. (Appendix II).

The in-month absence level equates to a loss of 4,096.28 /25.17 WTE..

The current average rolling 12 month sickness figure is 7.52% for the period 1June 2018 to 31 May 2019. This represents a lower figure than both previous years (2017/18 – 8.5%, 2016/17 - 8.35%). The current national target is to achieve a 0.5% reduction in sickness absence per annum over 3 years.

The main reasons for absence continue to be Anxiety/Stress/ Depression/Other Psychiatric Disorders (36%), Musculoskeletal (13%) and Fractures (11%) (Appendix I).

4. RECOMMENDATION

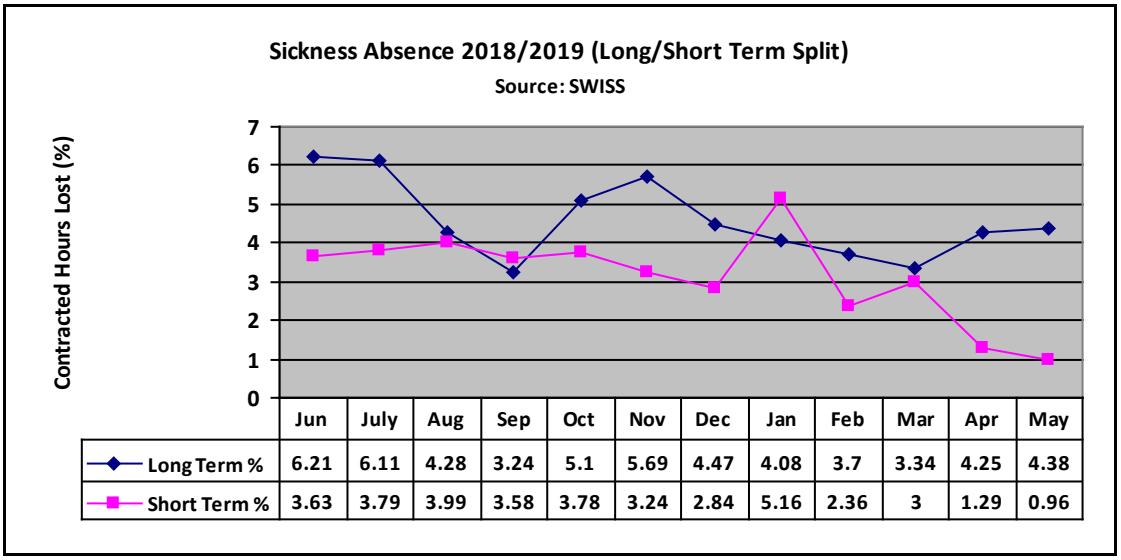
The Board is asked to **note** the content of the report.

Appendix I : Absence Reasons 1st June 2018 to 31st May2019

Absence Reason Description (1 June 2018 to 31 May 2019) Source: SSTS	Short Term Sick %	Long Term Sick %	Total (SL+II) Working Hours Lost	Total % inc Industrial Injury
Anxiety/stress/depression/other psychiatric illnesses	10.38 %	47.08 %	35348.39	36.37 %
Other musculoskeletal problems	6.66 %	8.53 %	12480.20	12.84 %
Injury, fracture	3.53 %	9.34 %	10362.77	10.66 %
Gastro-intestinal problems	19.03 %	3.77 %	6059.58	6.23 %
Back problems	8.53 %	5.25 %	5237.58	5.39 %
Cold, cough, flu - influenza	19.26 %	1.77 %	4730.79	4.87 %
Other known causes - not otherwise classified	4.94 %	4.66 %	4364.80	4.49 %
Genitourinary & gynaecological disorders - exclude pregnancy related disorders	2.24 %	5.39 %	4114.08	4.23 %
Heart, cardiac & circulatory problems	0.97 %	5.02 %	3627.98	3.73 %

Details all absences amounting to greater than 2%. Source: SSTS

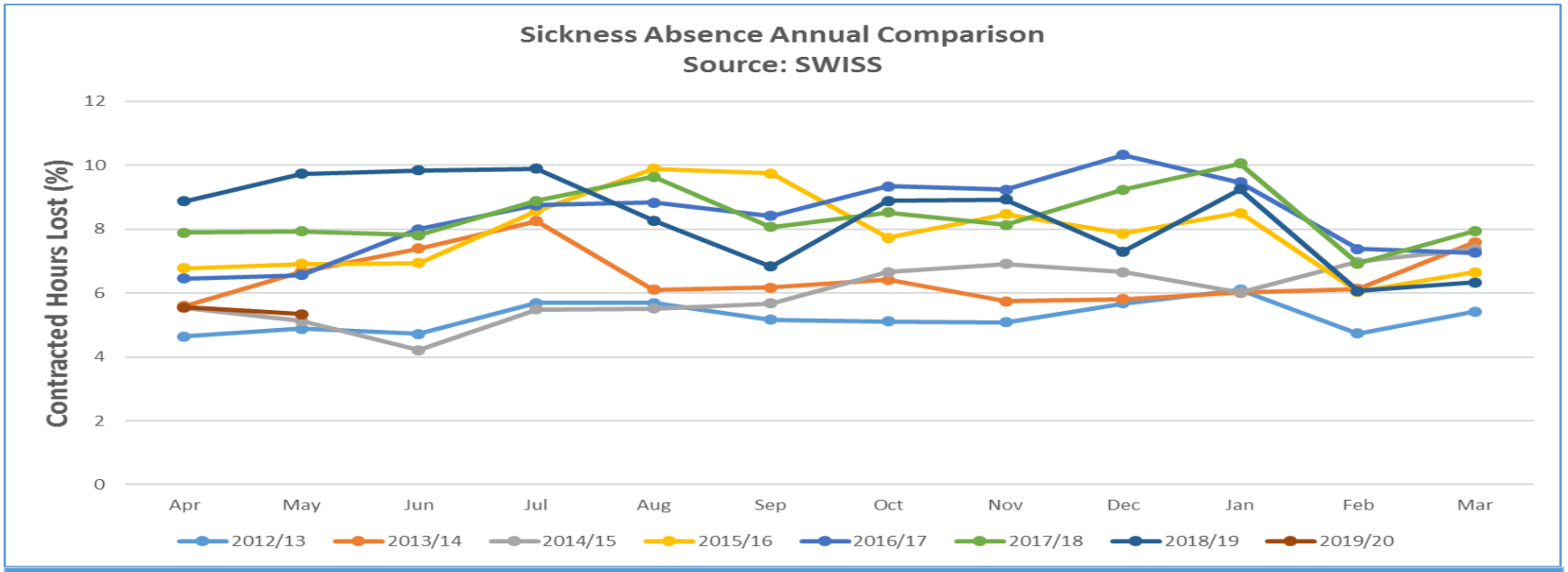
Appendix II : LONG / SHORT TERM ABSENCE BREAKDOWN – NATIONAL DATA (SWISS)



	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Long Term %	6.21	6.11	4.28	3.24	5.1	5.69	4.47	4.08	3.7	3.34	4.25	4.38
Short Term %	3.63	3.79	3.99	3.58	3.78	3.24	2.84	5.16	2.36	3	1.29	0.96

Chart 1 provides a rolling monthly comparison of long and short-term absence from SWISS for the State Hospital only.

Appendix III : YEARLY AND MONTHLY COMPARISON - details the breakdown in percentage of sickness absence for the financial years 2012/13, 2013/14, 2014/15, 2015/16, 2016/17, 2017/18, 2018/19. This data is derived from SWISS.
In the previous 12 months absence peaked during July 2018 at 9.9%.



Year/Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	4.64	4.88	4.72	5.69	5.69	5.17	5.11	5.09	5.67	6.1	4.74	5.42
2013/14	5.6	6.67	7.4	8.26	6.1	6.17	6.42	5.74	5.81	6.01	6.13	7.59
2014/15	5.54	5.13	4.21	5.49	5.52	5.68	6.66	6.91	6.65	6.02	6.98	7.38
2015/16	6.78	6.91	6.94	8.58	9.9	9.75	7.73	8.47	7.87	8.51	6.04	6.66
2016/17	6.46	6.56	8	8.75	8.83	8.42	9.34	9.23	10.32	9.46	7.38	7.26
2017/18	7.89	7.93	7.81	8.89	9.64	8.07	8.53	8.13	9.23	10.06	6.92	7.94
2018/19	8.87	9.73	9.84	9.9	8.27	6.83	8.88	8.93	7.3	9.25	6.06	6.34
2019/20	5.55	5.34										

Appendix IV : National Comparison with NHS Scotland and The State Hospital - May 2019

	Absence Rate			Instances			Absence Reason	
	Total	Long Term [1]	Short Term [2]	Total	Long Term [1]	Short Term [2]	Yes	No [3]
Scotland	**5.17**	**3.45**	**1.72**	**25,274**	**7,813**	**17,461**	**22,018**	**3,256**
NHS Ayrshire & Arran	4.84	3.29	1.55	1,408	460	948	1,274	134
NHS Borders	4.57	2.79	1.79	520	126	394	435	85
NHS National Services Scotland	4.45	2.91	1.54	509	137	372	491	18
NHS 24	7.80	5.21	2.59	424	130	294	365	59
NHS Education For Scotland	1.25	0.67	0.58	69	13	56	58	11
NHS Healthcare Improvement Scotland	3.43	2.37	1.06	53	15	38	47	6
NHS Health Scotland	2.24	1.22	1.02	32	5	27	28	4
Scottish Ambulance Service	8.05	5.98	2.06	840	366	474	800	40
The State Hospital	5.34	4.38	0.96	85	41	44	81	4
National Waiting Times Centre	4.48	2.81	1.67	257	83	174	231	26
NHS Fife	5.54	3.88	1.66	1,273	463	810	1,181	92
NHS Greater Glasgow & Clyde	5.54	3.91	1.63	6,156	2,243	3,913	5,499	657
NHS Highland	5.53	3.54	1.99	1,702	435	1,267	1,152	550
NHS Lanarkshire	5.56	4.09	1.47	1,669	667	1,002	1,433	236
NHS Grampian	4.46	2.56	1.90	2,454	529	1,925	1,958	496
NHS Orkney	5.09	2.78	2.30	107	23	84	101	6
NHS Lothian	4.61	2.64	1.97	4,058	955	3,103	3,586	472
NHS Tayside	5.10	3.51	1.60	1,859	596	1,263	1,645	214
NHS Forth Valley	5.49	3.82	1.67	893	317	576	825	68
NHS Western Isles	5.26	3.09	2.17	195	40	155	174	21
NHS Dumfries & Galloway	4.00	2.38	1.62	623	149	474	569	54
NHS Shetland	3.18	1.77	1.41	88	20	68	85	3

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Links to the Attendance Management Policy and aids monitoring of 5% attendance target set by the Scottish Government
Workforce Implications	Failure to achieve 5% target will impact ability to efficiently resource organisation.
Financial Implications	Failure to achieve 5% target results in additional spend to ensure continued safe staffing levels
Route To BOARD Which groups were involved in contributing to the paper and recommendations.	Partnership Forum / SMT
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	Failure to achieve the 5% target will impact on stakeholder experience
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND *SG(M)19/02*

Minutes of the meeting of the Staff Governance Committee held on Thursday 23 May 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

Present:

Non-Executive Director	Bill Brackenridge ***(Chair)***
Employee Director	Tom Hair
Non-Executive Director	Maire Whitehead

In attendance:

Healthy Working Lives/EASY Manager – Salus	Gillian Archibald [Item 5]
Senior PMVA Trainer/Advisor	Lynn Clark [Item 12]
Board Chair	Terry Currie
Chief Executive	Gary Jenkins
Unison Representative	Anthony McFarlane
Clinical Operations Manager	Brian Paterson
Interim HR Director	Kay Sandilands
Board Secretary	Margaret Smith

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Brackenridge welcomed everyone to the meeting and noted apologies from Mr Nicholas Johnston and Ms Monica Merson.

NOTED

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted in respect of the business to be discussed.

NOTED

3 MINUTES OF THE PREVIOUS MEETING HELD ON 17 AUGUST 2017

The Committee approved the Minutes of the previous meeting held on 7 February 2019 as an accurate record.

APPROVED

4 ACTION POINTS AND MATTERS ARISING FROM THE PREVIOUS MEETING

Members noted that each item either had been completed or was on the agenda for today's meeting.

NOTED

5 SALUS – EASY ANNUAL REPORT 2018/19

A report was submitted to the Committee for the EASY (Early Support for You) Service for 2018/19. Ms Gillian Archibald was in attendance to lead Members through the detail of the report.

The report demonstrated a high compliance rate for EASY, within The State Hospital (TSH). Absence trends demonstrated a high level of sickness absence for mental health issues, as well as injury/ fracture; and Ms Archibald suggested that the organisation may wish to focus further on these areas. She highlighted the case management service, especially in the context of mental health related absence, which had a low uptake rate within TSH, and how the service could be promoted with the aim of it being better used to support staff. Ms Archibald also suggested that the organisation may wish to seek further input for staff exceeding six months absence to consider appropriate supports going forward.

Members asked for further advice around the case management service, and Ms Archibald suggested that this could be taken forward through training sessions with line managers in order to raise awareness of the service. She also suggested that a case study from someone who had use the service and found it beneficial could be an effective way to promote it. This could be someone from either within TSH or outwith the organisation. Mr Jenkins advised that work was ongoing within Psychological Therapy Services (PTS) for further staff support, and this could be overlaid with this approach through Occupational Health. The Committee also asked about how training was delivered to line managers, especially in areas which could be difficult, such as support for women experiencing the menopause. Ms Sandilands suggested that HR could explore any areas line managers find challenging as part of the training sessions being delivered to line managers over July and August.

Action - Ms Sandilands

Ms Archibald noted that EASY provided additional data for the organisation over time, about reasons for absence. This could be especially helpful in TSH as a unique environment, allowing better benchmarking.

The Committee requested that absence rates for colds, coughs and flu, especially over long term absence, as well as gastrointestinal complaints. Ms Sandilands confirmed that this would be investigated further within HR.

Action – Ms Sandilands

The Committee thanked Ms Archibald for her attendance, and noted the content of the report.

NOTED

6 ATTENDANCE MANAGEMENT REPORT

The Committee received the Attendance Management Report for March 2019 and Ms Sandilands was in attendance to summarise the key issues. The absence rate was 6.34%, which represented a continued fall in the overall rate of absence.

Ms Sandilands advised that compliance with EASY had dropped slightly, and that it would be an area of focus to identify any hot spots for non-compliance across TSH.

The Committee noted the content of the report.

NOTED

7 ATTENDANCE MANAGEMENT IMPROVEMENT WORKING GROUP

Mr Jenkins provided the Committee with an update on the work of the task group which had met earlier in the week. He noted the work carried out by the group over time, and the effect this had on attendance management figures.

The aim was now to look further into the causes of sickness absence and the effect sickness absence could have on the organisation. The focus was on ensuring that TSH was an empowering and welcoming place to work, taking this wider focus on the culture, values and behaviours within TSH.

Mr Paterson advised Members that work was being taken forward to chart the impact of sickness absence to overtime across time, although staffing was influenced by a number of factors including clinical activity. Ms Sandilands added that further work would be progressed in this regards on the analytics around vacancies and recruitment.

The Committee noted the content of this report.

NOTED

8 HR PERFORMANCE – EMPLOYEE RELATIONS ACTIVITY

The Committee received a report, which provided an update on employee relations activity up to and including 30 April 2019. Ms Sandilands provided Members with a summary of the key data from the report.

Members noted national policy guidance was awaited, which also require local knowledge and skill in terms of implementation.

The Committee noted the content of the report.

Action – Ms Sandilands

NOTED

9 PERSONAL DEVELOPMENT PLAN REPORT

A paper was submitted to the Committee to provide a progress update in relation to personal development planning and review of staff governance standards and associated compliance.

The Committee was content to note progress made in this area.

NOTED

10 FITNESS TO PRACTICE

The Committee received a paper, which outlined the process for monitoring professional registration status at TSH, with the assurance that all members of staff held current professional registration.

The Committee noted the content of the report.

NOTED

11 VALUES AND BEHAVIOURS REPORT MARCH 2019

The Committee received a report from the Interim Human Resources Director as an update on the work of The Values and Behaviours Group in embedding the values of NHs Scotland into TSH. Ms Sandilands led Members through the report, underlining that it was helpful to take this review in the context of the Sturrock Report into NHS Highland.

Mr Currie agreed that this was a timely report, and should be considered alongside the self-assessment undertaken by the Board through the Corporate Governance Blueprint, which had highlighted the impact of culture and values and behaviours within the organisation.

The Committee asked for there to be particular focus on the visibility of Directors across the hospital. It was agreed that it was important that the engagement was meaningful for staff groups. Mr Currie added his agreement to this, and also emphasised the role that Non-Executive Directors could play through their presence at key events in TSH. There was discussion around how to put this into effect, on a practical level and Mr Jenkins advised that this would be taken forward through Organisational Development.

Action – Ms Sandilands

The committee noted that this meeting would include a fuller discussion of the recommendations in the Sturrock Report [Item 21]. Mr Jenkins suggested using the report as a baseline to help to lead change. This was a good opportunity to effect change especially on a single site hospital, and this would be taken forward through engagement with the workforce.

NOTED

12 STATUTORY AND MANDATORY TRAINING COMPLIANCE

The Committee received an update report on organisational compliance levels for statutory and mandatory training as at 31 March 2019. Ms Lynn Clark was in attendance to provide a summary of the key points. She highlighted the changes coming into effect at a national level this year as part of the Once for Scotland approach. It has been proposed that in future pay progression would be contingent of completion of statutory and mandatory training. The Committee considered this a positive change, but also noted that staff needed to be appropriately supported to undertake the training. Ms Clark advised that in TSH, the Learning Centre could be accessed at any time, to help staff to get access to online training.

Members asked for assurance on actions taken on non-compliance of mandatory training by line managers, and Ms Clark confirmed that a targeted approach was taken to this. Ms Sandilands added that line managers receive a monthly report on compliance levels for their teams.

Ms Sandilands advised the Committee that TSH had a wider framework of mandatory training than some other Boards, and it was agreed that a benchmarking exercise should be undertaken in this regard and a report brought back to this Committee

Members also asked for further assurance on non-compliance of core statutory training modules, e.g. manual handling, and asked that this was reviewed within the training department.

Actions – Ms Sandilands

The Committee noted the content of the report.

NOTED

13 IMATTER UPDATE – MARCH 2019

The Committee received a report on the 2018 cycle of iMatter for TSH, and Ms Sandilands provided a summary of the report for Members.

Members noted that there had been a drop in the completion of action plans**,** and the need to re energise the process for this year's cycle. Members asked the Organisational Lead to review what actions were taken by other NHS Boards with a view to improving the completion of Action Plans.

The Committee noted the report.

NOTED

14 STAFF GOVERNANCE ANNUAL MONITORING TEMPLATE

A report was received, requesting that the Committee approve the submission of the completed Staff Governance Monitoring template for 2018/19.

The Committee approved this, subject to minor amendment as well as noting the need to cross reference to the Corporate Governance Blueprint and to the Sturrock report.

APPROVED

15 EQUALITY DIVERSITY AND HUMAN RIGHTS ANNUAL MONITORING REPORT

A report was received, which completed a review of the hospital's equality data across the workforce profile, recruitment as well as employee relations and was presented to meet the Board's legal obligation to do so as part of the Equality Act 2010.

Ms Sandilands provided a summary of the report, and Mr Jenkins underlined that further focus would be brought to youth employment within the organisation in the coming year.

The committee noted the report.

NOTED

16 HEALTHY WORKING LIVES (HWL) STRATEGY – MAY 2019

A report was received to update the Committee on the HWL strategy and action plan for 2019/2022. TSH had achieved and continued to maintain the HWL Gold Award.

The Committee approved the Strategy Plan.

APPROVED

17 STAFF GOVERNANCE COMMITTEE – ANNUAL REPORT 2018/19

Members noted and approved the Committee's Annual Report for the year ended 31 March 2019, including the Terms of Reference.

APPROVED

18 NHS CIRCULARS

The Committee received a report, which summarised NHS Circulars PCS (AFC) 2019/02, 2019/03 and 2019/04 on attendance management, Appraisal and Incremental progression and Use of Time Off in Lieu.

It was noted that these had been discussed through the Partnership Forum and accepted.

The Committee noted this update report.

NOTED

19 HEALTH, SAFETY AND WELFARE COMMITTEE, DRAFT MINUTES - 15 JANUARY 2019

Members received and noted the draft minutes of the Health, Safety and Welfare Committee, which had taken place on 15 January 2019.

NOTED

20 PARTNERSHIP FORUM – MINUTES OF MEETINGS HELD 19 MARCH 2019

Members received and noted the minutes from the meeting held on 19 March 2019.

NOTED

21 ANY OTHER BUSINESS

Mr Jenkins introduced a discussion on the Sturrock Review into Cultural Issues related to allegations of Bullying and Harassment in NHS Highland, describing this as an opportunity to take a significant pause within the organisation. He advised that the Cabinet Secretary for Health and Sport had written to all NHS Boards requesting that they consider the report's recommendations and provide a response by 28 June 2019.

Mr Jenkins emphasised the need to engage as widely as possible throughout the organisation, as a conversation through the governance structure seeking different perspectives and the Staff Governance Committee was invited to provide their own views. Mr Hair, as Employee Director, would act as a focal point for feedback. Mr Jenkins added that this should be a bottom up approach led through engagement with and feedback from staff.

Mr Hair noted that he was also taking this conversation to union colleagues and this would also be valuable feedback.

Members discussed the difficulty of defining what bullying was, and how to remedy it. The focus should be on building up a culture of openness and conversation. Mr McFarlane added that day to day contact with the leadership team from the hospital could be very influential on the culture of the organisation as a whole. Mr McFarlane went on to say that it was important to understand that staff could adopt the culture they were employed into – and may not even realise that it was of a bullying nature if behaviours were accepted as the norm.

Members agreed and there was consideration of how to initiate and sustain direct links from the leadership of the hospital to wider staff groups. Leadership Walkrounds were noted to be useful in this regard, especially for Non-Executive Directors. Mr Hair also underlined his commitment to engaging with staff across the site, in his role as Employee Director.

This engagement would take place firstly with employees, with further consideration as to involving carers as well as patients.

This would also be added to the agenda of the next Board Meeting to take place on 20 June 2019, to support the Board's response to the Cabinet Secretary on 28 June 2019.

Action – Mr Jenkins/ Mr Hair

NOTED

22 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 29 August 2019 at 9.45am in the boardroom, The State Hospital, Carstairs.

THE STATE HOSPITAL BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 16
Sponsoring Director:	Director of Finance and Performance Management
Author(s):	Head of Management Accounts
Title of Report:	Financial Position as at 31 July 2019
Purpose of Report:	Update on current financial position

1 SITUATION

1.1 The Senior Team and the Board consider the Revenue and Capital plans, and financial monitoring. This report provides information on the financial performance to 31 July 2019, which is also included in the Partnership Forum agenda, the Board agenda and sent monthly to Scottish Government, with the financial template.

1.2 Scottish Government are provided with an annual Operational Plan (narrative plan – with a financial template forecast submitted for a 3-year period) which was confirmed at the 20 June 2019 Board meeting.

1.3 This Plan sets out a balanced budget for 2019/20 based on achieving £2.103m efficiency savings, as referred to in the tables in section 4. There is however a significant savings gap.
Confirmation by email was given from SG to capitalise the perimeter fence project facilitation / support staff, which is in the process of being confirmed and will help relieve the unidentified savings, since it is being funded from revenue just now (offset with increasing the savings gap). We have also currently assumed the reversal of the £0.127m tranche 2 saving for the territorial boards, which then reduced the unidentified savings. Employer's Sup'n is now adjusted in our Allocation, with a benefit of £0.060m taken to reserves, which should help some of the pressures noted in Table 2.2.

2 BACKGROUND

2.1 Revenue Resource Limit Outturn

The annual budget of £37.248m is primarily the draft Scottish Government Revenue Resource Limit / allocation, and anticipated monies.

The Board is reporting an under spend position of £0.047m to 31 July 2019, the table below shows analysis by expenditure type.

July 2019 movement £0.038m underspend. Nursing overtime is down again this month, although still overspent to date. Utilities is under spent in month.

Spend Type	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 4	Budget WTE	Actual WTE (volume)
Other Operating Income	(582)	(194)	(210)	16	(2.00)	(2.00)
Pay	31,514	10,179	10,163	16	621.32	623.21
Savings	(1,629)	(76)	0	(76)	0.20	0.00
Purchase Of Healthcare	797	250	241	8	0.05	0.00
Non Pay	4,894	1,609	1,525	84	0.00	0.00
Hch Income	(603)	(264)	(255)	(9)	(9.07)	(9.22)
Capital Charges	2,857	952	945	8	0.00	0.00
	37,248	**12,456**	**12,409**	**47**	**610.50**	**611.99**

2.2 The table below highlights areas of key pressures / expected benefits to be received.

PRESSURES	Risk	Best estimate £'k
Holiday Pay (& possible retrospection) - Locke v British Gas	High	130
Rebandings arrears	High	tbc
Clinical Model Review	High	tbc
Legal Fees	High	80
EU Exit (may get guidance from sub group)	Low	tbc
Perimeter Fence - FBC - Additional Staff (Capital pending)	Low	193
3 yr up for opt out sup'an Nov 19 (approx 100 staff not sup'an)	Med	
BENEFITS	**Risk**	
Exceptional Circumstance Patients (new - recharging host Board)	Low	290
VAT element on Utilities in our favour (v HMRC)	Low	120

2.3 **Forecast Outturn**

The forecast outturn trajectory was an over spend of £0.150m, however the position is £0.047m underspent, therefore a favourable movement of £0.197m.
Unidentified savings are phased to month 12; therefore, there is the requirement to recognise an apportionment for the year to date.

HMRC has settled in our favour to reduce VAT on utilities to 5% from 20%, this windfall will benefit TSH in 2019/20 – for which the Electricity should be concluded July (there has been a delay due to VAT recognition on the invoices and credit notes), and we are awaiting detail re Oil and Gas.

We have been informed that arrears for one year will be funded from SG for the Locke v British Gas, but we will have to fund from 1st April 2018, we have a reserve set aside for 2019/2020 but unsure if until we have enough for both years until clarity on the payments.

A year-end breakeven position was forecast in the Operational Plan, pending outcomes on a number of pressures (most significant noted in the above table at 2.2).

3 ASSESSMENT

3.1 YEAR TO DATE POSITION – BOARD FUNCTIONS

Directorates	Annual Budget 19/20 £'k	YTD Budget July 19 £'k	YTD Actuals July 19 £'k	YTD Variance (budget - actual) (adverse) / favourable July 19 £'k	Budget wte	Actual WTE
Cap Charges	2,857	952	945	8	0.00	0.00
Central Reserves	109	59	16	43	0.00	0.00
Chief Exec	1,849	614	606	9	22.45	21.73
Finance	2,844	985	992	(8)	37.53	34.72
Human Resources Directorate	825	275	278	(3)	13.38	13.38
Medical	3,763	1,193	1,149	44	35.18	32.34
Misc Income	(294)	(98)	(15)	(83)	0.00	0.00
Nursing And Ahp's	19,397	6,466	6,455	10	378.53	377.66
Security And Facilities	5,898	2,010	1,982	28	123.63	118.56
Under / (over) spend	**37,248**	**12,456**	**12,409**	**47**	**610.70**	**598.39**

Key Highlights

Central Reserves – Charges are for non-AFC pay awards pending.
Finance – legal fees pressure, invoices exceptionally high to date for this year (pressure re specific cases).
HR – Occupational Health – pressure from backdated invoicing for 18/19.
Medical – Pressure in invoices from other Boards for Senior Trainee Doctors. **Psychology** – continuing vacancies (due to continued closure of two wards).
Miscellaneous Income – targeted saving for VAT benefit on Utilities, not yet realised.

3.2 Further detail on Nursing & AHP's

Nursing & AHP's	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 4	Budget WTE	Actual WTE
Advocacy	147	49	49	0	0.00	0.00
AHP's & Dietetics & SLA'S	645	215	208	7	12.83	12.36
Hub & Cluster Admin & Clinical Operations	809	270	262	7	23.17	20.93
PCI & Pastoral	219	73	60	13	3.40	2.40
NPD & Infection Control & Clin Gov	429	143	127	16	5.80	4.99
Skye Centre	1,720	573	487	86	38.33	33.80
Ward Nursing	15,427	5,142	5,262	(120)	295.00	303.18
Total Nursing and AHP's	**19,397**	**6,466**	**6,455**	**10**	**378.53**	**377.66**

Key Highlights

Skye Centre – has a considerable number of vacancies.
Ward Nursing – Further detail in table below.

Ward Nursing	2019/2020						
Ledger Nursing	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) £'k	Budget WTE	Actual WTE	Contracted/ conditioned wte's
Total April 19		1,286	1,350	(65)	295.00	318.77	289.30
Total May 19		1,286	1,343	(58)	295.00	315.33	289.30
Total June 19		1,286	1,282	3	295.00	309.54	286.30
Total July 19		1,286	1,286	(1)	295.00	303.18	288.28
Cum July 19	15,427	5,142	5,262	(120)			
				(120)			
Variance analysis:							
Overtime for vacancies backfill				(123)			
Phased savings (not yet realised)				(50)			
Requiring further investigation by Nursing Resource				54	*		
				(120)			

3.3 **Further detail on Security and Facilities**

Security & Facilities	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 4	Budget WTE	Actual WTE
Facilities	4,234	1,431	1,386	45	83.86	76.29
Security	1,627	542	560	(17)	39.77	38.87
Perimeter Security	37	37	37	(0)	0.00	3.40
Total Security & Facilities	5,898	2,010	1,982	28	123.63	118.56

Key Highlights

Facilities – Estates: Repairs spend, held back March 19, funded this year, also vacancies. Housekeeping: under spend re ward closures.

Security – Backfill pressure and acting post.

Perimeter Fence - revenue staff have been 'funded' by increasing the unidentified savings gap, pending capital funding.

4 Savings

The target column of the table is an extract from the Operational Plan, further information shows savings achieved to date and remaining balance to be achieved by the year-end.

Savings Annual Target LDP	Savings Annual Target LDP 2019-20 Rec £'k	Non-Rec £'k	Total £'k	Savings (Achieved) YTD, as at July 19 2019-20 Rec £'k	Non-Rec £'k	Total £'k	Savings still to be achieved by year end 2019-20 Rec £'k	Non-Rec £'k	Total £'k
Efficiency & Productivity Workstreams:									
Service redesign (Clinical)	(22)	(95)	(116)	0	25	25	(22)	(70)	(91)
Drugs & Prescribing	0	(20)	(20)	0	11	11	0	(9)	(9)
Workforce	(57)	(481)	(538)	15	256	271	(42)	(225)	(267)
Procurement	0	0	0	0	0	0	0	0	0
Infrastructure *(e.g.facilities mgt, IT, other support services)*	(56)	(309)	(365)	0	15	15	(56)	(294)	(350)
Other	0	(100)	(100)	0	0	0	0	(100)	(100)
Financial Management / Corporate Initiatives	0	0	0	0	0	0	0	0	0
Unidentified Savings	0	(965)	(965)	0	152	152	0	(813)	(813)
Total In-Year Efficiency Savings	**(134)**	**(1,969)**	**(2,103)**	**15**	**459**	**474**	**(119)**	**(1,510)**	**(1,629)**
Trajectory (1/12ths of LDP)				**45**	**656**	**701**			
(under) / over achieved				**(30)**	**(197)**	**(227)**			

The following table, by Directorate, provides further clarification on savings.

As at July 2019	Savings - Annual Target	Achieved to date	(Still to be achieved) / over achieved
Directorate	**£'k**	**£'k**	**£'k**
Chief Executive	(162)	75	(87)
Finance	(99)	18	(81)
Nursing & AHP's	(261)	106	(155)
Human Resources	(33)	10	(23)
Medical	(117)	63	(54)
Security & Facilities	(367)	50	(317)
Unidentified (may offset contingency reserve if not required)	(100)	0	(100)
Unidentified	(965)	152	(813)
Total	**(2,103)**	**474**	**(1,629)**

Targeted saving 33%, actual saving 22%, underachieved 11%.

5 CAPITAL RESOURCE LIMIT

Capital allocation from Scottish Government is £0.269m.

Plans greater than resources need to be prioritised to bring projected expenditure back in line with the allocation.

	Annual Plan £'k	YTD Plan £'k	YTD Actual £'k	YTD Variance £'k
Estates	114	30	30	-
IM&T	105	75	75	-
Vehicles	50	-	-	-
Other equipment	-	-	-	-
Security Fence Dvpt	-	15	15	-
TOTAL	**269**	**120**	**120**	**-**

6 RECOMMENDATION

6.1 **Revenue: Under spend of £0.047m year to date. Year-end projection: Breakeven.**

Overtime in Nursing is still higher than budget year to date, however in comparison to previous years there is much improvement, and with many measures in place it is hoped to stabilise over the remaining months.

Quarterly Financial Review meetings, over and above the monthly Management Accounts meetings, help eliminate any surprises in the accounts and aids forecasting the year-end outturn.

6.2 The Board is asked to note the content of this report.

Capital: Breakeven year to date. Year-end projection: Breakeven

The Board is asked to note the content of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of Financial Position

Workforce Implications	No workforce implications – for information only
Financial Implications	No workforce implications – for information only
Route to SG/Board/SMT/Partnership Forum Which groups were involved in contributing to the paper and recommendations.	Head of Management Accounts
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed. □ There are privacy implications, full DPIA included.

Board Paper 19/60

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 17a
Sponsoring Director:	Director of Finance and Performance
Author(s):	Head of Corporate Planning and Business Support
Title of Report:	Update on Strategic Review of Performance
Purpose of Report:	Update Board on progress

1 SITUATION

The State Hospital has developed an Annual Operating Plan 2019 – 20, this plan replaces the previous Local Delivery Plan. The State Hospital's performance targets are aligned with the three quality ambitions in the national NHS Scotland Healthcare Quality Strategy; person centred, safe and effective. There is a need to review the current performance management framework to ensure that we are using the performance management cycle to support continuous improvement and have performance measures in place that provide effective monitoring towards achieving organisational outcomes.

2 BACKGROUND

The State Hospital has reported on a range of targets and key performance indicators, which have been nationally or locally set. Whilst there remains the requirement to report on and measure specific national targets, some the NHS Scotland's targets do not fit into the unique care environment provided by The State Hospital. There is an opportunity for hospital to strategically review its performance management framework and report data to assure the Board that it is measuring and reporting on the key priorities for the organisation. The Risk, Finance and Performance Group requested that a task group be established to progress a strategic review of performance management. This group met in November 2018, January 2019, March 2019 and again in May 2019.

3 ASSESSMENT

A performance framework and the associated measures demonstrate the progress towards delivering our strategy for improving the quality of patient care and organisational effectiveness. Performance measures are not an end in themselves but are a proxy measure for a wider system change. Data and measurement are key aspects of performance management and staff should be engaged in all aspects of performance management and measurement to encourage ownership of the data and outcomes.

To inform the strategic review of performance management a performance measurement scoping activity was carried out by the Task Group to review current position and future ambition for a performance management framework. From this scoping exercise the group noted:

What do we want for the future in terms of a performance monitoring framework?

- Clear escalation route for data for KPI's.
- Clarity on the scope and prioritisation of KPI's.
- Operational definition of KPI's so that we have clarity on what they are and their associated data sources.
- Clarity of governance and how the data collected for KPI's links to strategic objectives and operational priorities.
- Clarity of who are the KPI owners and what authority and responsibility they have for progressing measures

Key points for any new performance management system

- Communication is central to engaging people across the site and providing clarity on what we are doing
- Need to make the performance framework tangible for people so that can see how they link into it and what their role is
- Need to have a tone of improvement through performance – not punitive approach to targets and indicators, which can be perceived as blaming people if progress not made.
- Ownership of KPI and links form these to strategic objectives and operational priorities
- Clear explanation of why we measure what we do and clear operational definitions of our targets and measures
- Links between data collection and changes to practice as a result of what this tells us.

The Performance Management Task Group used the Strategic Objectives within the Strategy Map (appendix 1) as a structure to develop logic models for key organisaitonal priorities. The draft logic models identify the range of work ongoing and the data collected within the hospital that can act as measures or indicators of performance and will support the identification of key performance indicators. Further development of the models and detailing of indicators is required to ensure there is clarity on the operational definition of each indicator.

The Performance Management Group also identified the importance of the interface between its work and that of the 3 key Tableau Working Groups. There is cross over with each of the Tableau working groups to ensure active links between these two work streams. The linked logic models and tableau groups are noted below.

Performance Management Group Logic Model	Tableau Working Group
LM1: Staff attendance and Resilience	Patient Acuity and Dependency grp
LM2: Physical Health	Physical Health and Activity grp
LM4: Staff right place at the right time	Workforce Utilisation grp

Logic Model 3: Embedding a culture of continuous quality improvement and quality assurance to deliver excellent care; will be directly linked into the hospital Quality Improvement Forum.

There is a need to ensure benchmarking of our performance framework against similar organisations to ensure that we learn from examples of good practice that already exist. A balanced scorecard approach is regularly used across NHS Scotland and this is being explored as a potential structure for The State Hospital to adopt.

Next steps

- Develop a structure for the performance framework that represents a balanced scorecard approach to performance monitoring and reporting

- Benchmarking the range of KPIs, and associated measures identified with similar processes conducted within NHS Scotland and the English High Secure Counterparts

- Continue to link the work of the Performance Management Group with the work ongoing within each of the 3 Tableau working groups given their direct alignment to the areas of performance addressed within three of the PM group Logic Models. It is crucial that the two work streams are linked to prevent duplication of work, but also to ensure that the expertise available to each group are supportive of both work streams.

- Developing a matrix to collate the wide range of data measures available for each performance indicator. The range of measures then need to be distilled down through an appraisal process to define the most appropriate measure for each KPI. The focus should be on the best indicator and not data availability with issues of availability and consistency addressed as a secondary stage.

- Consultation with clinical groups and other relevant data owners to ensure the KPIs identified are considered appropriate measures of performance across all areas of the organisation. The Performance Management Group membership is aimed at ensuring multi-disciplinary representation.

- Consideration given to stratifying the data being utilised and presented across the hospital to ensure that the right groups have the rights data to support their function e.g. governance, organisational planning and performance, service planning, performance monitoring and evaluation, patient care level of decision making.

4 RECOMMENDATION

The Board is invited to note the progress made by the Performance Management Group on the Strategic Review of Performance Management, provide ongoing support and advise on the development of the performance framework

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The Strategic Review of Performance will link directly to organisational strategy and corporate objectives.
Workforce Implications	No financial implications if approved
Financial Implications	No financial implications if approved
Route To Board Which groups were involved in contributing to the paper and recommendations.	Risk Finance and Performance Group
Risk Assessment (Outline any significant risks and associated mitigation)	No risk assessment required at present
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed. □ There are privacy implications, full DPIA included.

Appendix 1

The State Hospital Strategy Map 2018 – 2020

NHS Scotland aims to:

Provide high quality health care | Have financial sustainability | Improve population health

The State Hospital mission:

To excel in the provision of high quality, safe and secure forensic mental health treatment and care and to strive to be an exemplar employer

The State Hospital values are at the heart of what we do:

Care and compassion | Dignity and respect | Openness, honesty and accountability | Quality and teamwork

The State Hospital Strategic objectives:

Safety | Security | Effective care and treatment | Quality Improvement | Person centred

Key outcomes, by 2020 The State Hospital will have:

- reduced staff absence levels to 5% and increased workforce resilience
- reduced the proportion of patients with a BMI in the overweight and obese category and increased access to physical activity

- embedded a culture of continuous quality improvement and assurance to deliver excellent care
- ensured that the right staff are in the right place at the right time

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 17b
Sponsoring Director:	Finance and Performance Management Director
Author:	Head of Corporate Planning and Business Support
Title of Report:	Performance Report Q1 2019/2020
Purpose of Report:	To provide KPI data and information on performance management activities.

1 SITUATION

This report presents a high-level summary of organisational performance for Q1 April - June 2019. A summary table and run charts for the performance indicators may be found in Appendix 1. We have added Q4 red, amber, green data to this table to give some trend data.

The only national LDP standards directly relevant to the State Hospital are as follows: Psychological Therapies Waiting Times and Sickness Absence. Additional local KPIs are reported to the Board and included in this report. Going forward, the LDP process has been replaced by a requirement for each Board to submit an Annual Operational Plan for 2018-19. A review of the broader LDP standards is also being undertaken at a national level.

2 BACKGROUND

Members receive quarterly updates on Key Performance Indicator (KPI) performance as well as an Annual Overview of performance and a Year-on-Year comparison each June.

3 ASSESSMENT

We have maintained good levels of performance in many areas but performance in the following areas merit comment:

No 1 Patient have their care and treatment plans reviewed at 6 monthly intervals.

On 30 June 2019 there were 105 patients in the hospital. Ten of these patients were in the admission phase. 7 CPA documents had not been reviewed within the 6 month period. All 7 were out of date (uncertain currently of reasons – being checked with relevant staff). This gives a compliance of 92.6% which is a drop from December's 96.1% compliance. This indicator has moved into amber.

Health Records staff continue to send reminder emails to RMOs and medical secretarial staff to advise that a patient's review or renewal of detention is due. The renewal of detention ties in with the annual CPA document being completed. These continue to be completed and uploaded to RiO by secretarial staff in shorter timescales than previously noted.

No 3 Patients will be engaged in off hub activity centres

For Q1, 83% of patients were involved in off-hub activities. This is a slight increase on last quarter (Q3 82%). This increase is due to new admissions being approved by Clinical Team to attend activity at the Skye Centre.

This percentage doesn't include patients planned to attend the hospital shop, patients scheduled to attend the Health Centre or those who regularly attending the Café Area. This means that patients engaging in off hub activities remains in the amber zone.

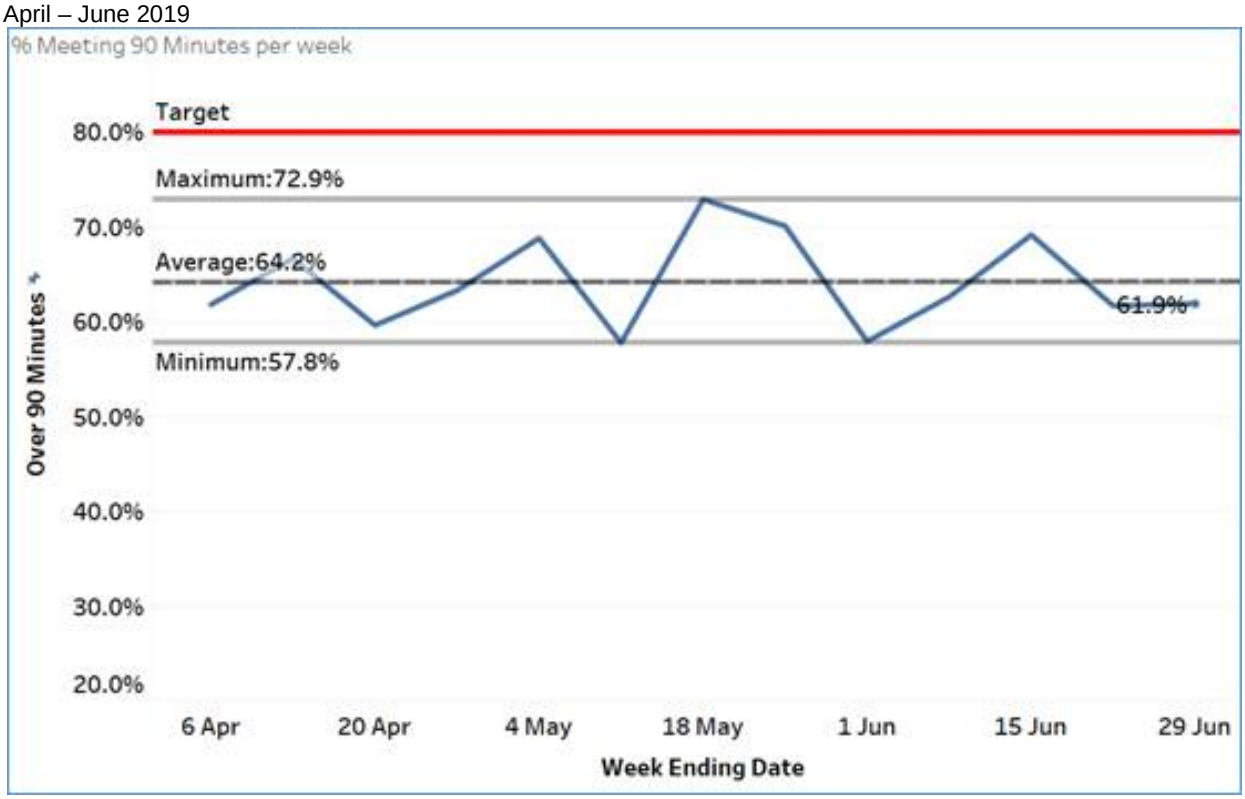
No 5 Patients will undertake 90 minutes of exercise each week

The Physical Activity levels over the first quarter have averaged 64.2%. This is an increase from 59.3% in the last quarter. The Physical Health Steering Group are currently reviewing data over the last year to look at trends and possible ways of improving the uptake of Physical Activity. Due to the 80% target this indicator remains in the red zone.

To ensure robustness of the data, spot checks were carried out to ensure a minimum of 2 physical activity entries were being completed in a 24 hour period. The spot check showed that there were 2 entries consistently being made per day and the data is therefore robust.

Data recorded is patient participation in Moderate physical activity intervention, this data includes patients participating at the Sports and Fitness, Gardens, ward and hub based activities, escorted walks, Walking Groups. This data also includes patients using Ground Access as a means of physical activity. Caution should be used to this however, as this is based on patient self-reporting.

April – June 2019



No 6 Healthier BMI.

The RiO report shows that 10% of patients have a healthy BMI in June 2019. This is the same figure as March 2019. This compares with 11.6% in December 2018, 14.5% in September and 18.8% in June 2018. This is concerning as there has been a steady decline since June 2018. The data collection has moved to monthly in December 2018 for this indicator with nursing staff taking measurements as opposed to the Dietetic Technician measuring on a 6 monthly basis. This means we have more data being collected more regularly for all patients. This indicator remains in the red zone.

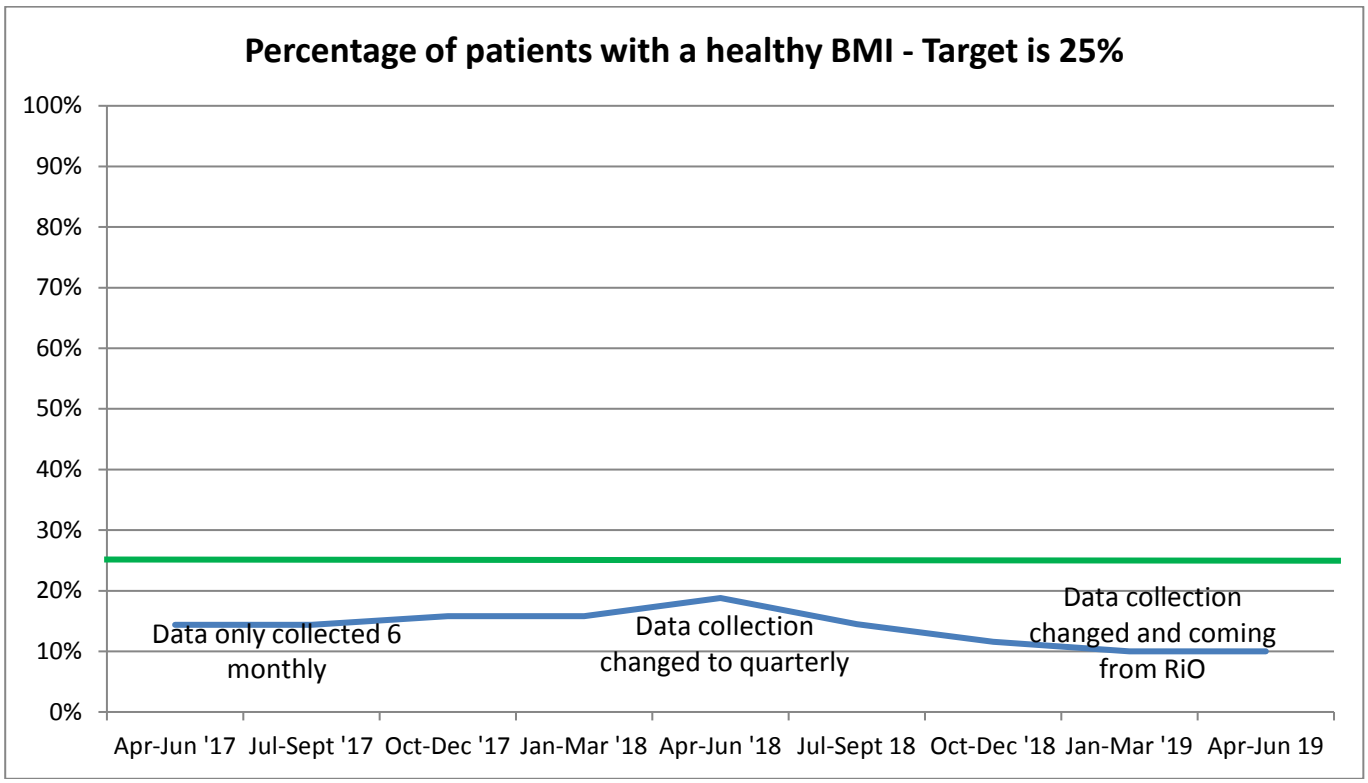


Table 1

Weight Range by BMI	Number of Patients (Q1)	% (Q1)	Number of Patients (Q4)	% (Q4)	Number of patients (Q3)	% (Q3)	Number of patients (Q2)	% (Q2)
<18.5 underweight	0	0	0	0	0	0	1	0.9
18.5-24.9 healthy	11	10	10	10	12	11.6	15	14.5
25-29.9 overweight	38	89	39	90	36	88.4	30	85.5
30-39.9 obese	48		46		48		49	
>40 obese	6		8		7		8	

No 7 Sickness absence.

The sickness absence rate for the quarter was 5.48% with 4.33% long term and 1.15% short term. The monthly figures were 5.55% in April with 4.25% long term and 1.29% short term, 5.34% in May with 4.38% long and 0.96% short and 5.56% in June with 4.36% long and 1.19% short.

This moves this indicator from red to green as the hospital is less than 0.5% away from their target.

No 8 Staff have an approved PDP.

The PDR compliance level at 30 June was 86.3%. This is an increase of 5.4% from the last reporting period (i.e. 31 March 2019).

Although this indicator remains in the red zone, monthly monitoring continues to show a positive upwards trajectory and there is clear evidence of month-on-month improvements in organisational compliance.

Of staff that do not have a completed and approved review, 11.3% have an out-of-date PDR (i.e. the annual review meeting is overdue) and 2.4% have not yet had an appraisal and have no PDP. The latter group are predominantly new staff with an initial set-up review meeting overdue.

No 15 Attendance by clinical staff at case reviews.

Key Worker attendance has decreased slightly to 72% from 74% in Q4. This is still a significant improvement from the Q3 figure of 49%. The target is 80%.

Occupational Therapy attendance has increased from 52% in Q4 to 83% in Q1 against a target of 80%. This indicator moves from the red to green zone.

Pharmacy has decreased from 71% in Q4 to 57% in Q1 against a target of 60%. They remain in the green zone at present.

Clinical Psychologist attendance fell further from the 80% target to 77%, compared to 79% in Q4. They remain in the green zone at present. The Psychology attendance decreased from 98% in Q4 to 91% in Q1. This moves this indicator from the green to amber zone.

Security attendance has increased slightly from 41% in Q4 to 42% in Q1 against a target of 60%. They remain in the red zone.

Social Work attendance decreased from 86% in Q4 to 74% in Q1. This indicator changes to amber as the target is 80%

4 RECOMMENDATION

The Board is asked to **note the contents of this report.**

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Monitoring of Key Performance Indicator Performance in the TSH Local Delivery Plan (2017-2020) and the Operational Plan.
Workforce Implications	No workforce implications-for information only.
Financial Implications	No financial implications-for information only.
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Leads for KPIs contribute to report.
Risk Assessment (Outline any significant risks and associated mitigation)	There is a dependency on the Business Intelligence project. While we can identify other ways of obtaining and analysing data there will be continue to be limitations on the timeliness and granularity of the information reported.
Assessment of Impact on Stakeholder Experience	The gaps in KPI data which make it difficult to assess.
Equality Impact Assessment	No implications identified.

Appendix 1

Item	Principles	Performance Indicator	Target	RAG Q1	RAG Q4	Actual	Comment	LEAD
1.	8	Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	G	92.6%	The figure for March 2019 was 96.1%	LT
2.	8	Patients will be engaged in psychological treatment	85%	G	G	92%	*Figures for June 2019* – 92% (average) engaged in therapy. In June 8 patients were not engaged in therapy. 7 had recently completed treatment and one patient is difficult to engage.	JM
3.	8	Patients will be engaged in off-hub activity centres	90%	A	A	83%	Excludes shop / health centre information (brief visits). This also doesn't include patients who are regularly attending the Café Area	MR
4.	8	Patients will be offered an annual physical health review	90%	G	R	100%	All patients eligible for an annual physical health review were offered for Q1.	LT
5.	8	Patients will undertake 90 minutes of exercise each week	80%	R	R	64.2%	For this quarter the indicator remains in the red zone but has increased from 59.3% in the previous quarter.	MR
6.	8	Patients will have a healthier BMI	25%	R	R	10%	March figure as also 10%. Steady decline since June 2018.	LT
7.	5	Sickness absence rate(National HEAT standard is 4%)	** 5%	R	G	5.48%	5.55% in April, 5.34% in May and 5.56% in June gives a quarterly figure of 5.48%. This is an improvement of 0.86% in the last quarter (6.34%)	KS
8.	5	Staff have an approved PDR	*100%	R	R	86.3%	This indicator has been showing a steady improvement since October 2018.	KS
9.	1, 3	Patients transferred/discharged using CPA	100%	G	G	100%	This indicator maintained at 100% in Q1. All patients had a CPA meeting prior to transfer/discharge. This indicator remains in the green zone.	KB
10.	1, 3	Patients requiring primary care services will have access within 48 hours	*100%	G	G	100%	*Figures for Jan –March 2019*. 97 referrals requiring to meet 48 hour standards. All met.	LT
11.	1, 3	Patients will commence psychological therapies <18 weeks from referral date	**100%	G	G	100%	All patients referred and not already in treatment met the standard	JM
~~12.~~	~~1, 3~~	~~Patients will engage in meaningful activity on a daily basis~~	~~100%~~	-			~~*New indicators and business processes in development as reported to the June Board.*~~	~~MR~~
13.	2, 6, 7, 9	Patients have their clinical risk assessment reviewed annually.	100%	G	G	97.9%	105 patients. 10 new admissions, 93 patients with current risk assessments and 2 risk assessments out of date (one due to section change, the other completed one day late).	LT
~~14.~~	~~2, 6, 7, 9~~	~~Hubs have a monthly community meeting.~~	-	-		-	~~*New indicators and business processes in development as reported to the June Board.*~~	~~MR~~
15.		Refer to next table.						All Clinical Leads

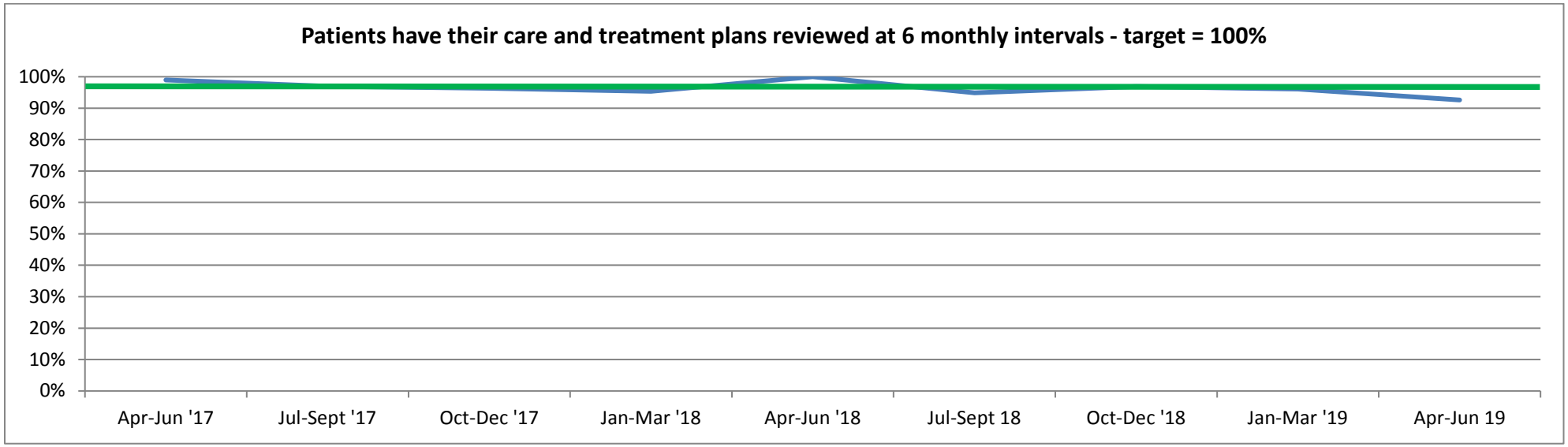
Item	Code	Principles	Performance Indicator	Profession (Lead)	Target	RAG Q1	RAG Q4	Overall attendance April – June 2019(n=50)	Overall attendance Jan-Mar 2019 (n=53)	Overall attendance Oct-Dec (n=51)	Overall attendance July-Sept 2018 (n=44)
15	T	2, 6, 7, 9	Attendance by all clinical staff at case reviews	RMO **(LT)**	90%	G	G	93%	93%	90%	89%
				Medical **(LT)**	100%	G	G	96%	98%	96%	96%
				Key Worker/Assoc Worker **(MR)**	80%	A	A	72%	74%	49%	77%
				Nursing **(MR)**	100%	G	G	100%	98%	96%	96%
				OT**(MR)**	80%	G	R	83%	52%	61%	75%
				Pharmacy **(LT)**	60%	G	G	57%	71%	41%	59%
				Clinical Psychologist **(JM)**	80%	G	G	77%	79%	92%	80%
				Psychology **(JM)**	100%	A	G	91%	98%	98%	89%
				Security**(DW)**	60%	R	R	42%	41%	39%	34%
				Social Work**(KB)**	80%	A	G	74%	86%	71%	80%
				Skye Activity Centre **(MR)** (only attend annual reviews)	tbc	-	-	0%	0%	4%	0%
				Dietetics **(MR)** (only attend annual reviews)	tbc	-	-	67%	59%	30%	0%

Definitions for red, amber and green zone

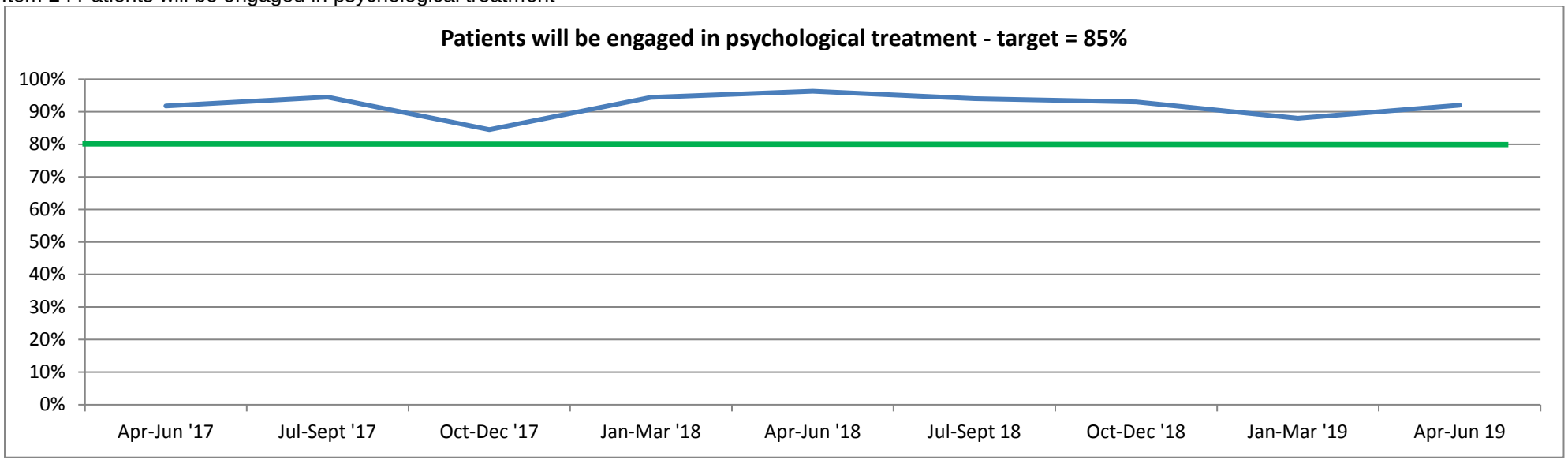
- For all but item 6 and 7 green is 5% or less away from target, amber is between 5.1% and 10% away from target and Red will mean we are over 10% away from target
- For item 6 'Patients have a healthier BMI' green will be 3% or less away from target, amber will be between 3.1% and 5% away from target and red will be over 5% away from target
- For 7 'Sickness absence' green is less than 0.5% from target, amber will be between 0.51% and 1% away from target and red will be over 1% and away from target

Trend Graphs for Performance Management Data

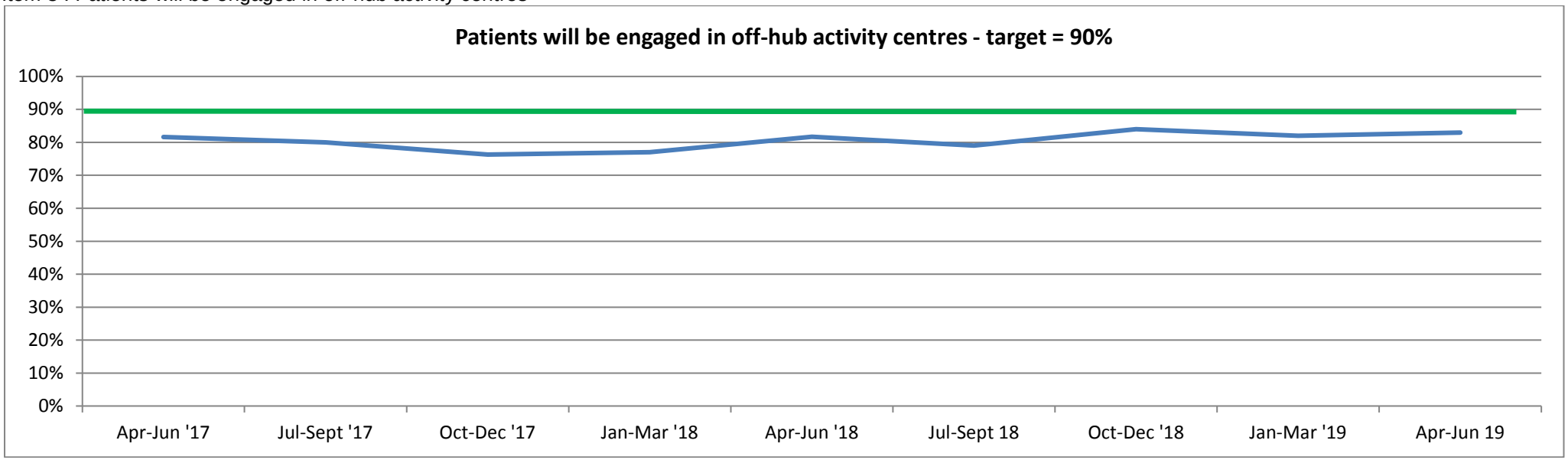
Item 1 : Patients have their care and treatment plans reviewed at 6 monthly intervals



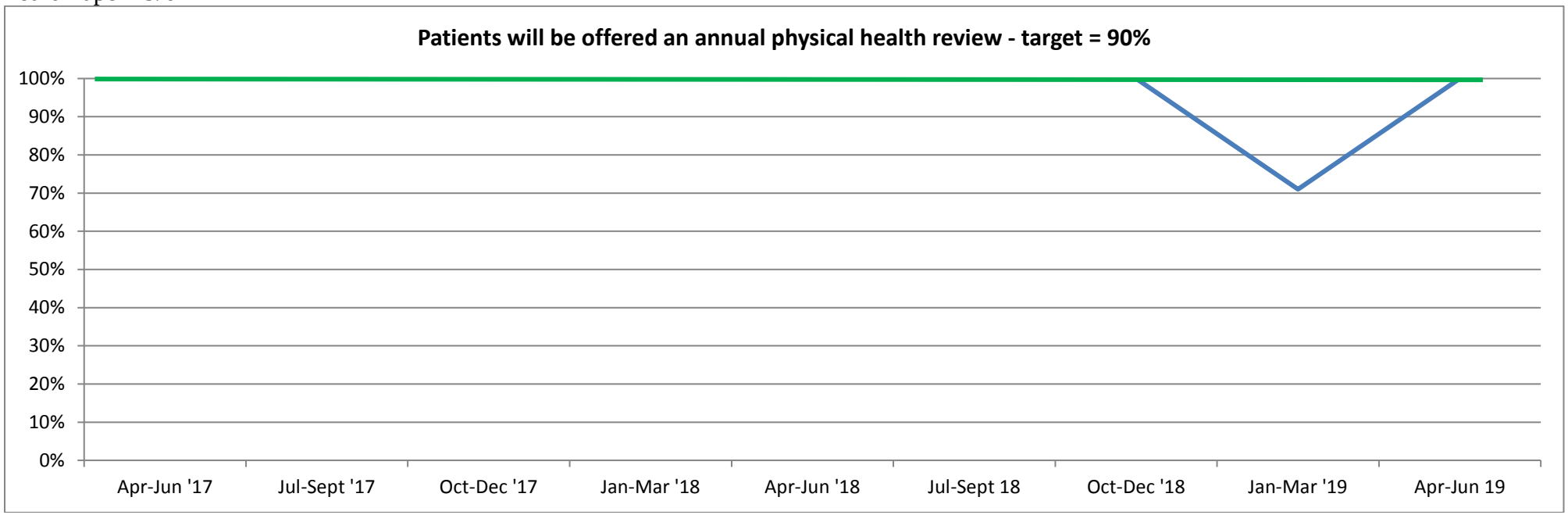
Item 2 : Patients will be engaged in psychological treatment



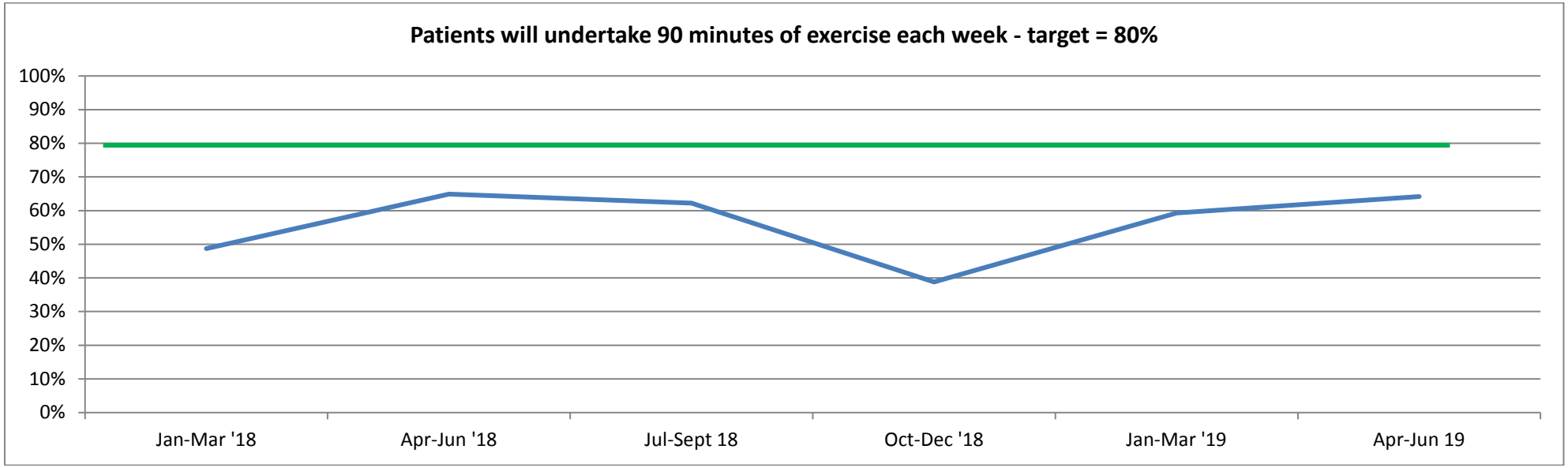
Item 3 : Patients will be engaged in off-hub activity centres



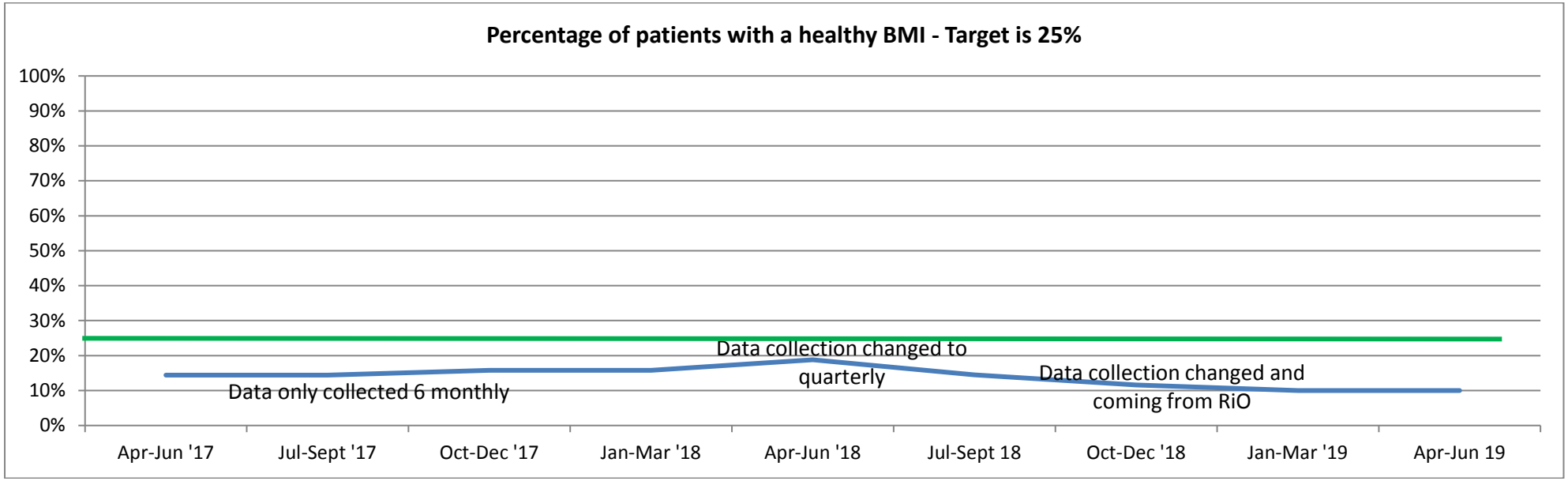
Item 4 : Patients will be offered an annual physical health review



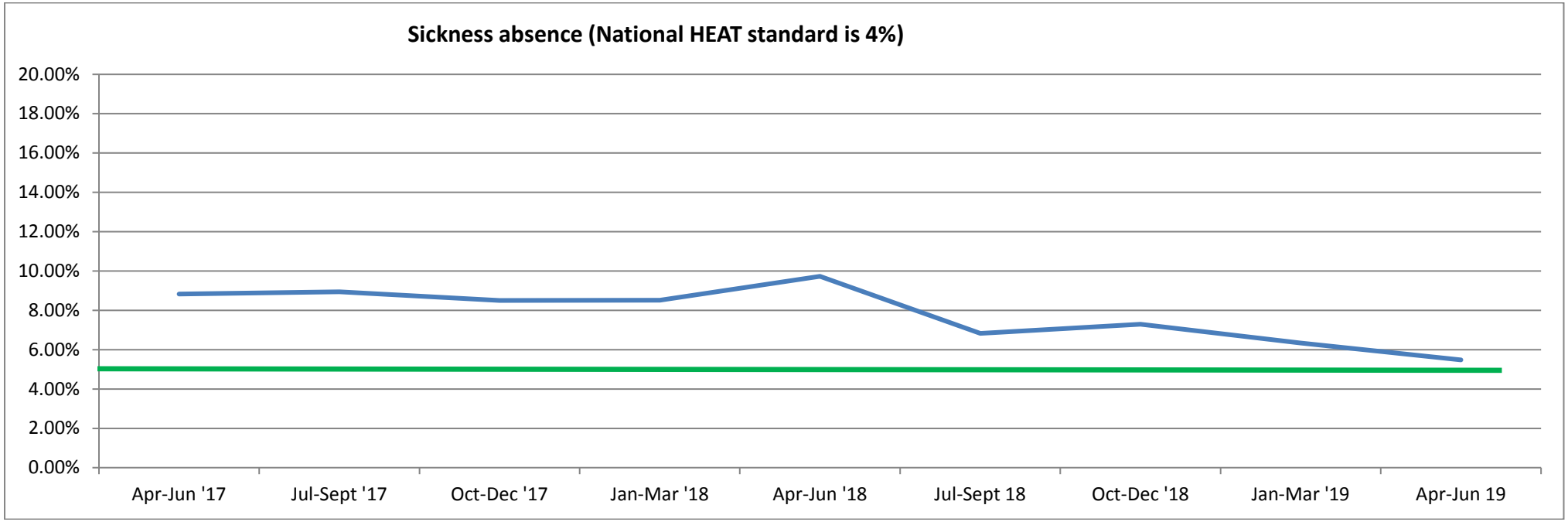
Item 5: Patients will undertake 90 minutes of exercise each week



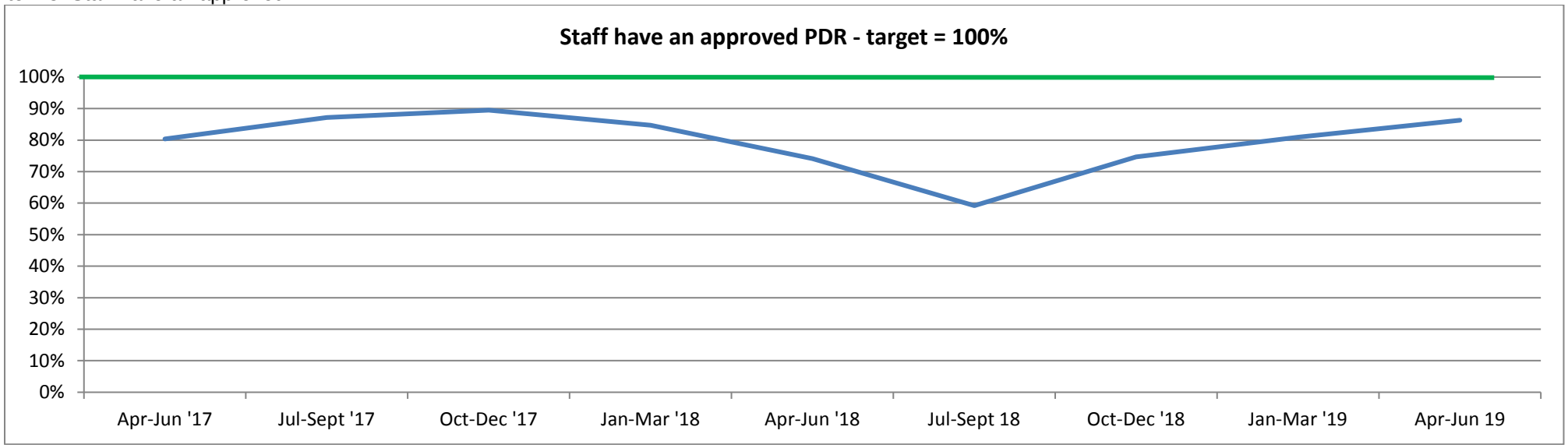
Item 6: Patients will have a healthier BMI



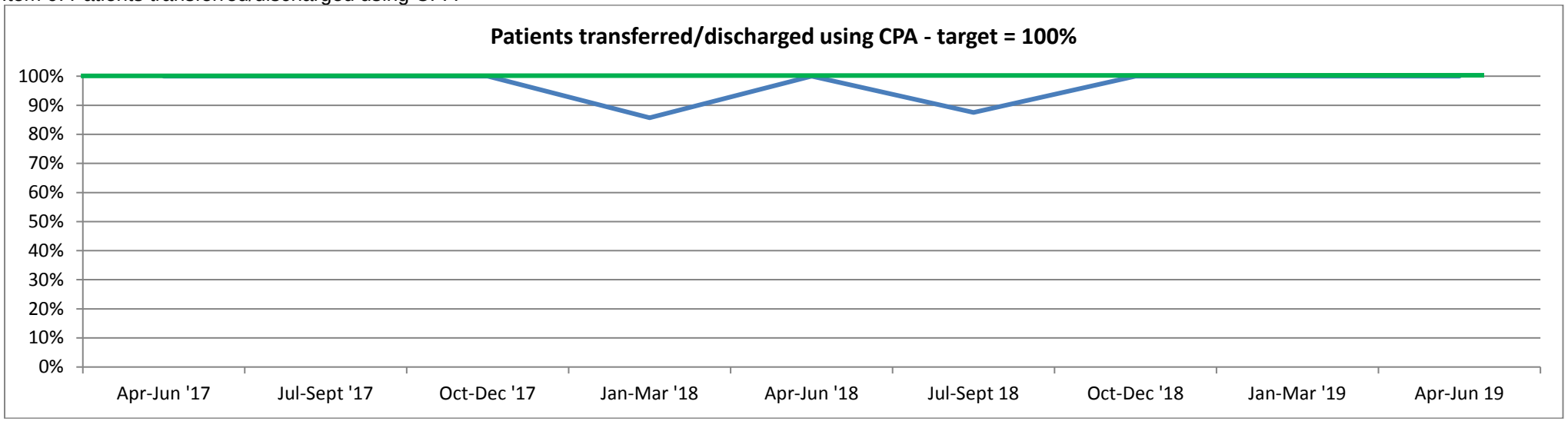
Item 7: Sickness Absence



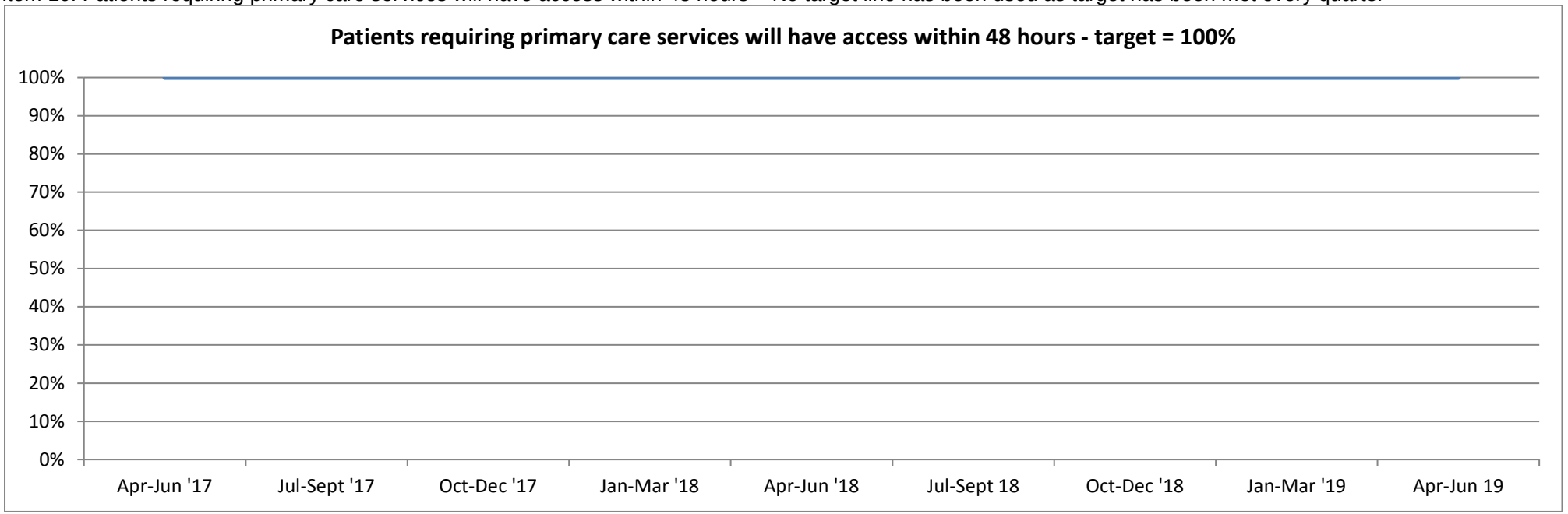
Item 8: Staff have an approved PDR



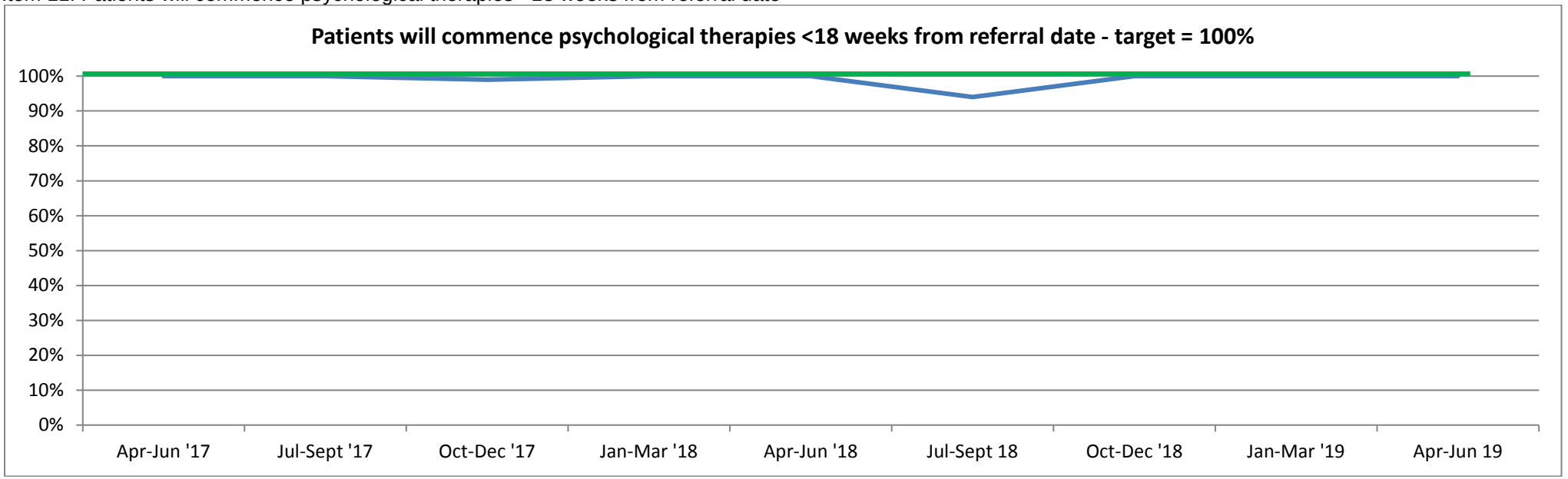
Item 9: Patients transferred/discharged using CPA



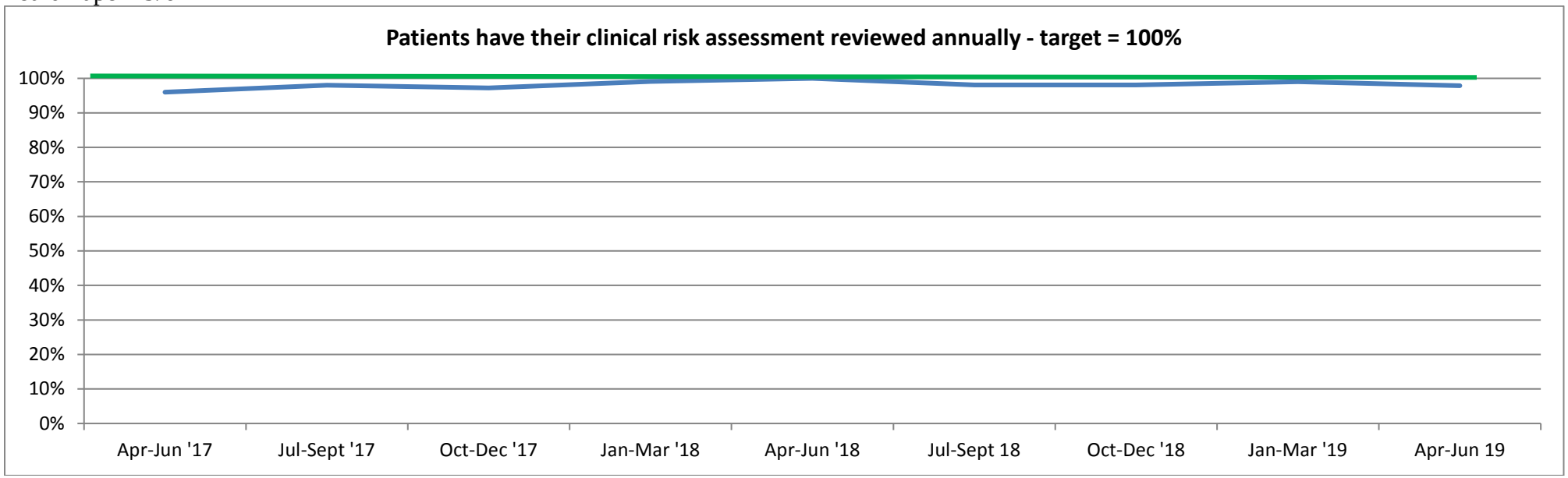
Item 10: Patients requiring primary care services will have access within 48 hours – No target line has been used as target has been met every quarter



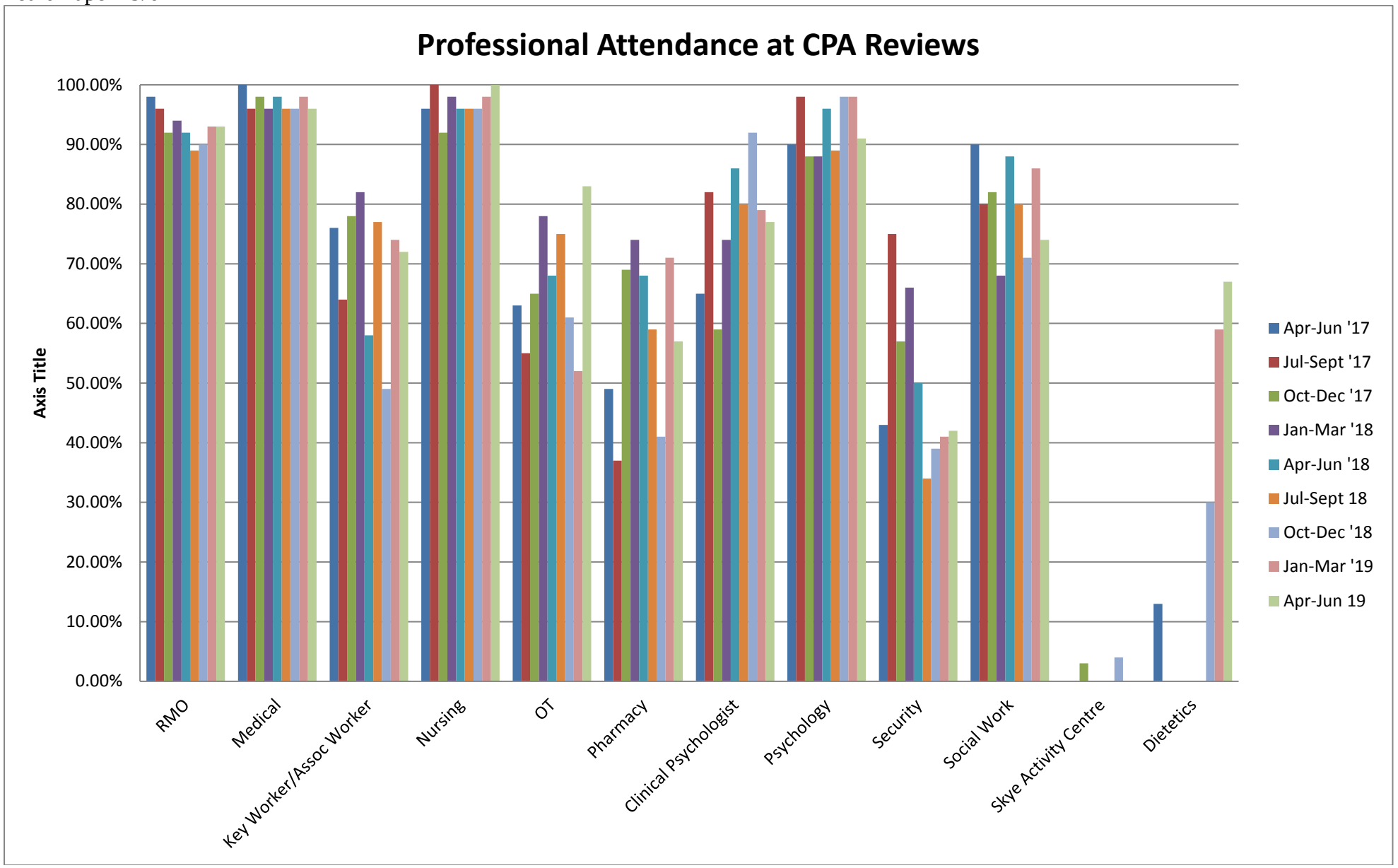
Item 11: Patients will commence psychological therapies <18 weeks from referral date



Item 13: Patients have their clinical risk assessment reviewed annually



Item 15: MDT Attendance at Case Review


Professional Attendance at CPA Reviews
Axis Title
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
RMO
Medical
Key Worker/Assoc Worker
Nursing
OT
Pharmacy
Clinical Psychologist
Psychology
Security
Social Work
Skye Activity Centre
Dietetics
Apr-Jun '17
Jul-Sept '17
Oct-Dec '17
Jan-Mar '18
Apr-Jun '18
Jul-Sept 18
Oct-Dec '18
Jan-Mar '19
Apr-Jun 19

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 18
Sponsoring Director:	Finance and Performance Management Director
Author(s):	Head of eHealth
Title of Report:	eHealth Annual Report
Purpose of Report:	For Noting

1 SITUATION

In order for the Board to have an overview of the work carried out by the eHealth Department, an annual report has been created for consideration of the Board members. The eHealth Annual Report aims to highlight the activities of the department during 2018/2019 while also detailing work required for 2019/2020.

2 BACKGROUND

The eHealth Annual Report aims to highlight the activities within the teams that make up the eHealth Department.

3 ASSESSMENT

The report highlights the main areas of activity and concerns form the previous year (2018-2019) The report has no impact on resources or finances for the department.

4 RECOMMENDATION

The Board is asked to **note** the attached report for the year 2018/19 in advance of its publication on the Hospital's internet web site.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	The Report follows good practice and also links in with the eHealth Strategy
Workforce Implications	Not applicable
Financial Implications	No financial implications if approved
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	None
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None
Equality Impact Assessment	No identified implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ☑ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed. ☐ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

ANNUAL eHEALTH REPORT

APRIL 2018 - MARCH 2019

Responsible Director	Robin McNaught – Finance and Performance Management Director
Lead Manager	Thomas Best – Head of eHealth
Approved by	
Date Approved	
Date for Review	00/8/19

Contents

1 Overview

2018/2019 has been another challenging year for the eHealth department.

The new Infrastructure team members are now settled and in place with several new team members getting familiar with our working environment. While there are certain projects carried forward for delivery in 2019/20, much has been achieved in the year with prioritisation of the department's focus

Reprioritising projects allowed the Infrastructure and Information teams to deliver most work streams on time but a few unfortunately had to have their delivery dates extended to ensure their successful delivery.

Overall it is recognised that the department has had a successful year with successes such as "Tableau" being rolled out and the Patient Learning Centre hardware refresh now ready for deployment.

Challenges into 2019/20 will be maintaining the momentum of our Records Management Plan, Tableau, upgrading our EPR system RiO, being a pathfinder site for the national eRostering system, the move to Windows 10 and the ground work for identifying what is needed for the organisation's move to Office 365.

2 Information Team

The eHealth Information team will temporarily expand to three members until 2020. The new post will be funded in part by the Excellence in Care Project (EIC) with the funding gap met by eHealth Strategic Funds. This team now provides support for RiO, Tableau and other systems, as well as maintenance and development of our new data warehouse.

The Information Team have also carried out significant work to support nursing resource utilisation and have contributed to national projects including Excellence in Care and the eRostering system procurement.

A major focus has been the delivery of Tableau. Following completion of an extensive requirements gathering process and prioritisation workshop, three task groups have been formed to deliver dashboards for Patient Acuity and Dependency, Physical Health and Activity and Workforce Utilisation. Depending on Information Analyst resources, these dashboards are scheduled for delivery in 2019 and the Project Board will then prioritise the next phase of delivery from the requirements.

Major developments to RiO (Electronic Patient Record) include new modules to support:

- Dynamic Appraisal of Situational Aggression (DASA)
- Health and Well Being Plans
- Clinical Team Meetings (CTMs)
- Psychology Formulations
- Anthropometric Monitoring
- Observation Plans
- Clinical Pause Meetings
- Integration of the Social Work Service
- Patient Timetabling
- New Nursing Care Plans

3 Infrastructure Team

As noted above, the Infrastructure team have been impacted by absence this year. This had held back some projects but plans implemented to resolve this issues were successful. The team have maintained the level of support required and expected by the organisation, while at the same time ensuring that "business as usual" activities are always supported.

Major projects to be delivered in 2019/20 are the deployment of Windows 10, groundwork for our move to Office 365, the RiO Upgrade and the development of out of hours support.

4 Health Records Department

The Health Records Department has had another busy year, with a variety of 'business as usual' tasks as well as proactively undertaking improvements within processes to provide a better service. Requests for patient records (Subject Access Requests, police and other healthcare providers and other miscellaneous bodies) have continued. Records Management has been taken forward with a Records Survey being started and liaison with other departments being a priority for Health Records staff, focussing on patient information in the first instance. Discussions are ongoing with regard to restructuring the department as a Records Services Department. Changes to legislation have meant alterations in processes and some extra pressure on the team, however overall levels of performance and service have remained high.

Work has begun on appraisal of patient records, with some notes now being identified for permanent preservation and others for destruction. Archive material relating to The State Hospital is being catalogued in preparation for removal to archives, or for permanent storage within the department. Department staff continue to attend internal and external meetings and groups, relating to a wide spectrum of topics including Information Governance, Records Management and Healthy Working Lives. Working relationships are being formed and encouraged with external bodies, in particular local and national health boards to maintain knowledge and contribute to future legislation and guidance. There is recognition that the Health Records Department's workload has changed and plans are in place to formalise this. It is noted that the Department is small, and resources are stretched, however improvements continue to be made.

5 Project Management

The demands on our part-time Senior Project Manager also continue to be significant, with a focus on delivering The State Hospital Tableau Business Intelligence system. The Senior Project Manager is also the nominated Evangelist for the National Finance Tableau project with the dashboards for budget holders due to be rolled out from August 2019 onwards.

As The State Hospital is one of three pathfinder sites for the rollout of the national eRostering system, the Senior Project Manager has also been heavily involved in the national procurement process. This system is expected to be rolled out towards the end of 2019 and will require additional project management and eHealth resources.

The planned transition to Version 7 of our Electronic Patient Record RiO will also require project management resources.

6 Key eHealth Projects 2018/19

Storage and backup replacement.

This was the main priority project in 2018/19, and after extensive evaluation the replacement solution was procured in March 2019 and installed in the following weeks, going went live on 20th June without any issues at the time – a matter arose in early July which was addressed promptly and effectively with full supplier support provided.

Going forward, key benefits gained from installing this system are – doubling the amount of storage available (which was strained at its previous capacity), lower power consumption, less cooling requirement and a reduction in licencing costs.

Patients' Learning Centre Infrastructure refresh.

The deployment of new equipment was evaluated and procured in the year, completed on 26th June and the system is now live. Staff and patients will continue to have dedicated IT support for the next few weeks until they are confident everything is operating as required.

Windows 10

We are still working towards deploying Windows 10 to all hospital computers by January 2020. This is the time when Windows 7 goes "out of support" from Microsoft. Through the year, there has been a test group of staff with Windows10 who have helped resolve a number of issues encountered during initial testing.

Preparations are now being made to start the rollout of Windows10 to all new laptop and desktop computers. Testing of our existing laptops and desktop computers has highlighted that some may not be compatible with Windows 10 – and there is a possibility that additional capital funding may be required to purchase more new computers due to this problem. This will be evaluated and addressed through the Hospital's Capital Group.

Office 2016 deployment

Testing of Office 2016 has been completed in 2018/19 with several staff already using this - so no additional testing is expected to be required. Funding for the purchase of Office 2016 has to be reviewed although eHealth Strategic Funds may be a suitable funding source. The eHealth Strategic Fund is used to implement eHealth strategy. It is a funding stream from Scottish Government which is a ring-fenced resource to support a range of eHealth priorities such as upgrading software to meet the Network Information Systems Directive compliance. Once the licences have been purchased Office 2016 will be gradually rolled out to all hospital computers – these licences are only intended for temporary use until all boards move to Office 365 in the few years. (They are supplied via NSS at a reduced price that was agreed as part of the Office 365 Project.) This will allow us to completely remove the unsupported Office 2007 package and ensure our Microsoft Office software is compliant with the forthcoming NIS Directive and the requirements for Cyber Essentials accreditation.

RiO EPR upgrade to version 7

This has been under review through the year, and while upgrade was initially planned to begin in April 2019 but has been held back due to delays by the supplier. A kick off meeting has still to be held and a revised start schedule will be delivered from this.

Tableau business intelligence tool

Extensive work has been undertaken in the year to develop Tableau and the Information Team are keen to harness the power of Tableau and use their BI skills to deliver information at the point

of decision making. The team are working with short term tasks groups and taking an agile, prototyping approach to the development of the dashboards prioritised for the first phase of the rollout, and will work with the Project Board to agree the scope and priority areas for the next phase of the project delivery.

7 eHealth Cyber Security

Cyber Essentials

We have had two Cyber Essentials assessments in the last twelve months. We unfortunately did not achieve full compliance due to older unsupported software still in use at the hospital. There is now a focus to improve this position but the 2019/20 replacement of the Security Visitor System and the upgrade to Office 365 from 2007 will require completion before re-assessment.

Although these two application had an impact on our Cyber assessment our network access was found to be secure and could not be breached internally. Our Internet connection was also secure and is protected by devices on site and nationally on the SWAN network. Our staff have the minimum computer access rights needed to undertake their roles and this can prevent computer viruses form installing and preventing them for taking hold.

The changes made to the IT Infrastructure over the last few years has strengthened our protection against cyber-attack. However we need to keep vigilant as technology develops and new threats to our Infrastructure are developed.

Software Patching

Software patching is seen as the most effective way to ensure the security of our digital estate. This process was previously undertaken “ad hoc” with patches being rolled out when possible. However there has been a key development in 2018/19 with the deployment of a product called Ivanti Heat to assist with managing this process. This application was provided as part of a national initiative funded by the Scottish Government’s eHealth Department. The software monitors the patching level of all hospital computers and helps to manage the deployment of both Microsoft and non-Microsoft computer patches. The output for this system is also available to the Security Team at NSS to help with monitoring our patch level and the patch level of other board who are part of this project.

8 Priority eHealth Projects for 2019/20

Continuation of Windows10 roll-out

Office 2016 deployment

Rio EPR upgrade to version 7

Introduction of patient timetables

eRostering pilot (National – TSH is a Pathfinder Board)

Continuation of Tableau roll-out (TSH)

Finance Tableau Dashboard roll-out (National)

Excellence in Care (National)

Visitor booking system replacement

Remote site connectivity

9 eHealth Collaborative Working

The eHealth department represents the hospital at several national eHealth groups. This ensures we have sight of national programs and projects within NHS Scotland, and highlights the potential of national solutions where applicable. This also allows us to benefit from national pricing on such products rather than going alone to procure services and solutions.

The groups on which State Hospital eHealth staff are represented are – eHealth Leads Group, National Infrastructure Group, National IT Security Group, National Board Digital Group, West of Scotland Infrastructure Group and the West of Scotland IT Security Group

Board Paper 19/63

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 19
Sponsoring Director:	Finance and Performance Management Director
Author(s):	Senior IM & T Analyst & ITSO
Title of Report:	Network Information Systems Regulation (NIS) and the Information Security Policy Framework (ISPF) 2018
Purpose of Report:	To raise awareness and provide an understanding of the requirements to be compliant with the regulation

1 SITUATION

The recent introduction of the Network and Information Systems Regulation 2018 (NIS 2018) has placed a legal requirement on organisations within the United Kingdom that are considered part of the critical infrastructure. Over the past year there has been frequent discussions about NIS and the Information Security Policy Framework 2018 (ISPF 2018) in National Information Security meetings. As yearly audits will be carried out to ensure compliance, there is a real concern that not much, if any, consideration has been given to the NIS Regulation and the ISPF 2018 by the organisation. As there are big financial fines, up to £17 million, for organisations that are not compliant, action needs to be taken to ensure we avoid those fines.

2 BACKGROUND

The NIS Regulation, based on the EU's NIS Directive, was passed around the same time as the General Data Protection Regulation (GDPR) 2018, was brought in to apply security standards to the United Kingdom's critical infrastructure and services. As everyone is affected by GDPR there was a lot of media attention and plenty of information available when it was due to be implemented. Unfortunately, NIS has not received the same attention due to the regulation only being imposed on organisations that provide critical services, such as energy, transport, health, digital infrastructure and water supply.

3 ASSESSMENT

More awareness has needed to be raised in regards of the NIS Regulation and the ISPF 2018. Endorsement by the SMT and from the Board will assist in highlighting the importance of being compliant with the NIS Regulation using the ISPF 2018, as there will be a requirement for other directorates, within the organisation, to have some direct involvement.

The SMT has noted the need for a board-level individual, currently assigned to the Finance and Performance Management Director, who has overall accountability for the security of networks and information systems, the requirement for a new post/role to be created or changes to a current post/role with the responsibility of overseeing and advising on information security concerns, the

need for other directorates to have direct involvement in evidence gathering for compliance audits and noted there may be a requirement for funding for security systems, tools and training.

4 RECOMMENDATION

The Board is invited to: (note / endorse / agree to) the following recommendations:

- Note progress in this matter has been raised to the SMT, who in turn noted the actions required and have requested further updates in due course.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To ensure compliance with regulation. Legal obligation.
Workforce Implications	Directorates and personnel need to be identified to carry out gap analysis and provide evidence. Possible new role to be created/adjusted and/or group setup to check/ensure compliance with regulation (suggested at IT SUB Group).
Financial Implications	Fines can be imposed if the organisation is not compliant with the regulation. Systems/Tools may be required to comply with the regulation.
Route To SMT Which groups were involved in contributing to the paper and recommendations.	IT SUB Group
Risk Assessment (Outline any significant risks and associated mitigation)	Financial, reputational, information security, non-compliance with other regulations (GDPR), non-compliance with NIS regulation.
Assessment of Impact on Stakeholder Experience	
Equality Impact Assessment	There should not be any impact on equality, or none that has been identified yet.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 20
Sponsoring Director:	Chief Executive
Author(s):	Head of Communications Person Centred Improvement Lead
Title of Report:	Communications Annual Report 2018/19
Purpose of Report:	For Noting

1 SITUATION

The Head of Communications is required to produce a Communications Annual Report. This report covers performance from 1 April 2018 to 31 March 2019.

2 BACKGROUND

All communications activity supports the Board in the delivery of its core objectives and legal obligations. The establishment of a Communications Annual Report is therefore an important assurance process in considering the effectiveness of State Hospital internal and external communications.

Given the nature and organisational arrangements of the Board, patients are uniquely viewed as internal communication stakeholders in addition to Non-Executive Directors, Volunteers, the Chaplaincy Team, Advocacy and staff. Carers, the public and the media are included within external communication arrangements.

The two services predominately delivering internal and external communications are the Communications Service and the Person Centred Improvement Service (PCIS).

3 ASSESSMENT

Overall, core Communications tasks were delivered, all legislative requirements were met, and all financial targets / savings were achieved.

A breakdown of the 78 key areas of activity is shown below:

- There were 26 tasks relating to core objectives (compared to 22 in 2017/18). Of these 13 were Key Performance Indicators (KPIs) (as per 2017/18), and the remaining 13 (nine in 2017/18) on outputs in respect media, public, patient, carer, volunteer, external, and staff activity.

- Additionally, 52 objectives focused on quality (compared to 36 in 2017/18); 19 relating to quality assurance (same as 2017/18) and 33 to quality improvement (24 in 2017/18). The latter evidencing our commitment to continuous improvement.

However more needs to be done to address negative media reporting and to raise the profile of The State Hospital (both within and outwith NHSScotland) with all stakeholders including regulators, partner organisations, the public, the media etc. Disappointingly, as in previous years, some negative coverage has been initiated via leaks by staff to the media. Attempts to source these individuals have been unsuccessful. These media issues should in no way detract from the good work that has taken place across all strands of communications, both internal and external, attracting positive attention.

4 RECOMMENDATION

The Board is asked to note the Communications Annual Report 2018/19.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	All communications activity supports the Hospital to meet its strategic objectives as outlined in the Hospital's Local Delivery Plan / Annual Operating Plan.
Workforce Implications	Resilience challenge identified.
Financial Implications	N/A
Route To Board Which groups were involved in contributing to the paper and recommendations.	Person Centred Improvement Service (PCIS)
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	No direct impact other than protecting the Hospital's reputation and patient / staff confidentiality as well as ability to keep all stakeholders properly informed.
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	The Head of Communications works closely with the Person Centred Improvement Lead to support an inclusive approach to ensuring patients who experience significant barriers to communication are enabled to contribute meaningfully to all aspects of care and treatment.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ☑ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included.

COMMUNICATIONS ANNUAL REPORT 2018/19

THE STATE HOSPITALS BOARD FOR SCOTLAND

1. CORE PURPOSE

Effective communications plays a key role in how all stakeholders perceive The State Hospital.

The core purpose relates to all aspects of communications both internally and externally - from consultancy / advice and guidance to the provision of electronic communications and the production of corporate publications. In particular, the The Head of Communications acts as communications link between the Hospital and stakeholders including staff, the local community, general public, professional bodies, and local and national government, and drives forward improvements in communication. This enables the influencing and shaping of communication planning and strategy at all levels, ensuring good communications practice is firmly embedded in everyday service development, delivery and change.

Given the nature and organisational arrangements of the Board, patients are uniquely viewed as internal communication stakeholders in addition to Non-Executive Directors, Volunteers, the Chaplaincy Team, Advocacy and staff. Carers, the public and the media are included within external communication arrangements. This is where communications differ from that of other Boards. The State Hospital's general public (patients) are long stay therefore our internal stakeholders. The general public as a whole are potential patients of territorial Boards and are viewed by them as external stakeholders. These Boards will therefore undertake direct engagement with their general public in relation to health, wellbeing and services provided.

Key results areas include:

- Stakeholder Communications (internal and external).
- Public Relations.
- Media Relations.
- Crisis Communication.

2. CORE OBJECTIVES

All communications activity supports the Hospital in the delivery of its core objectives. In particular those relating to:

- National Staff Governance Standard (4th edition), June 2012.
- NHSScotland Healthcare Quality Strategy, May 2010.
- NHSScotland 2020 Workforce Vision (*Everyone Matters*), June 2013.
- Scottish Health Council – Participation Standards, August 2010.
- Healthcare Improvement Scotland (HIS) – What Matters To You? August 2016.

3. STRATEGY AND POLICY

Communications is delivered in line with our Corporate Communications Strategy which meets the legal obligations contained within:

- Human Rights Act 1998.
- Public Interest Disclosure Act 1999.
- Freedom of Information (Scotland) Act 2002.
- Equality Act 2010.
- Public Services Reform (Scotland) Act 2010.
- Patient Rights (Scotland) Act 2011.
- Mental Health (Care and Treatment) (Scotland) Act 2003 / 2015.
- Carers (Scotland) Act 2016.
- Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.
- General Data Protection Regulations (GDPR) 2018.
- Duty of Candour Procedure (Scotland) Regulations 2018.
- Fairer Scotland Duty 2018.

The Board's Corporate Communications Strategy 2015/20 – which is available on The State Hospital's Website under Board Business - focuses on internal and external corporate communications. It supports the aspirations of the Board and is regularly reviewed in a collaborative manner in line with effective partnership working practices, and best practice in involvement, engagement and consultation processes.

The Media Policy & Procedure, Website Maintenance & Development Policy and other relevant documentation support the Corporate Communications Strategy including the discrete Pandemic Influenza Communications Strategy 2015/20.

Additionally:

- The Supporting Patient Communication Policy is currently being developed in collaboration with stakeholders in response to legislation, national drivers and local feedback. The policy will support an individually tailored approach to meaningfully engaging all patients throughout their time in the Hospital.

- In response to feedback from internal and external stakeholders, the Person Centred Improvement Service Delivery Plan was developed in 2018/19 replacing the Involvement and Equality Strategy. This title more appropriately describes the wider function of the service, making explicit the contribution of its diverse workstreams to strategic objectives.

4. KEY PERFORMANCE INDICATORS (KPIs)

Established KPIs relate to the core Communications function as detailed below:

No	KPI	Source	Timescale	Status / Outcome
01	To produce a Communications Annual Report for presenting to the Board.	Board	By August each year	Continues to be met
02	To produce the Board's Annual Report.	Board	By 31 October each year	Continues to be met
03	To produce at least 44 weekly bulletins for staff.	CEO	By end March 2019	Complete A total of 52 were produced.
04	To produce at least 40 special bulletins as a support to staff.	CEO	-	Complete At the request of staff, 66 were produced.
05	To produce Staff Newsletter 'Vision' twice a year as a minimum.	CEO	By end March 2019	Complete Four issues were produced.
06	To deliver on 100% of all appropriate requests for Talks to the Community.	General Public	By end March 2019	Complete Three general State Hospital presentations were delivered.
07	To respond to 100% of urgent Media Enquiries within the timescale requested and within one working day.	Media	By end March 2019	Complete There were 40 media enquiries.
08	Meet the requirements of the 'Well Informed' Staff Governance Standard.	Staff Governance Standard	March / April 2019	Complete Achieved and evidenced by way of the 'Well Informed' section of The State Hospital's Staff Governance Standard Monitoring Return 2018/19.
09	To ensure attendance at four of the six State Hospital Board Meetings.	Board	Annually	Continues to be met Criteria met.
10	Ensure Board business is published on the Website. This includes: Board Meeting Dates, Public Notices, Agendas, Minutes & Papers.	Board	Ongoing	Continues to be met Additionally, after each Board Meeting a review all Board papers takes place with a view to identifying information / communication for the staff bulletin, staff newsletter 'Vision', Intranet, Website and the Media as appropriate.

No	KPI	Source	Timescale	Status / Outcome
11	To attend 90% of NHSScotland Strategic Communications Network Meetings.	NHSScotland	By end March 2019	Complete Criteria met.
12	To ensure representation at the annual NHSScotland Event.	NHSScotland	Annually in June	Continues to be met The Board agreed that no 'stand' would be taken at the June 2018 event.
13	Annual re-design of Weekly Staff Bulletin and Special Bulletin.	Chairperson	By end March annually	Continues to be met

The table below details activity not covered by KPIs:

No	Workstream	Lead	Outcome	Key Result Area
01	Media Releases	Head of Comms	Two Media Releases were issued to the local press: (1) Annual Review – 24/12/18 and (2) New CEO – 16/01/19.	Media Relations
02	Media Features	Head of Comms	There were none.	Media Relations
03	Media Leaks	Head of Comms	Seven were reported through Datix.	Media Relations
04	FOI Enquiries	FOI Lead	Thirty three enquiries were responded to.	Public Relations
05	Academic Published Articles	Research & Development Manager	The Research Committee and Research Funding Committee Annual Report 2018/19 notes 19 published journal articles and the delivery of 45 presentations.	Public Relations
06	Continue to invite visitors to the Hospital to learn about our work. Visitors include MSPs, Health Board Chairs and senior officials as well as other stakeholders.	Executive Team	Ongoing annually as outlined in the Chief Executive's Report to each Board Meeting.	Public Relations
07	Patient Newsletters	Person Centred Improvement Advisor (PCIA)	A weekly patient bulletin is produced which is displayed on all patient noticeboards within the Hospital.	Patient Relations
08	Carer Updates	PCIA	In response to GDPR requirements from 2018, Carer Newsletters were replaced by specific, targeted Carer Updates, e.g. service delivery, safety and security, infection control.	Carer Relations

No	Workstream	Lead	Outcome	Key Result Area
09	Carer Events	PCIA	From 2018, in line with GDPR, information about social events is shared with carers who have consented to receiving such communication.	Carer Relations
10	Volunteer Updates	PCIA	To meet GDPR regulations, the Staff Bulletin and other relevant information is shared with volunteers who have consented to receive same.	Volunteer Relations
11	Networking: Presentations / Workshops	Person Centred Improvement Lead (PCIL)	To share best practice, address stigma and respond to national drivers on a range of topics including Spiritual & Pastoral Care, What Matters To You?, Volunteering including development of Impact Assessment Tool & Volunteer Visitor Programme, Person Centred Quality Improvement initiatives including flexible visiting and engaging hard to reach patients, Equality agenda including Protected Characteristics and Equality Impact Assessments.	External Networking
12	Stakeholder Stories	PCIL	Present feedback from patients, carers and volunteers regularly directly to the Board.	Board Awareness
13	Leadership Walkrounds	Executive Team	Seven took place.	Staff Relations

5. QUALITY ASSURANCE (QA) OBJECTIVES

The table below shows all QA Objectives for 2018/19 and progress against same:

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
Internal Communications					
01	Review all patient publications in line with 'Accessible Information' standards.	Patient Feedback	PCIL and Head of Comms	March 2020	Work commenced in 2018. Around 75% complete
02	Annual review and update of all Person Centred Improvement Service text on The State Hospital Intranet.	Person Centred Improvement Steering Group (PCISG)	PCIL	Annually	Continues to be met

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
			Internal Communications		
03	Review the operating effectiveness of the Intranet for staff with a focus on content and the current document management system (i.e. Sharepoint).	Executive Team	Head of eHealth	March 2020	Outstanding Task timeframe was originally March 2018. Review has still to take place to agree the effectiveness and future direction of the Intranet. Review likely to commence early 2020. Currently Sharepoint is out of support with Microsoft and requires upgrading. Following the review, a paper will go to the IT sub group for discussion and recommendation, prior to options being presented to SMT re the way forward. Timescale adjusted accordingly.
04	Review and update publications (as appropriate) in the Hospital's Publications Database.	Comms	Head of Comms	Ongoing	**Completed 2018/19** New, reviewed and / or updated information sheets included: AHP Student information (AHP), Board Biographies (Corporate), State Hospital 'About Us' (Corporate), Health Centre timetable (Health Centre), Access to Patient Records (Health Records), EASY Sickness Absence (HR), Freedom of Information (FOI) (Information Governance), Stressful Incident (OHS), Time for Talking (OHS), Safety and Security Requirements (Security), Siren (Security), and Therapies and Activities (Skye Centre), Suicide booklet (Nursing Practice Development). **New for 2019/20** A review of all information sheets for Dietetics, the Health Centre, Infection Control, Physical Health Steering Group, Psychological Therapies Service, and Social Work.

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
			Internal Communications		
05	Review of the Staff Charter.	Comms Audit	Interim Director of HR	March 2020	**New for 2019/20**
			External Communications		
06	Annual review and update of all Person Centred Improvement Service publications.	PCISG	PCIL	Annually	Continues to be met
07	Undertake an annual review and update of the content on the Website.	Comms	Head of Comms	By August each year	Continues to be met
08	Annual review and update of all Person Centred Improvement Service text on The State Hospital Website.	PCISG	PCIL	Annually	Continues to be met
09	Production of Employment Monitoring Reports for the Website.	Equality Act	Interim Human Resources Director	Every two years – June 2021	Ongoing Report for 2018/19 published on web 06/06/19.
10	Produce an annual report on Website statistics for 2018/19.	Comms	Head of Comms	March 2019	Complete
11	Explore Web Archiving with National Records Scotland (NRS).	Records Management Plan	Health Records	December 2019	On target Initial meeting May 2018, Web Archive Questionnaire issued June 2018. Archiving to commence around June 2019.
12	Undertake an annual review and update of the content on the ONELAN screens.	Comms	Head of Comms	By August each year	Continues to be met
13	Undertake annual reviews and updates of the State Hospital's Speakers' Directory and general presentation slides.	Comms	Head of Comms	March 2019	Complete This is done based on feedback from presentations.
14	Ensure Contingency Planning Comms contacts (Police, Fire and Ambulance) are updated.	Security Director	Head of Comms	Annually	Ongoing Next update due June 2019.

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
			External Communications		
15	Review of Contingency Planning Comms Statements.	Comms	Chief Executive / Head of Comms	March 2020	On target Regular review takes place as per good practice.
16	Bi-annual review of Media Training requirements for Directors and other identified staff.	Comms	Chief Executive / Head of Comms	March 2020	On target
17	Familiarisation with **'**Dealing With The Media' Guidance for State Hospital Spokespeople	Head of Comms	On-Call Directors / CEO	December 2019	**New for 2019/20** This should be read in conjunction with the: • 'Drop the Pink Elephant' (15 ways to say what you mean…and mean what you say) book given to Directors following media training. • The State Hospital's approved 'Media Lines for On-Call Directors' which have been prepared to assist Directors in responding to media enquiries.
			Strategy / Policy		
18	Carry out an interim review and update (if required) of Communications strategies, policies and procedures.	Comms	Head of Comms	By December 2018	Complete
19	Undertake Equality Impact Assessments for Communications.	Equality Act	Head of Comms	March 2019	Complete

6. QUALITY IMPROVEMENT (QI) OBJECTIVES

The following table details QI Objectives for 2018/19 including progress against same:

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
		Internal Communications			
01	Undertake Annual Patient Experience Questionnaire.	PCISG	PCIL	Ongoing	Complete As a result of patient feedback, a decision was made 2018/19, supported by SMT, to cease facilitation of this questionnaire. **New for 2018/19** Feedback will continue to be sought through a range of methods including What Matters To You?, social events and targeted questionnaires.
02	Develop a Workbook to promote patient physical activity and wellbeing.	Supporting Healthy Choices Steering Group	Physical Health Steering Group (PHSG), Patient Partnership Group (PPG), PCIL and Head of Comms	March 2019	Complete Workbook produced March 2019.
03	Review the existing Patient communication resources.	What Matters To You (WMTY) initiative - June 2017	PCIL / PPG	March 2019	Complete Patient Welcome Pack produced January 2019.
04	Review the existing Volunteer communication resources.	WMTY	PCIL / Volunteer Service Group (VSG)	March 2019	Complete Volunteer Welcome Pack and Induction Workbook produced February 2019.
05	Develop a Volunteer Exit Feedback Form.	WMTY	PCIL / VSG	March 2019	Complete
06	Continue to undertake Staff Engagement Exercises to support corporate objectives.	Directors Objectives	Head of Comms	Ongoing	Continues to be met Clinical Model Principles in October 2018.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
Internal Communications					
07	Ensure effective communication with relevant stakeholders to share updates relating to strategic priorities including the Clinical Model, Sickness Absence, and Nursing Resource Utilisation.	Chief Executive / Service Strategy / Directors' Objectives	All Directors	March 2019	Complete
08	Promote the Hospital's Values and Behaviours through a communications campaign.	Values & Behaviours Group (Sub Group of the Partnership Forum)	OD Manager / Head of Comms	November 2018	Complete A range of items were produced in addition to written communication. These included: a banner stand, mousemats, spectacle cloths, staff banner paper, stickers and posters.
09	Review and update of Security Notices.	Security Director	Physical Security Manager / Head of Comms	End March 2019	Complete These related to Dogs, Key Security, Mobile Phone Detectors, and Restricted Items.
10	Promote the launch of Staff and Volunteer 'Excellence Awards' through a communications campaign.	Values & Behaviours Group	OD Manager / Head of Comms	End June 2019	**New for 2019/20** This will include a banner stand, poster, logo, certificates, nomination boxes, and staff information.
11	Deliver a communications campaign to promote the launch of Staff Long Service Awards.	Values & Behaviours Group	OD Manager / Head of Comms	End June 2019	**New for 2019/20** This involves the production of certificates and badges for 20, 30 and 40 years' service.
12	Promote Manual Handling through a communications campaign.	Manual Handling Advisor	Manual Handling Advisor / Head of Comms	End August 2019	**New for 2019/20** A Display Screen Equipment (DSE) banner stand and patient information 'Manual Handling – Taking Care of Your Back' to be produced.
13	Directors to explore and implement opportunities for becoming more visible across the site.	iMatter	CEO / Directors	March 2020	**New for 2019/20** Specific action as this is a recurring theme from iMatter.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			External Communications		
14	Undertake (and respond to) feedback from the annual Visitor Experience Questionnaire.	PCISG	PCIL	Ongoing	Complete As a result of carer feedback, a decision was made 2018/19, supported by SMT, to cease facilitation of this questionnaire. Feedback will continue to be sought through a range of methods including What Matters To You?, Carers' Week, social events and targeted questionnaires.
15	Explore measures to raise the Hospital's profile and address negative media reporting.	Comms	Chief Executive / Head of Comms	March 2019	Complete Meetings with Editors and the placing of features in appropriate magazines / journals was discussed. As in previous years, a decision was made not to progress at this time. Two letters were written to the Editor of the Daily Record (Nov 18 and Jan 19) with no response. Contact was made with the new Programme Director at See Me (Callum Irving) (Jan 19). Media Synopsis for January and February 2019 was produced for Board discussion following 21 published articles; most of these relating to an individual patient. Additionally in March 2019 the Board considered and subsequently declined a request for a documentary by the BBC.
16	Review the existing Patient Visitor communication resources.	What Matters To You initiative - June 2017	PCIL / Carers' Support Group (CSG)	March 2019	Complete Patient Visitor Information Pack produced March 2019.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
External Communications					
17	Produce a PCIS banner for the Patient Visitor Reception Area.	PCIS	PCIL / Head of Comms	End June 2019	**New for 2019/20**
18	Develop clinician recruitment marketing materials to take out to recruitment fairs.	Director of Nursing & AHPs	Head of Comms	March 2019	Complete Recruitment materials for registered and unregistered nursing staff have been developed by our Professional Nurse Advisor, and used at recruitment fayres during 2019. These have been developed at zero cost. State Hospital branded pull up banners have also been provided for these events, which are a shared resource for the Board.
19	Produce Media Lines for On-Call Directors.	Directors	Head of Comms	December 2018	Complete
20	Redesign and relaunch of State Hospital Website.	Board	Head of Comms	March 2020	On target
21	Ensure research is shared through the Website.	Board	Research & Dev Mgr Medical Director	March 2020	On target R&D Manager to provide web links to all confirmed publications and also include link to the Forensic Network Current Awareness Bulletin which includes details of all State Hospital Journal publications.
22	Create a new section on the State Hospital Website for Freedom of Information (FOI) Disclosure Logs and populate.	FOI legislation	Information Governance and Data Security Officer / Head of Comms	March 2019	Complete – new section. Ongoing – population.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			Collaborative Working		
23	Align outputs arising from the recommendations of the internal audit (November 2015) relating to the efficacy of feedback processes, together with feedback from Scottish Public Services Ombudsman (SPSO), Scottish Health Council (SHC) and internal audit relating to complaints.	Internal and External Audits	PCIL (Feedback) Head of Corporate Planning and Business Support (Complaints)	March 2019	Complete
24	Facilitate What Matters To You? Initiative seeking the views of patients, carers and volunteers.	HIS	PCIL	Annual	Continues to be met every June
25	Be actively involved in the National Board Review Groups and work supporting the National Collaborative.	National Boards Collaborative	Head of Comms for Comms strand	As required	Continues to be met In Spring 2018 The State Hospital was part of group looking at efficiencies across four strands: Design, Media, Print Publishing, and Web. This included assessing options appraisals. This resulted in the production of a Publications Protocol for NHSScotland in November 2018. In January 2019 The State Hospital contributed to the development of the National Collaborative logo and engagement plan. **New for 2019/20** State Hospital features evidencing collaborative working to be produced Summer 2019 for the National Collaborative newsletter.
26	Explore a Memorandum of Understanding with another National Board as a means of strengthening resilience during any long-term absence.	National Boards Collaborative	Head of Comms / Chief Executive	Postponed to March 2020	On target Draft MoU produced for approval in July 2018 by the Golden Jubilee Foundation. Postponed pending recruitment of new GJF CEO and State Hospital CEO.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			Collaborative Working		
27	With NHSScotland Comms colleagues to provide communications around EU Exit Preparedness.	Strategic Comms Group	Head of Comms	As required	Ongoing in parallel with local resilience planning.
28	Develop the leadership needs of NHSScotland Communications professionals: Directors of Comms and Heads of Service.	Strategic Comms Group	Strategic Comms Leadership Sub Group	December 2019	On target Sub Group comprises State Hospital Head of Comms and a member from Greater Glasgow and the Golden Jubilee. An audit of needs was undertaken in 2018 with 18 of the 22 Boards responding. Three key areas were highlighted for development: • How to persuade at senior management / board level. • Demonstrating value delivered by our teams. • How to build credibility of communications work across the organisation. Options are currently being explored to meet these particular needs.
			Equality, Diversity and Rights		
29	Undertake a scoping exercise relating to carer involvement in Care Programme Approach (CPA) review meetings / transfer planning process.	CSG	PCIL	April 2020	On target The Mental Health Practice Steering Group are supporting this piece of work. Timeframe is a three year plan as part of the Equality Outcomes workstreams.
30	Consult, publish and implement updated 2017/20 Equality Outcomes.	PCISG	PCIL	Every three years	Complete for 2017/18. Next update due April 2020.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
		Strategy / Policy			
31	Develop a Person Centred Improvement Service Delivery Plan.	Feedback from internal and external stakeholders	PCIL	July 2018	Complete
32	Produce a Supporting Patient Communication Policy.	Legislation, national drivers and local feedback	PCIL	March 2020	On target 50% complete.
33	Review Communications Resilience Risk Assessment (departmental risk register).	Risk Management	Head of Comms	December 2018	Complete This is subject to regular review.

7. OUTCOMES AND EFFECTIVENESS

The following are examples of positive outcomes evidencing effectiveness achieved during the year.

7.1 Patient / Carer / Volunteer Focus

- A Patient Engagement Workshop took place in October 2018 to review the Principles of the Clinical Model.
- A Patient Workshop was facilitated in February 2019 to elicit patient feedback as part of the review of the Clinical Care Model.
- Patients, carers and volunteers shared their feedback directly with the Mental Health Minister within the Stakeholder session of The State Hospital's 2018/19 Annual Review meeting (January 2019).
- The new information packs produced for patients, patient visitors and volunteers were positively received.
- The 2018 Carers' Week event produced consistent feedback relating to the value placed on engaging in socially inclusive events in the Hospital as well as understanding the therapeutic value of Skye Centre patient activities.
- The 2018 What Matters to You? Initiative was well supported throughout the Hospital with 31 of the 52 actions achieved by the end of the financial year.
- To meet GDPR legislative requirements, all patient, carer and volunteer information was reviewed and updated.

- Networking: Presentations / Workshops were delivered throughout the year to share best practice, address stigma and respond to national drivers on a range of topics including Spiritual & Pastoral Care, What Matters To You?, Volunteering including development of Impact Assessment Tool & Volunteer Visitor Programme, Person Centred Quality Improvement initiatives including flexible visiting and engaging hard to reach patients, Equality agenda including Protected Characteristics and Equality Impact Assessments.

- To ensure the Board has the opportunity to learn from the experience of patients, carers and volunteers, emotional touchpoint presentations regularly feature on the Board's agenda.

7.2 Internal Communications

- iMatter continues to have a good response rate – with results being shared with staff at all levels - and actions embedded within the Staff Governance Action Plan. The National Health and Social Care Staff Experience Report 2018 showed The State Hospital having achieved a response rate of 77% and we received a board report. The average response rate for NHSScotland was 59% for 2018, below the required 60% to produce a national report.

- Staff continue to contribute to the Staff Bulletin and Staff Newsletter 'Vision' which evidences success. Additionally, the Staff Bulletin ensures that all staff are well informed, no matter where they work or what their role is.

  - ✓ Internal and external events are advertised through the Staff Bulletin, Intranet and Email. As a result, high attendance at the following events, shows that these communication methods continue to work well: the weekly Journal Club, annual State Hospital Clinical Effectiveness & Research Conference, annual NHSScotland Event, health promotion events, learning opportunities, and general conferences and events internal and external. Additionally, a significant amount of lego was donated for a patient project following a request for same in the staff bulletin.

  - ✓ The staff bulletin continues to be a key communications tool to support the work of departments, groups and committees. For example, in terms of training opportunities promoted throughout the year:

    - o Further / Higher Education Bursary Award Scheme - applicants for 2018/19 sought (Apr 18) – there were 11 applicants of which seven were supported / approved.

    - o Further / Higher Education Bursary Award Scheme – applicants for 2019/20 sought (Mar 19) – seven applicants of which six were supported / approved.

    - o Staff Development Opportunity! Forensic Mental Health (SCQF Level 8) (Jan 19) – three applicants and all completed the course.

    - o Motivation, Action & Prompts (MAP) Training (Sep 18) – 11 staff attended / completed the course.

    - o New Turas Appraisal Tool – Awareness Sessions (Apr 18) – 32 awareness sessions delivered with 235 staff attending.

- ✓ The staff newsletter 'Vision' is used to provide feedback to staff on the aforementioned events and activities. It is also used to introduce staff through the regular 'Getting To Know Your' article. In 2018/19 over 20 staff appeared in Vision including a Non-Executive Director. These numbers don't include a feature which included around 20 members of staff in a photograph.

- Feedback arising from the policy consultation process (housed on the Intranet and advertised through the Staff Bulletin and Email system) evidences that staff are taking the time to read formal communications and respond. For example, there were: (1) 26 responses to the Patient Use of the Telephone Policy (some were collective, (2) six responses (including two collective) to the Palliative and End of Life Care Policy and Procedure, (3) four responses to the Food Fluid and Refusal Policy, (4) two responses plus one collective to the Unescorted Grounds Access Policy.

- Responses to Staff Engagement Exercises (issued by Email, housed on the Intranet and advertised through the Staff Bulletin) show that our electronic communications are well utilised by staff. For example, Clinical Model Principles in October 2018.

- Through dedicated communications staff were made aware of the financial pressure that the Board was experiencing in the year and measures that needed to be put in place to ensure year-end financial targets were met. As a result, our financial target for 2018/19 was met and were able to plan for sustainable service delivery in 2019/20 and onwards.

- Email is used to support staff with items sought or no longer required. This works very well.

- During January 2019, Communications assistance was given to the writing of poster abstracts for submission in respect of the NHSScotland Event 2019. This included researching the scoring criteria and subsequently developing a State Hospital staff information sheet providing guidance. Two of the Hospital's three abstracts were successful. This was a major achievement for the Board having not had an abstract accepted for many years.

7.3 External Communications

- Our State Hospital general presentation to local community groups continued to be received well. This is evidenced through our feedback forms which are extremely positive. Our presence in the local community leads to requests for further talks and helps to reduce stigma around mental health.

- Hosting visits to the Hospital ensures a wider audience learns about our work and enables the opportunity of sharing best practice and networking. Details of these visits are included in the Chief Executive's Report to each Board meeting.

- At each Board Meeting, the Chairperson provides feedback from the NHSScotland Chairs' Meeting. This ensures the Board is aware of what is happening nationally and includes updates on targets and priorities.

- An 'At a Glance' summary information sheet covering Key Performance Indicators (KPIs) was developed in December 2018 for the 2017/18 Annual Review in January 2019. This was the first time an 'accessible information sheet' had been produced and was positively received.

- Through the effective management of media enquiries, we were able to protect the Hospital's reputation by either (1) squashing what could have been a potential news story or (2) by lessening the impact of a negative story through rebutting inaccuracies and providing information to ensure fair and balanced coverage. Details of media enquiries / contacts are shared with Scottish Government colleagues and we often work together to ensure a joined up response by sharing lines etc.

- Every day we receive enquiries through the State Hospital's general email address: tsh.info@nhs.net.

- Freedom of Information (FOI) requests and general enquiries continue to be received through the general State Hospital email box (tsh.info@nhs.net) evidencing that this is not only effective but a popular resource.

- In 2018/19 a total of 24,304 people visited The State Hospital's Website; a slight increase from 21,161 in 2017/18. 77.7% were returning visitors. This shows that the Website is a good source of information and people are visiting again and again.

    - ✓ The most popular publications downloaded were About Us, Student Nurse Leaflet, Board Biographies, Safety and Security Requirements, and Restricted / Prohibited Items.

    - ✓ Our home page was the most popular page in 2018/19 (receiving 17,151 visits) followed by Jobs – 1,570, Contact Us - 873, Board Who's Who - 648, followed by Official Visitors, Public Safety, Board Papers and Patient Visitors.

8. SUMMARY

Given the nature and organisational arrangements of the Board, patients are uniquely viewed as internal communication stakeholders in addition to Non-Executive Directors, Volunteers, the Chaplaincy Team, Advocacy and staff. Carers, the public and the media are included within external communication arrangements.

The two services predominately delivering internal and external communications are the Communications Service and the Person Centred Improvement Service (PCIS) although the Intranet is managed by eHealth.

Overall, core Communications tasks were delivered, all legislative requirements were met, and all financial targets / savings were achieved. However more needs to be done:

- To review the functionality / effectiveness of the Intranet which is currently unsupported by Microsoft.
- To address negative media reporting and to raise the profile of The State Hospital (both within and outwith NHSScotland) with all stakeholders including regulators, partner organisations, the public, the media etc. Disappointingly, as in previous years, some negative coverage has been initiated via leaks by staff to the media. Attempts to source these individuals have been unsuccessful.

These issues should in no way detract from the good work that has taken place across all strands of communications, both internal and external, attracting positive attention.

June 2019

Paper No: 19/65

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 21
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Corporate Governance Improvement Action Plan
Purpose of Report:	For information

1 SITUATION

Following Board self-assessment, an improvement plan was developed to support key corporate governance priorities as part of the Corporate Governance Blueprint.

The Board submitted its improvement plan to Scottish Government in April 2019.

2 BACKGROUND

The five key areas of the improvement plan are outlined as follows:

- Setting the Direction
- Holding to Account
- Assessing Risk
- Engaging Stakeholders
- Influencing Culture

3 ASSESSMENT

The improvement plan has been updated to indicate progress against each item (Appendix A) and the Board is asked to note the content of the updated plan, as well as the assurance mechanism through which progress will continue to be monitored.

In particular, the Board is asked to note the work progressed on the development of a strapline statement to be included in corporate documentation. A competition was held in the hospital, and the following strapline has been developed and implemented: *Safe and Secure, Care and Treatment*. [Refer to Action Point 1]

The Board will receive an update on a review of the performance framework presented to the Board separately on today's Board Agenda at Item 17. [Refer to Action Point 7]

Work is on track in relation to attendance management with a roll out of training sessions to Human Resources officers as well as line managers across the organisation, which commenced in June and is ongoing. This is alongside focus on the ongoing roll out of the national HR policy framework. [Refer to Action Point 5]

There has been significant progress made to implement a staff recognition scheme, and the first staff awards ceremony will take place in the Skye Centre on 25 September 2019. It is of note that this venue has been chosen as enables attendance by patients who have been able to participate in nominating staff. All Board Members are welcomed to attend the ceremony. In the meantime, some awards for long service to the NHS have already been presented to individuals by the Chief Executive. [Refer to Action Point 16]

The Board is asked to note that it is proposed that the next meeting of the Board in October should take place outwith the hospital, at an external location in the local area to support accessibility and engagement with the wider public. [Action Point 16].

Senior Management visibility through regular front line staff engagement with the Chief Executive and the wider Executive cohort has been promoted through the Lead for Organisational Development. The Chief Executive has met with a range of staff groups through attendance at their business meetings. The second phase of this engagement will be a roll out of engagement sessions with the wider Executive cohort commencing in October 2019. This is in conjunction with the specific measures outlined within the Board's response to the Sturrock report. [Action Point 18]

Non-Executive Board Members wish to increase their own visibility on site. However, the secure environment of TSH means that this is a more complex undertaking than for NHS Boards more generally, particularly in relation to engagement with patients. [Refer Action Point 21]. The Board Secretary will plan and implement the following suggested routes to help to increase Non-Executive Director visibility across TSH.

The most appropriate route for patient engagement is through the Patient Partnership Group which meets regularly on Monday mornings. The Person-Centred Improvement Lead will support Non-Executive's attendance at these meeting and can be a helpful route through which to ascertain patient feedback in this regard to help monitor the effectiveness of the engagement experience.

The Chair and the Non-Executive Directors already participate in Leadership Walkrounds in the hospital and this formal role should still be supported as a priority. In addition, Non-Executives have committed to increasing their visibility within TSH through attendance at hospital events and use of hospital facilities such as the canteen regularly. To support further engagement in clinical areas, Non–Executives will be invited to participate in clinical walkrounds that take place regularly led by the Medical Director and Director for Nursing and AHPs. As access to clinical areas can present challenges, it is important that this be tested over the coming months for appropriateness and effectiveness.

The Chair and Non-Executives are also invited to participate in staff induction sessions – to help welcome new staff coming in to the organisation, outlining TSH aims and values. A programme will be rolled out in line with the staff induction programme.

4 RECOMMENDATION

The Board is asked to note progress in implementation of the improvement plan, and to discuss the progress made to date as well as further suggested routes to take the action plan forward.

A further update will be brought to the next meeting of the Board in October 2019.

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MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Corporate Governance Blueprint
Workforce Implications	None identified to date
Financial Implications	None identified to date
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board Standing Committees/ SMT
Risk Assessment (Outline any significant risks and associated mitigation)	None identified to date
Assessment of Impact on Stakeholder Experience	Implementation will benefit stakeholder engagement through the workstreams indicated in the improvement plan
Equality Impact Assessment	Not formally assessed
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No impact identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND - IMPROVEMENT PLAN **Appendix A**

BLUEPRINT FUNCTION		ACTION	LEAD	ASSURANCE SYSTEM	TIMESCALE	PROGRESS
SETTING THE DIRECTION	1	Reconfirm the Board's strategic direction, and communicate this through the Strategy Map and development of strapline statement for corporate documents.	CEO	CEBM	June 2019	**Completed:** Strapline finalised following hospital wide competition. Strategy Map reviewed as part of review of Corporate Objectives.
	2	Review of effective rostering system within nursing as component of focus on effective workforce utilization and safe staffing legislation.	Director of Nursing and AHPs	SMT	March 2020	Review In progress.
	3	Development of more robust processes to compare planned and actual spend and to account for any variance.	Director of Finance	SMT /Board	September 2019	Update to October Board.
HOLDING TO ACCOUNT	4	Ensure compliance with new national guidelines in management of Executive pay and performance through remuneration Committee approval for annual ESM pay and performance cycle.	Chair /Interim HR Director	Remuneration Committee	Ongoing	On Track
	5	Ensure implementation of attendance management policy through support from HR to line managers help identify and act upon patterns of absence. Continued implementation of the action plan developed through the Attendance Management Improvement Task Group (AMITG).	Interim HR Director	AMITG/ SMT	October 2019	On Track. Training for Line Managers and HR Managers implemented in June and July, with further sessions ongoing. Update presented on attendance management to each Board Meeting.

	6	Implementation and compliance with Once for Scotland HR policies within TSH. Focus on policy awareness through completion of metacompliance / staff bulletins/ staff training in Single Investigatory process.	Interim HR Director	Partnership Forum/SMT	December 2019	On Track – following roll out of the national guidance.
	7	Review performance framework and assurance information systems to support review of performance.	CEO	CEBM	July 2019	Update to August 2019 Board Meeting.
	8	Blueprint Improvement Plan to be placed on Board Workplan for review at each Board Meeting.	Chair	Board	June 2019	**Completed**
ASSESSING RISK	9	Further development of risk management with focus on risk register to ensure this is clearly defined with set of mitigating measures against each risk which also have a focus on improvement actions.	Director of Finance	Audit Committee / Board	December 2019	Update to Audit Committee – October 2019
ENGAGING STAKEHOLDERS	10	Review and develop the Communications Strategy to include proactive engagement with aim of addressing dissonance between strategic aims of the hospital and public perception of these aims.	CEO	Board	March 2020	Review in progress with regular updates to the Board.
	11	Promotion of The State Hospital as an employer in the local area. Increase number of modern apprenticeships. Participate in local school careers	Interim HR Director	SMT	March 2020	Ongoing – engagement commenced in university recruitment fairs. Recruitment Fair at TSH in September 2019

		events, local and university recruitment fairs				(Outwith secure area to enable public engagement).
	12	Encourage carers / volunteers /staff / local population to attend public Board Meetings through additional promotion and links with local community.	Board Secretary	Board	September 2019	In progress – Update to October Board
	13	Hold two Board Meeting each year at external locations to promote role as national Board.	Board Secretary	Board	April 2020	Plan In progress – Update to August Board
	14	Annual Review - Public Meeting to be held outside of the hospital to help engage public engagement and attendance.	Board Secretary	Board	April 2020	Plan to be progressed as part of Annual Review 2018/19.
INFLUENCING CULTURE	15	Define culture in The State Hospital in terms of key strengths and weaknesses - take forward through development sessions	CEO	Board	December 2019	Review in progress – Update to December Board.
	16	Implement a Staff Recognition Scheme for long service as well as individual contribution to the organisation.	Interim HR Director	SMT	September 2019	On Track - first ceremony scheduled for 25 September 2019.
	17	Embed a culture of quality across the organisation through initiatives such as TSH3030, Quality Forum and sharing our work more widely.	CEO	SMT	March 2020	On Track - QI Forum initiatives underway. TSH 3030 planning initiated for November 2019
	18	Senior Management visibility through regular front line staff engagement meetings with CEO / Directors' Group	CEO	SMT	July 2019	CEO Business Meetings venue held weekly across site, for visibility. CEO attending staff groups across site. OD Lead

		- plan a calendar of events to ensure regular engagement.				supporting wider engagement plan for Exec Leads commencing October 2019.
	19	Senior Team / RMO presence at key events in hospital calendar e.g. patient learning awards/ sportsman dinner. Promote this through management structures.	CEO / Medical Director	SMT	September 2019	Coordination of central diary of events to help facilitate attendance.
	20	Link in with Scottish Government once appointment of the Independent National Whistleblowing Champion has been appointed.	CEO	Board	April 2020	National Recruitment underway
	21	Plan a schedule of Non-Executive Director informal visits across TSH to help promote the values and behaviours of the organisation.	Chair	Board	August 2019	Update to August Board, with planned schedule including walkrounds, staff induction and patient engagement.

Board Paper 19/66

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 22
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Annual Review Outcome Letter
Purpose of Report:	For Noting

1 SITUATION

The Minister for Mental Health has written to the Board Chair to summarise the key points from the Annual Review 2017/18, which took place at The State Hospital on 14 January 2019.

2 BACKGROUND

The purpose of the letter (Appendix A) from the Scottish Government is to inform the Board of the outcome of the 2017/18 Annual Review. The letter provides a summary of the main points of discussion and actions arising from the review.

3 ASSESSMENT

The Board should note the summary provided in relation to the meetings that took place as part of the review with the Clinical Forum, the Partnership Forum and with Patients, Carers and Volunteers.

The letter provides an update on the progress made by the Board in relation to the actions arising from the 2016/17 Annual Review; as well as setting out the actions arising from the 2017/18 Annual Review.

The Board has not yet been notified of the date of the 2018/19 Annual Review – an update will follow in this regard, once this is available.

4 RECOMMENDATION

The Board is invited to note this update.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Update information only
Workforce Implications	As detailed within report
Financial Implications	Not relevant
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested information
Risk Assessment (Outline any significant risks and associated mitigation)	Not required
Assessment of Impact on Stakeholder Experience	As detailed within report
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	This is not relevant
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Minister for Mental Health
Clare Haughey MSP

Scottish Government
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Mr Terry Currie
Chair, The State Hospitals Board for Scotland
The State Hospital
Carstairs
Lanark
ML11 8RP

18 June 2019

Dear Terry

I am writing to summarise the main points from the 2017/18 Annual Review at the State Hospital on 14 January 2019. Following the format from last year, this letter provides a brief summary of the key points from the Annual Review, progress on actions from the 2016/17 Review and agreed actions for 2018/19.

Clinical Forum

I welcomed the update on how the Clinical Forum has established itself since 2017 and its ongoing work. In particular, I was pleased to hear about the TSH3030 quality improvement initiative, which has engaged staff and delivered improvements across the Hospital, and the ongoing work to review the clinical model, in consultation with patients and staff.

The Mental Welfare Commission for Scotland's report following their visit to the Arran and Mull hubs on 30 August 2018 noted that there were not sufficient staff to ensure provision of activities in line with patients' need. I welcome the recent recruitment of staff to the Hospital, with further recruitment to take place shortly, and I was also pleased to hear about the Patient Active Day project, which aims to increase patient participation in activities despite challenging circumstances, and some additional out-of-hours activities at the request of patients. I look forward to hearing how the new staff and increased focus on activities lead to further participation by patients in the future.

The physical health of patients is a crucial part of their care and treatment, so I was encouraged to hear about the Primary Care team within the Hospital and the improved liaison and handover processes with Wishaw General Hospital for offsite treatment. I was also interested in the various ongoing measures to tackle obesity – I look forward to hearing how effective these measures are over time and how their impact is assessed. I would encourage the Clinical Forum to consider having the Primary Team represented on the Forum and to further broaden connections with other clinicians and organisations outside of the Forensic Network.

Partnership Forum

I was encouraged to hear that both management and staff-side representatives are committed to partnership working, particularly given some of the challenges presented in 2018.

As in the Clinical Forum, I welcomed the recent recruitment of staff, along with further imminent recruitment, which will provide more staffing flexibility and reduce pressure on existing staff. The plans to encourage newly-qualified nurses to work at the Hospital were interesting, particularly given the number of current staff who are approaching retirement age.

Given the historically high levels of sickness absence at the Hospital, I was pleased to hear about the reformation of the Attendance Management Group, the various measures in place to tackle sickness absence levels and the ambition to reduce sickness absence by 3% by the end of 2018/19.

Regarding leadership, there were a number of positive steps including an increase in the number of senior charge nurses, a new development course for existing senior charge nurses and a National NHS Board collaboration project on development for managers.

I look forward to seeing the effects that all we discussed have on standards of patient care, patient and staff safety, overtime and sickness absence levels.

Meeting with Patients, Carers and Volunteers

It was a privilege to meet with patients, carers and volunteers as part of the Review and I wish to thank them again for giving their time to meet with me.

The patients I met were involved in representing patients on different groups and boards, evidencing positive engagement and a willingness from the Hospital to involve patients in decisions that affect them. The patients spoke positively about the staff, volunteers, social events, family visits and activity placements at the Skye Centre, but raised issues with staff continuity and familiarity, having to remain in their rooms during periods of reduced staffing and not being more involved in the types of activities that were planned.

The carers I met also praised the staff and the work done at the Hospital, although they raised frustrations with having to travel long distances for meetings at the Hospital which are scheduled early in the morning, necessitating travelling the day before and staying overnight.

The two volunteers shared their experiences of visiting patients who would otherwise have no visitors at all and highlighted the positive effect that this has on the patients, particularly those who are extremely unwell.

I look forward to the Board increasing engagement with patients, carers and volunteers and handling the issues raised by them. In particular, I'm interested in how they might use technology to solve issues such as carers travelling long distances to visit patients and attend meetings.

Actions

I have set out the progress on action points from 2016/17 Annual Review in the attached Annex A – further detail on all of the points is provided in your Self-Assessment document which has been published on your website. Annex B lists the action points arising from the 2017/18 Annual Review. While I appreciate the delay is inconvenient, the actions in Annex B were discussed in depth on the day of the Annual Review and I recognise that State Hospital management are already looking at these matters. I look forward to hearing about the progress that has already been made in 2018/19.

In closing, I would like to thank all of the staff, patients, carers and volunteers that I met for being generous with their time. In particular, I'd like to extend my thanks to the Board Secretary, Margaret Smith, for organising the Annual Review programme, especially the impromptu ward visit that was arranged on the day.

Since the Annual Review took place, I note that Gary Jenkins has been appointed to the post of Chief Executive. I look forward to working with Mr Jenkins and I'd like to thank outgoing Chief Executive Jim Crichton for his service. Additionally, Terry Currie's appointment as Board Chair has been extended to provide continuity as Mr Jenkins takes up his post and to assist with the Scottish Government's review for forensic mental health services across Scotland. I thank Mr Currie for agreeing to remain in post for a further 12 months while this crucial work is carried out.

Clare Haughey

ANNEX A

The State Hospital Annual Review 2017/18 – Progress on Actions from 2016/17 Review

1. The State Hospital to keep Health Directorates up to date on progress in partnership working.

    - Both management and staff-side representatives remain committed to partnership working, although staffing levels, sickness absence, informal action and negative media coverage have been challenging. Achievements include the cap on overtime, recruitment of staff to a flexible nursing pool and consultation on a new Clinical Model.

2. The State Hospital to keep the Health Directorates up to date on improving the physical wellbeing of patients, particularly on work to support patients in relation to diet and obesity.

    - Physical health remains a challenge, but staff upskilling to improve this is in progress and better connections with the local hospital are in place for offsite care. Various measures are in place to reduce obesity among patients and their effectiveness should be closely monitored.

3. The State Hospital to keep Health Directorates up to date on action to address reducing the levels of aggressive incidents by patients.

    - All high-graded incidents are regularly reviewed and a new risk assessment tool is in place across wards. A small number of patients are often responsible for a large number of assaults, so there should be focus on handling this. Staff training on preventing and managing violence and aggression is ongoing and uptake should increase following recruitment of new staff.

4. The State Hospital to keep Health Directorates up to date on action to improve performance in relation to sickness absence and on further work on value and behaviours.

    - Further focus on sickness absence is needed to reduce it, particularly in order to meet the 3% reduction target set by the State Hospital for the end of 2018/19. The effectiveness of the various measures in place should be closely monitored.

5. The State Hospital to continue to keep Health Directorates up to date on all matters relating to media activity and any correspondence with patients and families and/or carers which may require government officials and/or Ministers to become involved.

    - During the reporting period 1 April 2017 to 31 March 2018, no media activity or correspondence required Scottish Government officials or Ministers to become involved. However, there was significant negative media coverage in the second half of 2018. The State Hospital continue to keep officials up to date with the media queries they receive and their responses to these.

6. The State Hospital to liaise with the Health Directorates on succession planning for key senior roles.

    - The Board informed Scottish Government officials of various upcoming changes to senior posts. Effectiveness of handover to new staff should be monitored closely.

ANNEX B

The State Hospital Annual Review 2017/18 – Action Points for 2018/19

1. The State Hospital to keep the Scottish Government up to date on partnership working.

2. The State Hospital to keep the Scottish Government up to date progress to improve the physical health of patients.

3. The State Hospital to keep the Scottish Government up to date on progress to reduce the levels of aggressive incidents by patients.

4. The State Hospital to keep the Scottish Government up to date on progress to reduce levels of sickness absence.

5. The State Hospital to keep the Scottish Government up to date on all matters relating to media activity and any correspondence with patients and carers which may require government officials and/or Ministers to become involved.

6. The State Hospital to keep the Scottish Government up to date on succession planning for key senior roles, particularly the new Chair and Chief Executive.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the meeting of the Audit Committee held on Thursday 28 March 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

PRESENT:

Non Executive Director	David McConnell **[Chair]**
Non Executive Director	Maire Whitehead

IN ATTENDANCE:

Internal

Board Chair	Terry Currie
Finance and Performance Management Director	Robin McNaught
Director of Nursing and AHPs	Mark Richards
Interim Human Resources Director	Kay Sandilands [Items 5-6]
Board Secretary	Margaret Smith

External

Senior Manager, RSMUK	Asam Hussain
Director, Scott Moncrieff	Karen Jones
Head of Internal Audit, RSMUK	Marc Mazzucco

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting. Apologies for absence were noted from Mr Bill Brackenridge, Mrs Anne Gillan and Ms Monica Merson. Mr Mark Richards was in attendance in place of the Chief Executive, Mr James Crichton, who had also offered apologies to the meeting.

NOTED

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted.

NOTED

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 24 January 2019 were approved as an accurate record.

APPROVED

4 MATTERS ARISING AND ACTION NOTES UPDATE

Mr Richards provided an update on Action point three - in respect of the wider workforce (including non -professionally registered staff) being reminded on their duties around breach of confidentiality. He confirmed that appropriate reminders had been issued to all staff and that it was a mandatory requirement for all staff to complete an online learning module on information governance.

Mr McNaught provided a further update on the review of patients' funds - particularly those patients who do not meet the requirements for access to benefits. He noted that there were four patients within the hospital in this position. The payments were discretionary with no legal requirement to pay monies to these patients, but no legal barrier to doing so. A review of the individual circumstances indicated that to withdraw these payments could cause disadvantage and hardship. Members noted that in these circumstances, the payments should continue and the situation be kept under review, and were content with the decision resting with the Chief Executive Officer. Mr McNaught would ensure that this was noted within the policy.

Action - Mr McNaught

NOTED

5 ATTENDANCE MANAGEMENT REPORT

A report was submitted by the Interim Director of Human Resources (HR) which provided Members with an update on attendance across the organisation based on the data available from January 2019. Although this figure was 9.25%, there were early indications of a significant improvement for the month of February 2019.

Members noted the reasons for absence, highlighting the figure for anxiety, stress and other psychiatric illness. Ms Sandilands advised that the figure of 34.47% did not vary significantly with other NHSScotland Boards. Work was in progress with the Head of Psychological Services which was focussed on providing appropriate support to staff, particularly on preventative measures.

Ms Sandilands also highlighted the Once for Scotland national policies, and that the attendance management policy would be effective from 1 April 2019.

NOTED

6 LONG TERM SICKNESS ABSENCE TREND REPORT

A report was submitted by the Interim Director of Human Resources (HR) which provided Members with an update on the long term sickness trend data within the hospital. Members were content to note this report, following the discussion in the previous item.

NOTED

7 FRAUD UPDATE

A report was submitted by the Director of Finance and Performance Management to provide an update on fraud allegations and any notification received from Counter Fraud Services.

The Committee were content to note the detail of the report.

NOTED

8 FRAUD ACTION PLAN

The Committee received and noted the paper which provided an update on Board engagement with Counter Fraud Services (CFS). Mr McNaught advised that the annual review with CFS would take place later on this same day. A minor amendment was noted for the paper - as the workplan for CFS was note not yet to be available.

Action - Mr McNaught

Members also discussed and agreed that a review of the actions on the plan would be helpful with those actions already noted as closed being removed and the plan re-freshed.

Action - Mr McNaught

NOTED

9 CORPORATE RISK REGISTER UPDATE

The Committee received a paper from the Director of Finance and Performance Management which provided an update on the current risk registers.

Mr McNaught highlighted the key points noting that all risks were reviewed at the Risk, Finance and Performance Group which met on a quarterly basis. Further discussion in respect of the Corporate Risk Register would be picked up under Item 17 - Risk Management Audit Report.

NOTED

10 POLICY UPDATE

A paper was received from the Director of Finance and Performance Management, to advise of progress on updating of policies throughout the organisation. This continued to be led through the Clinical Effectiveness team. The good progress made to date was noted with a process of policy review and update agreed through the Senior Management Team (SMT).

Members discussed the consultation process for new or amended [policies?] with staff which included a three week period communicated through staff bulletins. This involved the policy holder undertaking review of the policy with a team of stakeholders as appropriate to each policy. Further was arrangements are in place in particular areas for detailed policy review e.g. the Infection Control Committee took a leading role in respect to infection control policies. It was also noted that, following consultation, all policies were submitted to SMT for final approval.

The Committee underlined the importance of staff engagement especially around cornerstone polices and indicated that there should be testing of the consultation process for robustness. Mr McNaught will take this forward, e.g. with a policy currently out for consultation.

Action - Mr McNaught

NOTED

11 CATEGORY 1 AND 2 ADVERSE EVENT REVIEWS

The Committee received an annual update report on all outstanding actions arising from Category 1 and Category 2 adverse event reviews, and noted that the Chief Executive took the lead in reviewing progress with the Director group.

In particular, it was noted that TSH was working with NHS Lothian in relation to Hospital Electronic Prescribing and Medicines Administration (HEPMA) in terms of the national programme.

Members expressed concern in respect of the timescales for completing adverse event reviews, and bringing these to SMT for approval. It was noted that a further report was being brought to the Clinical Governance Committee in this regard.

NOTED

12 RESILIENCE COMMITTEE - UPDATED TERMS OF REFERENCE

The Committee noted the minor changes made to the terms of reference for the Resilience Committee.

NOTED

13 AUDIT PROGRESS REPORT 2018/19

The Committee received a report from RSMUK which outlined the progress made against the internal audit plan for 2018/19. Mr Mazzucco summarised the report noting that all 2018/19 assignments had been completed. He noted that two reports had been issued and finalised since the date of the last Audit Committee meeting, including a follow up review of previously issued partial assurance opinion reports and that reasonable progress had been made to address the weaknesses found.

The Committee noted this report.

NOTED

14 MANAGEMENT ACTION TRACKING REPORT

The Committee received and noted the tracking report from RSMUK in relation to management actions taken forward in response to internal audit recommendations, which outlined an improving position. It was noted that staffing capacity issues within eHealth had made progress more difficult in that area. RSMUK would also provide further support to the Board through an Internal Audit Action Tracker tool.

NOTED

15 DRAFT INTERNAL AUDIT PLAN 2019/20

RSMUK submitted the internal audit plan for 2019/20 for The State Hospital based on the organisation's corporate objectives, risk profile and Corporate Risk Register as well as other factors affecting the organisation in the year ahead, including any changes known to be planned by Scottish Government.

The plan submitted focussed on five key areas: implementation of the clinical model, rostering and scheduling of workforce, clinical observations, patient property and payroll.

The Committee reviewed the plan, and asked for some amendments. In particular the review of payroll transactions should be conducted in quarter 2 to allow sufficient breadth of oversight that this longer time period would provide. The Committee also asked for a review of how the organisation was identifying and tracking sickness absence patterns as well as the actions taken in response.

Action - Mr McNaught/RSM

On the basis of these amendments, the Committee approved the internal audit plan for 2019/20.

APPROVED

16 SICKNESS ABSENCE MANAGEMENT /

POLICY AND PROCEDURE COMPLIANCE REPORT

The Committee was asked to note a report from RSMUK in respect of policy and procedure compliance - which provided a follow up opinion on progress made in implementing actions from the previous internal audit report. RSMUK reported that from their review and testing of the management actions, The State Hospital had made reasonable progress in implementing the actions outlined in the timeframe agreed upon.

The Committee noted the good progress made to date within Human Resources, as well as the need to sustain this progress.

NOTED

17 RISK MANAGEMENT AUDIT REPORT

RSMUK reported that an advisory review of risk management had been carried out as part of the approved Internal Audit Plan 2018/19. The report noted that whilst The State Hospital's risk management processes were still developing and being refined, the Corporate Risk Register was being actively monitored and reported upon to the Risk performance and Finance Group. The report identified further work required on risk management processes to ensure that risks and mitigating controls were properly defined and linked to strategic objectives. Further work was also identified in relation to local risk registers with clear escalation lines defined for transfer to the corporate risk register when appropriate.

The Committee noted the recommended actions within the report, and highlighted the importance of delivering on these.

NOTED

18 ANNUAL INTERNAL AUDIT REPORT 2018/19

A report was received from RSMUK providing their internal audit opinion on the overall adequacy and effectiveness of The State Hospital's risk management, control and governance processes. It was noted that of the seven reports issued in the year, three had provided a positive assurance opinion and four a negative (partial) assurance opinion. The areas in which partial assurance had been given were revisited by internal auditors either through bespoke follow up review or through routine management action tracking work. Given this follow up and the adequacy of controls at year end, RSMUK were able to provide an overall positive opinion that "The organisation has an adequate framework for risk management, governance and internal control".

The Committee noted and concurred with the advice given by RSMUK that The State Hospital should consider whether any of the control issues highlighted in the partial assurance reports should be included in its Annual Governance Statement together with the progress made to address the weaknesses identified. Mr McNaught noted that the draft governance statement would be shared with the Chair of this Committee as well as the Board Chair and Chief Executive.

Action - Mr McNaught

NOTED

19 INTERIM EXTERNAL AUDIT REPORT

Members received an update from Scott Moncrieff in their role as external auditor. Ms Karen Jones advised the Committee had been provided with a copy letter written to Mr Jim Crichton as Accountable Officer with a summary of findings following the 2018/19 interim audit visit to The State Hospital in February 2019. The interim audit work had not identified any significant

deficiencies in the adequacy or design of internal financial controls over the Board's financial systems. Ms Jones also asked the Committee to note that the final audit visit would take place in May 2019. The annual report on the 2018/19 audit would be presented to the June meeting of the Board.

The Committee were content to note this update.

NOTED

20 ANNUAL REVIEW OF STANDING DOCUMENTATION

The Committee received a report from the Director of Finance and Performance Management to advise that there were no proposed changes to the Standing Financial Instructions; Scheme of Delegation and the Standing Orders.

The Committee provided approval for this documentation to be submitted to the next meeting of the Board.

APPROVED

21 AUDIT COMMITTEE - TERMS OF REFERENCE

The Committee approved the terms of reference subject to one amendment - point 5.4.5 should be amended to note the additional role of the Auditor General in appraising the performance of the external auditors, further to any review by the Audit Committee.

Action - Mr McNaught

APPROVED

22 REVIEW OF ACCOUNTING POLICIES

A report was received from the Director of Finance and Performance Management to provide Committee with an update on the current position with regard to any changes to Accounting Policies based upon Financial Reporting Manual guidance.

It was noted that prior year adjustments are now replaced by retrospective restatements. IFRS16 on Leases is effective as of April 2019.

The Committee approved these changes.

APPROVED

23 ANY OTHER BUSINESS

The Board Chair, Mr Currie, advised colleagues that he had been invited by the Cabinet Secretary to remain in post until 31 March 2020 and that he had accepted this offer. The Committee offered its congratulations and support to Mr Currie.

NOTED

24 DATE AND TIME OF NEXT MEETING

The next meeting would take place on 20 June 2019 in the Boardroom, The State Hospital, Carstairs.

The meeting ended at 12 noon

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the meeting of the Audit Committee held on Thursday 20 June 2019 at 12.30pm in the Boardroom, The State Hospital, Carstairs.

PRESENT:

Non-Executive Director	Bill Brackenridge
Employee Director	Tom Hair
Non-Executive Director	David McConnell **[Chair]**
Non Executive Director	Maire Whitehead

IN ATTENDANCE:

Internal

Board Chair	Terry Currie
Chief Executive	Gary Jenkins
Finance and Performance Management Director	Robin McNaught
Head of Corporate Planning and Business Support	Monica Merson
Board Secretary	Margaret Smith

External

Partner, Scott Moncrieff	Chris Brown
Director, Scott Moncrieff	Karen Jones
Head of Internal Audit, RSMUK	Marc Mazzucco

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting. There were no apologies to be noted.

NOTED

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted.

NOTED

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 28 March 2019 were approved as an accurate record, subject to one minor amendment.

APPROVED

4 MATTERS ARISING AND ACTION NOTES UPDATE

Progress was noted on the Minute action points and it was agreed that a further update should be brought to the next Audit Committee in relation to Action Point 6 “Policy Update” in respect of testing engagement through the policy consultation process.

Action – Ms Merson

NOTED

5 INTERNAL AUDIT PLAN

Mr Mazzucco presented an update to Members on the Internal Audit Plan and Updated Strategy for 2019/20, highlighting the changes that had been made in response to the discussion and request to do so at the last meeting of the Audit Committee. These changes were summarised as now involving consideration of payroll policies and procedures in Quarter 2 and review of sickness and absence management in Quarter 3. There would be a short follow–up review of Patient Funds and Property in Quarter 2.

Members also discussed the review of the implementation of the Clinical Model planned in Quarter 4, and whether the timing of this would align with the progress of the Model's development and implementation. Subject to the Board approving the introduction of a new clinical model this year, it was agreed that the audit plan should reflect that this would be a review focused on the process of introducing a new model, rather than on final implementation as this was likely to be in progress during Quarter 4.

The Internal Audit Plan was approved on the basis of the updates provided.

APPROVED

6 INTERNAL AUDIT TRACKING REPORT

The Committee received and noted the tracking report from RSMUK in relation to management actions taken forward in response to internal audit recommendations. It was noted that a key area of focus for improvement was in Risk Management, and this was a key area for improvement.

Significant progress had been made within Policy and Procedure Compliance and Sickness and Absence Management. The Committee queried the action point on the requirement to return a self certificate within 7 days of the first day of absence and asked for the Interim Director of HR to clarify this point. Ms Smith would request this on the Committee's behalf.

Action – Ms Smith

It was also noted that The State Hospital (TSH) would take forward the action tracker software in a trial to help in the administration and managing of internal audit action points. Ms Merson would take this forward.

Action - Ms Merson

Members noted that it was essential for the timeframes for moving actions forward were reasonable and achievable and this should be an area of focus for the organisation. In particular it was noted that the actions for Cyber Security, although rated low had been outstanding since March 2018. Mr McNaught assured the Committee that these would be completed before the next Audit Committee.

Action – Mr Mc Naught

NOTED

7 CLINICAL GOVERNANCE COMMITTEE – ANNUAL REPORT 2018/19

The Audit Committee now received a series of reports from the State Hospital's key governance committees, which support its overall consideration of governance arrangements across the organisation.

The Committee received the annual report from the Clinical Governance Committee for 2018/19, and agreed that this detailed report provided assurance that the Committee was fulfilling its remit, and that adequate and effective clinical governance arrangements were in place throughout the year.

NOTED

8 STAFF GOVERNANCE COMMITTEE - ANNUAL REPORT 2018/19

The Committee received the annual report from the Staff Governance Committee for 2018/19. The Chair of the Staff Governance Committee, Mr Brackenridge, summarised this for Members who were noted the report provided assurance that the Committee was fulfilling its remit and that adequate and effective staff governance arrangements were in place throughout the year.

The Board Secretary was asked to make an amendment to the report on page three (the number of meetings) to clarify that the Committee had also met on 5 April 2018. This meeting had originally been scheduled to take place in March 2018 and required to be re-scheduled due to inclement weather.

Action – Ms Smith

NOTED

9 REMUNERATION COMMITTEE – ANNUAL REPORT 2018/19

The Committee received the annual report from the Remuneration Committee for 2018/19. The Chair of the Committee, Mr Currie, provided an overview of this report which demonstrates that the Committee has discharged its responsibilities. The Board secretary was asked to make some minor amendments to the dates of the meetings held as well as to note a change in membership with Ms Carmichael having retired and Mr McConnell having joined the Board as a Non – Executive Director.

It was also noted that the report should be amended to reflect that the Remuneration Committee provides aspects of reporting through the Audit Committee, but that its direct reporting line is to the Board.

Actions – Ms Smith

On this basis, the Audit Committee were content to note the report.

NOTED

10 AUDIT COMMITTEE - ANNUAL REPORT 2018/19

The Audit Committee received its Annual Report for consideration and approval. As Chair, Mr McConnell provided an overview of the report and Members were content to approve the report as giving assurance that the Committee had met its remit and was satisfied that internal controls are adequate to ensure that the Board can achieve its policies, aims and objectives.

APPROVED

11 NATIONAL SINGLE INSTANCE (NSI) AND NSS SERVICE AUDITS

The Committee received a report to provide an update on the service audits carried out on the NSS National IT Services Contract and NSI finance system. There was nothing of specific impact for TSH from the National Service audit in the year for IT services from which no significant control issues were raised.

There was also an audit on the National Single Instance finance system (which was noted to be delivered through NHS Ayrshire and Arran as host board) from which again there were no control weaknesses noted of relevance to TSH.

These were both unqualified opinions from the Service Auditors, with no critical or significant risk findings for TSH.

NOTED

12 AUDIT SCOTLAND NATIONAL REPORTS

The Committee received a report to provide an update of the recommendations made following publication of Audit Scotland National Reports, and in particular the report "NHS in Scotland". Members noted the content.

NOTED

13 EXTERNAL AUDIT ANNUAL REPORT -2018/19

The Committee received a report from Scott Moncrieff for the year ending 31 March 2019. Mr Brown led Members through the detail of the report, highlighting that the Board had achieved all of the key objectives within financial sustainability, financial management, governance and transparency as well as value for money. The auditor's report was unqualified in all respects. No major new risks had been identified and the key risks of managing sickness absence and overspends on nursing overtime continued to present a significant challenge to the Board's financial position.

Mr Brown gave particular thanks to the Finance Team for their work which had been of a particularly high quality. Ms Jones provided a detailed overview of the audit of the annual accounts, noting no material audit adjustment to the financial statements. She also outlined the key areas for the external audit plan as being management of sickness absence and overspend on nurse overtime.

Ms Jones re-confirmed Scott Moncrieff's position as independent auditors.

Members thanked Scott Moncrieff for their report and noted that an amendment was required to wording on page 31 under the recommendation for the Board on the Asset Register.

Action - Scott Moncrieff

The Committee noted the key messages form the report, and also that there should be continuing consideration of the balance between recurring and non-recurring savings, and that this report provided timely and appropriate recognition of this. Mr McNaught provided assurance that this would be reviewed as appropriate.

Action – Mr McNaught

The Audit Committee noted the content of this report.

NOTED

14 STATUTORY ANNUAL ACCOUNTS

The Committee received the Board's Annual Accounts, presented in the format directed by the Scottish Government.

Mr McNaught provided a detailed summary, and highlighted some minor amendments to be made. He thanked the Finance Team for their excellent work, and acknowledged the recognition of this from the external audit report, which would be cascaded to staff. Mr McNaught advised that the report and accounts had been reviewed in full by Scott Moncrieff as external audit, from whom an unqualified audit opinion had been given.

Mr McNaught advised that the Performance Report gave the main financial indicators, and confirmed that the Board was within budget for its revenue and capital limits. He outlined the Accountability Report including the Corporate Governance Report and the statutory compliance statement with regard to Chief Executive responsibilities – the format showing no change from prior years. There were some minor amendments noted for the number and attendance at governance Committees and this was agreed by Members as previously noted in the annual reports of each Governance Committee.

Mr McNaught highlighted the Governance Statement which covered internal controls and risk assessment, and detailed the governance committees, and noted that the overall structure and wording remained similar to previous years.

The report detailed the remuneration for the year for senior staff, and which included a new disclosure highlighting where we will publish Trade Union information on the Board's website. Mr McNaught also detailed the principal financial statements – Statement of Comprehensive Net Expenditure, Summary of Resource Outturn, Statement of Financial Position (formerly the Balance Sheet), Cashflow Statement and Statement of Changes in Taxpayers' Equity - showing the breakeven revenue position.

Mr McNaught advised that Mr Jim Crichton, on retiring from his role as Chief Executive Officer at the end of March 2019, had written a Letter of Assurance to Mr Gary Jenkins on governance for the financial year ending 31 March 2019. This assurance would allow Mr Jenkins to sign the annual accounts for the year 2018/19.

It was noted that a change may be required to the register of interests by the Medical Director, who would be asked to clarify and make any appropriate amendment required.

Subject to the minor amendments required, the Audit Committee recommended that the report on the annual accounts for the year ended 31 March 2019 be submitted to the Board for consideration and approval.

APPROVED

15 ANNUAL AUDIT COMMITTEE ASSURANCE STATEMENT

The Committee received a report recommending that it provides the Board with a statement of assurance to allow the approval for signing of the Performance Report, the Accountability Report as well as adoption of the Annual Accounts for the year ending 31 March 2019.

It was noted that the Committee had received and considered the annual Internal Audit Report as well as reports and assurances from the Director of Finance and Performance Management and the Chief Executive Officer. The Audit Committee had also received the annual reports from the Clinical Governance Committee, the Staff Governance Committee and the Remuneration Committee.

Members noted the minor amendments required to the governance committee annual reports as well as the annual accounts and on this basis, were content to provide the Board with a statement of assurance.

The Audit Committee recommended that the Board adopt the Annual Accounts for the year ended 31 March 2019 and approve submission to the Scottish Government Health and Social care Directorate.

The Audit Committee recommended that the Board authorises the Chief Executive to sign the Performance Report; that the Chief Executive to sign the Accountability Report; and that the Chief Executive and the Director of Finance and Performance Management sign the Statement of Financial Position.

APPROVED

16 PATIENTS FUNDS ACCOUNTS

The Committee received a report from the Director of Finance and Performance Management for Patients Funds Annual Accounts to the year ending 31 March 2019 – this relating to the balances of money held by TSH on behalf of patients. The report had been audited by Wylie and Bisset as external auditors which had provided an unqualified with one audit recommendation raised by this year's review which was noted as being addressed.

It was noted that in the future, the full report should be included within the papers. The full financial statement was circulated at the meeting today to ensure that Members had sight of this.

Action – Mr McNaught

The committee noted that the Patients Funds Accounts require to be approved by the Board and were content to recommend to the Board that it should give the Director of Finance and Performance Management and the Chief Executive approval to sign the summary income and expenditure statement.

APPROVED

17 WAIVER OF SFIs TENDERING REQUIREMENTS

The Committee received a report from the Director of Finance and Performance Management, to outline any instance during 2018/19 whereby the Chief Executive and Director of Finance and Performance Management have agreed to waive the requirement for competitive tendering or quotations should they jointly agree that it is not possible or desirable to undertake same having regard for all circumstances, and in accordance with Standing Financial Instructions (SFIs).

The Committee were asked to note that each case was closely reviewed to ensure that the use of a waiver was valid. There were no items this year for which this process was not followed when it should have been.

It was noted that in future, should the value of the service received vary from the waiver as signed, then a note to that effect should be added to this report. The Committee noted the report, as approval lies appropriately with the Chief Executive Officer as Accountable Officer for the Board.

NOTED

18 FRAUD UPDATE

A report was submitted by the Director of Finance and Performance Management to provide an overview on fraud allegations and any notification received from Counter Fraud Services.

Four alerts had been issued since the last report and these were summarised within the report. All incidents reported to CFS with regard to fraud matters in 2018/19 were closed, concluded satisfactorily with no further action required, and the Head of Service at CFS presented the Board with his annual update in March 2019.

The Committee noted the report, and agreed that it would be appropriate for the Committee Chair to write to Scottish Government to provide assurance that there had been no significant issues during the year ending 31 March 2019.

Action – Mr McNaught

NOTED /APPROVED

19 FRAUD ACTION PLAN

The Committee received and noted the paper which provided an update on Board engagement with Counter Fraud Services (CFS). The Committee noted the report and the progress made.

NOTED

20 SUMMARY OF LOSSES AND SPECIAL PAYMENTS

The Committee received a report from the Director of Finance and Performance Management, which provided an annual review of the Board's register of losses and special payments.

The Committee were content to note the report.

NOTED

21 ANY OTHER BUSINESS

There were no other items of competent business for this meeting.

NOTED

22 DATE AND TIME OF NEXT MEETING

The next meeting would take place on 10 October 2019 in the Boardroom, The State Hospital, Carstairs.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2019
Agenda Reference:	Item No: 24
Sponsoring Director:	Board Chair
Author(s):	Board Secretary
Title of Report:	Annual Schedule of Board and Sub Board Meetings – 2020
Purpose of Report:	For approval

1 SITUATION

The draft Annual Schedule of Meetings for Board and Sub Board Committees in 2020 is attached.

2 BACKGROUND

The Board requires to agree the schedule of meetings for 2020, and to make the dates of the Board Meetings publically available on its website.

3 ASSESSMENT

There are no proposed changes to the usual pattern of the schedule for Board and Committee Meetings in 2020.

4 RECOMMENDATION

Members are asked to approve the attached Annual Schedule of Meetings for 2020.

The State Hospital

ANNUAL SCHEDULE OF MEETINGS - 2020
BOARD AND SUB-BOARD

MEETING	Chair/ Members	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
BOARD	**Terry Currie*** B Brackenridge T Hair N Johnston D McConnell M Whitehead		Thursday 27.02.20 9.45am Boardroom		Thursday 23.04.20 9.45am Boardroom		Thursday 25.06.20 12.30pm Boardroom		Thursday 27.08.20 9.45am Boardroom		Thursday 22.10.20 9.45am Boardroom		Thursday 17.12.20 9.45am Boardroom
AUDIT COMMITTEE	**D McConnell*** B Brackenridge T Hair M Whitehead	Thursday 23.01.20 9.45am Boardroom		Thursday 26.03.20 9.45am Boardroom			Thursday 25.06.20 9.45am Boardroom				Thursday 08.10.20 9.45am Boardroom		
CLINICAL GOVERNANCE COMMITTEE	**N Johnston*** D McConnell M Whitehead		Thursday 13.02.20 9.45am Boardroom			Thursday 14.05.20 9.45am Boardroom			Thursday 13.08.20 9.45am Boardroom			Thursday 12.11.20 9.45am Boardroom	
STAFF GOVERNANCE COMMITTEE	**B Brackenridge*** T Hair N Johnston M Whitehead		Thursday 20.02.20 9.45am Boardroom			Thursday 21.05.20 9.45am Boardroom			Thursday 20.08.20 9.45am Boardroom			Thursday 19.11.20 9.45am Boardroom	
RENUMERATION COMMITTEE **	**T Currie*** B Brackenridge T Hair N Johnston D McConnell M Whitehead		Thursday 27.02.20 2.00pm Boardroom				Thursday 25.06.20 3.30pm Boardroom				Thursday 22.10.20 2.00pm Boardroom		

* Chair of Committee
** Remuneration Committee also meets as and when required

2020

PUBLIC HOLIDAYS:
New Year : Wednesday 1 January & Thursday 2 January
Christmas : Friday 25 December & Monday 28 December
Easter : Friday 10 April & Monday 13 April
Autumn Holiday : Friday 25 September & Monday 28 September

THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 24 OCTOBER 2019
9.45am

The Boardroom, The State Hospital, Carstairs, ML11 8RP

A G E N D A

1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 22 August 2019	For Approval	TSH(M)19/08
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 19/73
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
	CLINICAL GOVERNANCE		
7.	**Review of the Clinical Service Delivery Model** Report by the Medical Director	For Decision	Paper No. 19/74
8.	**Overseas Travel Request** Report by the Medical Director	For Decision	Paper No. 19/75
9.	**Medical Appraisal and Revalidation – Annual Report** Report by the Medical Director	For Noting	Paper No. 19/76
10.	**Person Centred Improvement – 12 Monthly Report** Report by the Director of Nursing and AHPs	Fort Noting	Paper No. 19/77
11.	**Patient Safety, Infection Control and Patient Flow Report** Report by the Director of Nursing and AHPs	For Noting	Paper No 19/78
12.	**Clinical Governance Committee** Draft Minutes of meeting held 15 August 2019	For Noting	CG(M)19/03
	STAFF GOVERNANCE		
13.	**Attendance Management – Board Update** Report by the Interim Director of HR	For Noting	Paper No. 19/79
14.	**Attendance Management Improvement Task Group** Report by the Interim Director of HR	For Noting	Paper No. 19/80

15.	**Health and Care Staffing Bill – Update** Report by the Director of Nursing and AHPs	For Noting	Paper No. 19/81
16.	**Workforce Plan – Update** Report by the Interim Director of HR	For Noting	Paper No. 19/82
17.	**Staff Governance Committee** Draft Minutes of meeting held 29 August 2019	For Noting	SG(M)19/03

CORPORATE GOVERNANCE

18.	**Internal Audit Provision** Report by the Chair of the Audit Committee	For Decision	Paper No. 19/83
19.	**Finance Report to 30 September 2019** Report by the Finance & Performance Management Director	For Noting	Paper No. 19/84
20.	**Corporate Governance – Improvement Plan Update** Report by the Board Secretary	For Noting	Paper No. 19/85
21.	**Audit Committee** Chairs Report of meeting held 10 October 2019	For Noting	Verbal
22.	**Board and Committee Meeting Schedule 2020** Report by the Board Secretary	For Noting	Paper No. 19/86
23.	**Any Other Business**		
24.	**Date and Time of next meeting** 19 December 2019, 9.45am, venue to be confirmed.		

25. EXCLUSION OF PUBLIC AND PRESS

To consider whether to approve a motion to exclude the Public and press during consideration of the items listed as Part II of the Agenda in view of the confidential nature of the business to be transacted.

THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 24 OCTOBER 2019
9.45am

The Boardroom, The State Hospital, Carstairs, ML11 8RP

A G E N D A

1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 22 August 2019	For Approval	TSH(M)19/08  03 - Board Minute -Aug 19 - Draft versi
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 19/73  04 - Actions List - Public Session.doc
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
	CLINICAL GOVERNANCE		
7.	**Review of the Clinical Service Delivery Model** Report by the Medical Director	For Decision	Paper No. 19/74  07 - Clinical Model Board Paper - Octob
8.	**Overseas Travel Request** Report by the Medical Director	For Decision	Paper No. 19/75  08 - Overseas Travel Requests - b.c

9.	**Medical Appraisal and Revalidation – Annual Report** Report by the Medical Director	For Noting	Paper No. 19/76 09 - Medical Appraisal and Revali
10.	**Person Centred Improvement – 12 Monthly Report** Report by the Director of Nursing and AHPs	Fort Noting	Paper No. 19/77 10a - PCIS Twelve Month Board Repor 10b - PCIS Twelve Month Board Repor
11.	**Patient Safety, Infection Control and Patient Flow Report** Report by the Director of Nursing and AHPs	For Noting	Paper No 19/78 11 - Patient Safety - HAI - Flow.docx
12.	**Clinical Governance Committee** Draft Minutes of meeting held 15 August 2019	For Noting	CG(M)19/03 12 - Draft CG Minute - 15 August

STAFF GOVERNANCE

13.	**Attendance Management – Board Update** Report by the Interim Director of HR	For Noting	Paper No. 19/79 13 - Attendance Management Repor
14.	**Attendance Management Improvement Task Group** Report by the Interim Director of HR	For Noting	Paper No. 19/80 14 - AMTG Update.doc
15.	**Health and Care Staffing Bill – Update** Report by the Director of Nursing and AHPs	For Noting	Paper No. 19/81 15 - Health and Care Staffing Bill.do
16.	**Workforce Plan – Update** Report by the Interim Director of HR	For Noting	Paper No. 19/82 16 - Workforce Plan Update.doc

17.	**Staff Governance Committee** Draft Minutes of meeting held 29 August 2019	For Noting	SG(M)19/03 17 - Staff Governance Minute

CORPORATE GOVERNANCE

18.	**Internal Audit Provision** Report by the Chair of the Audit Committee	For Decision	Paper No. 19/83 18 - Internal Audit.doc
19.	**Finance Report to 30 September 2019** Report by the Finance & Performance Management Director	For Noting	Paper No. 19/84 19 - Finance Report to 30 September 201
20.	**Corporate Governance – Improvement Plan Update** Report by the Board Secretary	For Noting	Paper No. 19/85 20a - Report- CG Improvement plan.d 20b - CG Blueprint Improvement Plan.d
21.	**Audit Committee** Chairs Report of meeting held 10 October 2019	For Noting	Verbal
22.	**Board and Committee Meeting Schedule 2020** Report by the Board Secretary	For Noting	Paper No. 19/86 22a - Meetings Schedule 2020.doc 22b - Meetings Schedule 2020.doc

23. **Any Other Business**

24. **Date and Time of next meeting**
19 December 2019, 9.45am, venue to be confirmed.

25. EXCLUSION OF PUBLIC AND PRESS

To consider whether to approve a motion to exclude the Public and press during consideration of the items listed as Part II of the Agenda in view of the confidential nature of the business to be transacted.

TSH (M) 19/08

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 22 August 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

Chair:	Terry Currie
Present:	
Non-Executive Director	Bill Brackenridge
Employee Director	Tom Hair
Non-Executive Director	Nicholas Johnston
Chief Executive	Gary Jenkins
Non-Executive Director	David McConnell
Director of Finance and Performance Management	Robin McNaught
Director of Nursing and AHPs	Mark Richards
Medical Director	Lindsay Thomson
In attendance:	
Head of eHealth	Thomas Best [Item18]
Person Centred Improvement Lead	Sandie Dickson [Item 7]
Senior IT Analyst	John Fitzgerald [Item 19]
Acting Head of Social Work	Peter Di Mascio
Head of Communications	Carline McCarron
Vice Chair of Clinical Forum	Sheila Howitt
Head of Corporate Planning and Business Support	Monica Merson
Interim HR Director	Kay Sandilands
Board Secretary	Margaret Smith
Director of Security, Estates and Facilities	David Walker

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Currie welcomed everyone to the meeting, and apologies were noted from Mrs Maire Whitehead.

NOTED

2 CONFLICTS OF INTEREST

There were no declarations of conflicts of interests from Members in respect of the business to be discussed at this meeting.

NOTED

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 20 June 2019 were noted to be an accurate record of the meeting, subject to minor correction to Item 17 to add that it was also noted (in relation to Patient

Funds) that the full background report had been presented to the Audit Committee which recommended approval by the Board. The Board provided approval on this basis.

APPROVED

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board noted progress on the action points from the last meeting – each item either had been completed or formed part of the agenda of today's meeting.

NOTED

5 CHAIR'S REPORT

Mr Currie reported on the meeting of the NHS Chairs' group, which took place on 24 June 2019. There had been a presentation on NHS Endowments outlining the main task underway to address the conflict of interest in Endowments Committee, which in the main currently comprise of NHS Board staff and Non- Executive Directors. The direction of travel would be for the NHS Board to no longer be the trustee of the endowment fund, and for an independently chaired Endowment Board, the majority of members of which to be independent from the NHS Board.

The Chairs' Corporate Governance Group has prioritised the development of two eLearning modules for Board Member development on Finance and Audit and Risk to have effective learning material that will equip Board Members with the knowledge and skills for constructive scrutiny and challenge to ensure that systems of control were robust and reliable.

The Chairs' Group had a discussion on mental health trajectories, led by the Minister for Mental Health reflecting current focus on performance in the delivery of mental health care. NHS Boards were asked to set trajectories for Child and Adolescent Mental Health Services (CAMHS) and Psychological Therapies as part of their Annual Operational Plans and performance would be scrutinised in this respect. Board Chairs had been requested to provide updates for their Board relative to the 40 actions set out in the mental health strategy.

It was noted that all NHS Boards have submitted an Annual Operational Plan, which have been through a rigorous review process. Following this, the Director General for NHS Scotland has written to each NHS Board. Scottish Government would be monitoring the plans to ensure that swift action could be taken should there be deviation from the plans. NHS Boards will be held to account for the delivery of these plans at the Annual Reviews.

Dr Jason Leitch, National Clinical Director for Healthcare Quality & Strategy presented on the Use of Evidence and Implementation of Best Practice, recognising NHS Scotland as a world leader in quality improvement evidenced by work in patient safety, prison centred care and child health. He noted that a well developed understanding existed across health and social care systems of the technical and social factors required to support the spread and sustainability of quality improvement. In the region of 800 fellows were trained in delivering quality improvement across the public sector. NHS Chairs welcomed the update and were in agreement to having a more centralised approach to the sharing and spread of best practice and innovation. The Golden Jubilee Foundation would be involved taking forward any work on this along with Healthcare Improvement Scotland (HIS).

Mr Currie also noted that the Minster for Mental Health had written to the Board regarding the last Annual Review, and that this was an item on the agenda for today's meeting. Further, that a response had been submitted to the Cabinet Secretary for Health and Sport as a result of the Sturrock report, and that Mr Jenkins would be providing the Board with an update later in the meeting.

Mr Currie noted that the closing date for applications for Whistleblowing Champions was the 12 August 2019 with the recruitment process then taking place.

He noted that the results of the staff iMatter survey had been received, with levels of participation in the organisation being on a par with the last survey.

There had been a Carers' Event at the hospital on Monday 5 August, with a small number of carers and patients in attendance. Mr Currie and Mr Brackenridge had attended the event. Representatives from the Mental Welfare Commission and the Scottish Health Council had attended the event. Mr Derek Barron who is chairing the Review of Forensic Mental Health Services was attending the site that day and so was also able to attend the event.

Mr Currie asked the Board to note that the Moderator of the Church of Scotland is visiting Lanark Presbytery over a three day visit in October 2019, and asked to visit The State Hospital (TSH) on 30 October. Mr Brackenridge would be in attendance at that visit, as Mr Currie would on a period of annual leave.

Planning for staff recognition awards was underway and it was noted that Ms Smith would provide a further update on this under Item 21, Corporate Governance Improvement Plan.

NOTED

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins provided the Board with an update of his activities since the date of the last Board meeting.

In particular, he provided an update on the work of the National Boards Collaborative, most notably the collective buying power this gave in procurement to support efficient ways of working. Mr Jenkins advised that he had invited a review of IT infrastructure at The State Hospital (TSH) through National Services Scotland (NSS). A visit to TSH was scheduled with the CEO of NHS Education for Scotland (NES) Ms Caroline Lamb.

Mr Jenkins had attended the NHS Scotland CEO Group and assured the Board of the focus on the Sturrock report in that forum led by the Cabinet Secretary.

He advised that TSH had been put forward as a pilot site for the Health and Care Staffing legislation, and that the Chief Nursing Officer's team would be visiting the Board in this regard in the near future.

Mr Jenkins assured the Board that preparations for EU Withdrawal on 31 October 2019 were on course within TSH, under the leadership of the Director of Security, Estates and Facilities. TSH would continue to focus closely on developments and work collaboratively with partner organisations.

Mr Jenkins had attended the launch of the Independent Review of Forensic Mental Health Services, along with Professor Thomson. He underlined the multi-agency approach to each of the themes within the review. The review had an ambitious time frame to conclude the work. Mr Jenkins confirmed that he would act as the lead CEO for NHS Scotland on the group.

Mr Jenkins also advised that he had recently attended the Patient Partnership Group (PPG) and wished to support the PPG in delivering on their objectives, and had asked Mr McNaught to assist in reviewing possibilities for a funding mechanism in this regard.

He advised the Board the presentation of long service awards to staff had commenced in the hospital, and he was pleased to be involved in presenting awards directly.

He advised that he had taken on the role of Chair of the Police Care Network, and would also be attending the Health and Social Care Prisons Board.

Finally, Mr Jenkins confirmed that the Executive Team had participated in two Away Days with a focus on supporting a corporate team approach.

NOTED

7 PATIENT STORY

The Board received a presentation from the Director for Nursing and AHPs which included an emotional touchpoint story led by a patient and which flowed from the recent What Matters To You? Event at TSH.

Ms Dickson was in attendance to lead Members through this presentation, which highlighted what patients felt could make their days within the hospital good or bad. She noted that the themes did not present any new information from the patient group. The feedback was presented from the view of each day in ward areas, the Hubs as well as the Skye Centre.

Mr Richards underlined the involvement of and importance of local teams identifying any actions that should be taken following on from this feedback from patients.

There was positive feedback in particular around the availability of activities for patients although some concern for those occasions when activities had to be postponed due to staffing unavailability, Mr Richards provided assurance that focus within TSH was on how to manage staffing to ensure that the Skye Centre remained open consistently for activity sessions.

Ms Dickson asked Board Members to note positive patient feedback on undertaking involvement roles when possible e.g. in staff awards.

The Board received this presentation warmly and noted that patient feedback was a crucial reminder of the importance of delivering person centred care.

NOTED

8 REVIEW OF THE CLINICAL SERVICE DELIVERY MODEL

A paper was received from the Medical Director, which provided the Board with an update on the review and options appraisal process currently underway in relation to the clinical service delivery model.

Professor Thomson provided the Board with a summary of the key points, including the six options outlined. She provided an update on the next steps in the process, notably the options appraisal workshop scheduled to take place on 16 September 2019 in which a scoring of the options would take place based on the benefits criteria identified. This would produce an overall clinical assessment of each option for suitability for care delivery within TSH. This would be followed by financial analysis of each option as well as sensitivity analysis focussing on risk, reputation and workforce issues to find an emergent preferred option. She also noted that further engagement was planned to take place with staff, stakeholders and patients. .

Mr Jenkins provided further detailed assurance to Members on the process that would be undertaken in respect of financial and sensitivity analyses leading to the final decision. This would demonstrate the feasibility of each option weighting all the factors including costs. Professor Thomson also

provided further detail in respect of the clinical desktop exercise to be carried out in terms of how existing patient group would fit into the model options, and the suitability of each option in these terms. A further report would be presented to the Board at its next meeting on 24 October for their consideration of the preferred option as well as updating advice on the process undertaken to reach the emergent recommendation.

Mr Currie noted that the Board would be asked to consider the review and make a decision at its next meeting in October. He underlined the very detailed nature of the review process undertaken as well as the participation of patients, staff and wider stakeholders. He thanked Professor Thomson and Ms Merson for their leadership on this work and expressed the Board's thanks to all the staff involved.

NOTED

9 MEDICAL EDUCATION ANNUAL REPORT

A paper was received from the Medical Director, which provided the Board with an assessment of the undergraduate and postgraduate training undertaken at TSH during the period 1 August 2018 to 31 July 2019. This provided assurance to the Board for governance of medical education in the context of General Medical council (GMC) standards in this regard.

Professor Thomson led Members through the detail of the paper, underlining the continuing high standard of medical education within the hospital and highlighting the award of Good Practice Recognition from NES and the very positive first Scotland Deanery Quality Management visit.

Board Members received this report positively, and Mr Currie passed thanks to Dr MacCall and Dr Billcliff for their continued good work in this area.

NOTED

10 IMPLEMENTATION OF SPECIFIED PERSONS LEGISLATION – ANNUAL REPORT

A paper was received from the Director of Security, Estates and Facilities, which provided the Board with an annual report on the implementation of the specified person regulations at the TSH, under the terms of the Mental Health (Care & Treatment) (Scotland) Act 2006.

Mr Walker summarised the key points for the Board, advising that the data did not vary greatly from reporting in previous years. He noted that the data was routinely reported in more detail through the Clinical Governance Committee.

The Board approved the report for submission to Scottish Government as outlined in the report.

APPROVED

11 PATIENT SAFETY, INFECTION CONTROL AND PATIENT FLOW REPORT

A paper was received from the Director of Nursing and AHPs, which summarised activity within the hospital in relation to patient safety, healthcare associated infection (HAI) and patient flow. Mr Richards summarised the report for the Board.

In response to a query from Mr McConnell, Mr Richards confirmed that responsibility for funding of Hepatitis C treatment for patients lay with the host Board and this interface was being managed

through the Finance Department.

The Board noted that specific action should be taken on management of laundry tags given the impact on infection control, and asked that the Board's concern in this area this should be fed back to the Infection Control Committee

Action – Mr Richards

Members also requested that further context should be provided in respect of patient flow to provide historical context. Mr Richards that the next report to the Board would include the data from 2011 onwards, providing data since the hospital re-build.

Action - Mr Richards

NOTED

12 CLINICAL GOVERNANCE COMMITTEE

The Chair of the Committee, Mr Johnston provided an update to Members on the last meeting of the Clinical Governance Committee, which took place on 15 August 2019 which had focussed on the review of the clinical model. The Committee had also asked for a review of the timetable for delivery of the action plan on the Continuous Quality Improvement Framework Action Plan to ensure that this was realistic, given the substantial nature of the plan.

NOTED

13 TSH ACTION PLAN IN RESPONSE TO THE STURROCK REPORT

The Board received a presentation from the Chief Executive to outline progress of work at TSH in response to the Sturrock Report. The response had provided an opportunity within TSH to review staff feedback through recent iMatter reporting and through the engagement process undertaken as part of the review of the clinical model.

In addition, a specific engagement process was launched to seek staff feedback through a questionnaire, with work progressed in partnership by the Chief Executive, Interim Director of Human Resources and the Employee Director to draw out the emergent themes. He also acknowledged that the response rate to the exercise had been low and the need to engage widely throughout the organisation.

Mr Jenkins led the Board through these themes: Communications and Engagement, Leadership and Management, Human Resources, Culture and Behaviours, Staff Support and Governance. He outlined the process underway to provide this feedback through committee and forum structure throughout the organisation including the Partnership Forum.

Mr Hair added that, although the response rate had been low to and the results may not be indicative of the whole picture within the hospital, it did provide a good baseline from which to improve going forward. Mr Jenkins picked up from this point adding that the Partnership Forum had demonstrated a commitment to progressing this work further in partnership. This commitment to sharing leadership may be particularly effective in encouraging open and transparent engagement from across staff groups. Mr Jenkins also added a suggestion made through the Senior Management Team meeting for a role for focus groups across the hospital. A small partnership group would be set up to take this forward.

Mr Brackenridge asked whether making changes in the organisation was envisioned as a result of

the response to Sturrock. Mr Jenkins outlined his view for the way forward for the organisation overall and the opportunity for this work stream to help inform the structure. He referenced the ideas around

self organising systems approach and the importance of taking decision-making to the appropriate level of the organisation. This would be intertwined with the workstream on the review of the clinical model as well as iMatter reporting.

It was essential to take forward these conversations now through the partnership group, with all staff groups with an emphasis on a listening approach. This would be the focus over the next 12 weeks to help inform action planning towards improvement.

Mr Currie agreed that this was a great opportunity for TSH, and would enable a bigger survey of opinion from staff across the hospital allowing both negative and positive feedback to be taken on board. He summed up the feeling around the table form Board Members on the positive nature of the outlined approach.

The Board were content to note continued progress in respect of the TSH response to the Sturrock response.

NOTED

14 ATTENDANCE MANAGEMENT REPORT

A paper was received from the Interim Director of Human Resources, which outlined staff attendance data over the course of May 2019, and Ms Sandilands also provided a verbal update that the sickness absence figure for June 2019 was 5.56%.

This represented continued downward progress overall in sickness absence rates at TSH, and the Board received the report noting the excellent progress made in this area. At the same time it was acknowledged that sustaining this improvement was imperative.

Mr Hair noted the continued support provided from the Human Resource team to line managers especially in providing a supportive return to work for colleagues.

The Board asked that feedback should be cascaded to all staff on the positive nature of this improvement.

Actions – Ms Sandilands/ Ms McCarron

NOTED

15 STAFF GOVERNANCE COMMITTEE – UPDATE

The Board noted the minutes of last meeting of the committee, which had taken place on 23 May 2019, which had focused on attendance management and statutory and mandatory training; as well as initiating the workstream around TSH response to Sturrock.

NOTED

16 FINANCE REPORT AS AT 31 JULY 2019

The Finance Report to 31 July 2019 was submitted to the Board by the Director of Finance and Performance Management, and Members were asked to note the content of this report. Mr McNaught led Members through the report highlighting the key areas of focus.

The Board was reporting an overall underspend position of £47k. Mr McNaught noted that the Annual Operational Plan set out a balanced budget for 2019/20 based on achieving £2.103m efficiency savings which were set out in this paper, and that a significant savings gap existed.

He noted that overtime in nursing was still higher than budget year to date but that there was improvement in comparison to previous years with stabilising measures in place going forward. The year end projection for revenue and for capital were for a break even position.

Mr McConnell queried the consistency of presentation of efficiency savings in the report, Mr Johnston asked for an amendment to be considered on the presentation of the key pressures and benefits table. Mr McNaught noted the need for clarification on these points and would take this forward.

Action – Mr McNaught

There was discussion on the improved position in relation to nursing spend, and Mr Jenkins confirmed that trend analysis was underway in budgeting around variance, and the impact of control processes so that improvement is fully understood and lessons learnt in a concrete way leading to long term sustainability.

The Board noted the content of thus report, and the ongoing work on efficiency savings.

NOTED

17 PERFORMANCE REPORTING

a) UPDATE ON STRATEGIC REVIEW OF PERFORMANCE

A paper was submitted to the Board, from the Director of Finance and Performance Management which provided the Board with work undertaken to review the current performance management framework to ensure that performance measures were in place that provided effective monitoring towards achieving organisational outcomes. Mr McNaught outlined progress to date which involved a move toward a balanced scorecard approach to achieve this goal.

Provisional reporting should be in place allowing testing of data for validity by October 2019, and further reporting brought back to the Board thereafter.

Action – Mr McNaught

b) PERFORMANCE REPORT

A paper was received from the Director of Finance and Performance Management, which outlined performance during Quarter 1 of 2019/20 and the Board were content to note this report.

NOTED

18 e HEALTH – ANNUAL REPORT

A paper was submitted from the Director of Finance and Performance Management, which provided

the Board with an overview of the work progressed within eHealth over 2018/19. Mr Best was in attendance to lead the Board through the key points of the report.

There was discussion on the key achievements of the department with given resources and under challenging circumstances. The focus should be prioritisation of project work to achieve key results.

It was also noted that Mr Jenkins had commissioned an independent review of IT infrastructure within TSH through NSS. Mr Best provided assurance to the Board on the secure nature of the network and work progressed on data storage, and the resilience this provided to the organisation.

The Board noted the content of the report, and asked Mr Best to convey their appreciation to the eHealth team, of the good work undertaken throughout the year in challenging circumstances. It was agreed that further work around identifying the key priorities for eHealth should be taken forward.

Action – Mr McNaught

NOTED

19 NETWORK INFORMATION SYSTEMS (NIS) & INFORMATION SECURITY POLICY FRAMEWORK (ISPF) 2018

A paper was received from the Director of Finance and Performance Management, which outlined the work progressed at TSH in relation to the work progressed at TSH for the implementation of this legislation.

Mr Fitzgerald was in attendance and provided Board Members with a presentation to give assurance on the nature of the progress to date, with detailed reporting made through the Senior Management Team.

The Board were content to note the content of this report.

NOTED

20 COMMUNICATIONS – ANNUAL REPORT

A paper was received from the Chief Executive, which outlined work progressed and performance for 2018/19.

Ms McCarron led the Board through the key highlights of the report, and the report was received positively. There was discussion and appreciation of the volume of work undertaken within available resources; and Board Members congratulated Ms McCarron on the successful progress made. It was noted that the Board would receive further updates on the priorities and challenges of the department going forward.

The Board were content to note this report.

NOTED

21 CORPORATE GOVERNANCE IMPROVEMENT PLAN

A paper was received from the Chief Executive, which outlined progress made in relation to the Corporate Governance Improvement Action Plan since the date of the last Board Meeting.

Ms Smith provided Members with a summary of progress to date; as well as highlighting the steps suggested within the report to enhance visibility of Non- Executive Directors across TSH. The Board were receptive of this plan and agreed that this would meet the ambition of the improvement plan and should be taken forward. Mr Hair added his support Employee Director to help facilitate this workstream.

Ms Smith asked the Board to note that the staff award ceremony would take place on 24 October 2019, and that in order to accommodate this the Board meeting on that day would also take place at TSH. The intention would be to hold the following Board meeting in December at an external site.

The Board noted the content of this report, and through discussion provided their support to the direction of travel outlined therein. A further report would come to the next meeting of the Board.

NOTED

22 ANNUAL REVIEW OUTCOME LETTER

A paper was submitted to the Board to summarise the key points from the Scottish Government feedback letter regarding the Annual Review 2017/18, which took place at TSH on 14 January 2019.

Mr Jenkins asked Members to note the six action points and provided assurance that work was progressed in relation to each point.

23 AUDIT COMMITTEE

The Board noted the approved minutes of the meeting of the Audit Committee held on 28 March 2019, as well as the draft minutes of the meeting of the Audit committee which took place on 20 June 2019.

Mr McConnell outlined the key business undertaken at each meeting, highlighting the key nature of the work progressed at the June meeting in regard to the annual reports, annual accounts and patient funds accounts to enable the Committee to recommend approval by the Board.

NOTED

24 ANNUAL SCHEDULE OF BOARD AND SUB BOARD MEETINGS -2020

A paper was received on behalf of the Board Chair to propose a meeting schedule for the Board and its standing committees throughout 2020.

Ms Smith highlighted that this schedule did not propose any change from the existing pattern of meetings and Board Members were asked to provide feedback on the schedule so that it could be agreed electronically.

NOTED

25 ANY OTHER BUSINESS

Ms Merson asked the Board to note the launch of the hospital wide quality improvement initiative TSH3030 would take place on 5 September 2019, with an awards ceremony, which would include patients as well as staff to take place in December 2019. Board Members would be provided with

details to enable their attendance.

NOTED

26 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 24 October 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

NOTED

27 EXCLUSION OF PUBLIC AND PRESS

Members approved a motion to exclude the public and press during consideration of the items listed at Part II of the agenda in view of the confidential nature of the business to be transacted.

AGREED

ADOPTED BY THE BOARD

CHAIR _____
(Signed Mr Terry Currie)

DATE 22 August 2019

MINUTE ACTION POINTS
THE STATE HOSPITALS BOARD FOR SCOTLAND
(From August 2019)

ACTION NO	AGENDA ITEM NO	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	11	Patient Safety, Infection Control and Patient Flow Report	Feedback to Infection control Committee re concerns over laundry tagging. Incorporate patient flow data from 2011 to date, into reporting.	M Richards M Richards	Immediate October 2019	**Completed** **Completed**
2	14	Attendance Management Report	Communicate to wider staff group on improvement in attendance figures.	K Sandilands	October 2019	**Completed**
3	7	Finance Report	Clarification on presentation of efficiency savings/ key pressures and benefits data,	R McNaught	Immediate	**Completed**
4	13	Strategic Review of Performance	Provisional reporting in place to allow testing of data.	R McNaught	October 2019	**Completed**
5	22	E Health Annual Report	Further work to identify key priorities for e Health.	R McNaught	Ongoing 2019/20	**Remit to SMT to take forward – added to workplan**

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2019
Agenda Reference:	Item No. 7
Sponsoring Director:	Medical Director
Author:	Chief Executive Officer
Title of Report:	Clinical Service Delivery Model
Purpose of Report:	To seek approval on the option for a revised Clinical Service Delivery Model

1. SITUATION

The Board has received regular progress reports on the status of the Clinical Care Model process.

2. BACKGROUND

It was agreed at the August Board meeting that a report on the next stages of the process would be brought to the October Board meeting with a view to seeking support for a preferred option.

3. ASSESSMENT

This paper provides an overview of progress since August including:

Clinical Forum Engagement
- Definitions and Options: Clinical Function

Option Appraisal Methodology
- Benefits Criteria Development
- Weighting the Benefits
- Scoring of the Options

Testing & Adapting of the Preferred Option
- Clinical Overlay of Preferred Option
- Financial Analysis

4. RECOMMENDATION

The Board is asked to:

i. endorse the method applied to reaching the 'emerging preferred option'
ii. acknowledge the significant contribution of the Clinical Forum
iii. note the multi-professional and stakeholder engagement in the process to date
iv. be aware of the variable factors associated with the forensic mental health estate overall which could alter the known planning assumptions at this point in time
v. accept that the affordability of providing an eleven ward model would create significant financial pressures across the organisation
vi. endorse a detailed planning and implementation process allowing The State Hospital to move towards a ten ward model based on eight MMI wards and two ID wards (6.1.b)
vii. Support the establishment of a quarterly review process to assess the effectiveness and challenges of operating on the ten ward model

1. Context: The Clinical Care Model

The Clinical Care Model describes the way The State Hospital provides high secure services to patients with a mental disorder, many of whom have offended.

The need to review the Clinical Care Model arose from issues raised through a staff engagement exercise focussed on readiness for change. In that exercise, issues of safety were spontaneously raised in several responses. A presentation was given to the Board in June 2018 by the Service Transformation and Sustainability Group. The Board endorsed the need to progress with a Clinical Model Review.

The Clinical Model Review was divided in three elements:

a) Review of the clinical model principles:

A review of the clinical model principles was carried out through staff consultation and stakeholder engagement activities. The principles of the current model were found to be still current and applicable for the delivery of care and treatment with a small amount of revision required.

b) Review of safety data:

A review of safety data related to the delivery of clinical care in the hospital was carried out to examine trends over a 5 year period. This was commissioned in July 2018 and reported to the Board in October 2018. The data reviewed included incident reports on violence and aggression and a staff survey. The incident data indicated:

- There has been an increase in the number of violent and aggressive incidents in the last 5 years, however the trend was not linearly upward and numbers vary each year
- No evidence was found to support the theory that TSH is dealing with a higher number of the prison population with antisocial behaviour who would carry out assaults
- The Intellectual Disability (ID) population has more incidents and assaults than the Major Mental Illness (MMI) population allowing for its size
- There is a small number of patients who carry out assaults on staff, this varies and this number has not shown an increasing pattern. There are a very small number of patients (2-3 in 2017-18) who carried out the majority of assaults
- There is an increasingly complex use of enhanced observation, seclusion and use of soft restraint kit with additional staff

c) Review of the clinical service delivery model:

The review of the clinical service delivery model has been in process since December 2018 and builds on the findings from the clinical model principles and safety review themes. This paper provides an update on that work and a recommendation for the future clinical service delivery model at The State Hospital.

2. Progress Overview

A summary of the key engagement events associated with the overall process is recorded in table one below:

Table One – Key Engagement Events

Activity	Timescale	Status
Staff and Patient Safety Report	Oct 2018	Complete and action plan being implemented
Review of the Principles of the Clinical Model	Oct / Nov 2018	Complete with slight change to principles
Staff Questionnaire	Dec / Jan 2019	Complete and results shared with staff and participants
Staff Workshop (creation of options)	Feb 2019	Complete and options developed
Stakeholder Workshop	Feb 2019	Complete and options developed
Patient Workshop and Engagement	Feb 2019	Complete – will revisit and inform on decision making
Staff Engagement	Mar / Jun / Aug / Sep 2019	Complete and presentation given to Board
Benefits Criteria Workshop	May 2019	Further work agreed to define the options
Clinical Forum Activity	May – Aug 2019	Impartial definitions of the clinical environment developed
Benefits Criteria Workshop	Aug 2019	Complete
Options Appraisal	Sep 2019	Complete
Patient Partnership Engagement	Sep & Oct 2019	Complete
Stakeholder Engagement	Oct 2019	Complete
Overlay of Patients against defined ward criteria	Oct 2019	Complete
Financial Model	Oct 2019	Complete
Board Meeting	Oct 2019	-

The State Hospital Board have been provided with regular updates on the progress.

It was agreed at the August Board meeting that a report on the next stages of process would be brought to the October Board meeting with a view to seeking support for a preferred option.

This paper provides an overview of progress since August including:

Clinical Forum Engagement
- Definitions and Options: Clinical Function

Option Appraisal Methodology
- Benefits Criteria Development
- Weighting the Benefits
- Scoring of the Options

Testing & Adapting of the Preferred Option
- Clinical Overlay of Preferred Option
- Financial Analysis

3. Clinical Forum Engagement

A short life working group (SLWG) of the Clinical Forum was commissioned to provide further detail on proposed clinical configuration options. The SLWG provided objective clarification on the meaning of each option, including worked examples, and created a consistency in the use of the definitions to assist members of the scoring workshop.

3.1) Agreed Definitions

a) Admission and Assessment Wards
The purpose of these wards should be about the initial assessment (including multidisciplinary assessments, physical health investigations, completion of structured risk assessments and where appropriate personality assessments) resulting in the clinical team being confident they have a comprehensive and robust understanding of the risk presented by the patient, the needs they have and being able to formulate a comprehensive care and treatment plan to inform the next stages of treatment. The environment will be tailored to the needs of the patients within an assessment area – therefore may be more restrictive. Care and treatment should be based upon individual patient needs as far as possible, whilst assessment is being undertaken.

b) Treatment and Recovery Wards
These wards will meet the needs of a large proportion of the current patient cohort. The wards will provide ongoing treatment and rehabilitation once the individuals' care and treatment needs are understood. These wards are likely to include patients with complex needs, high dependency and patients with additional physical needs. Patients who are high risk, but where the risk is well understood and the management of their risk is clearly articulated with a defined care package, should be placed here.

c) Transition Wards
These wards will meet the needs of patients whose risk and needs are well understood and articulated, and the level of care and management required is lower and less intensive. The environment will offer the least restrictive area across the organisation as an opportunity to support appropriate rehabilitation for patients as they progress towards leaving The State Hospital.

Patients may have been identified as being ready to move onto less secure settings and should have full grounds access, be fully compliant with their care and treatment, met many of their treatment goals, have a full timetable, and not require to be cared for with increased or enhanced levels of observations. Should the status of these change significantly, the patient should be transferred back to a Treatment and Recovery ward. These wards are not limited to patients already on the transfer list, as long as the other criteria are met.

3.1.2) Clinical Configuration Options

Five potential clinical configuration options were shortlisted using the agreed definitions:

Option 1: Status Quo

Option 2: Hubs with 3 wards and x1 ID ward in a separate hub
Ward 1 Admission & Assessment, Ward 2 Treatment and Recovery, Ward 3 Transitions, ID x1 Ward in separate hub

Option 3: Hubs with 3 wards and x2 ID ward in a separate hub
Ward 1 Admission & Assessment, Ward 2 Treatment and Recovery, Ward 3 Transitions, ID x2 Ward in separate hub

Option 4: Hubs with different functions 3 wards and x1 ID ward
Hub 1 Admission & Assessment, Hub 2 Treatment and Recovery, Hub 3 Transitions, Hub 4 ID x1

Option 5: Hubs with different functions 3 wards and x2 ID ward
Hub 1 Admission & Assessment, Hub 2 Treatment and Recovery, Hub 3 Transitions, Hub 4 ID x2

Principles and assumptions were agreed which align to all five options:

- Clinical parameters should guide when a patient moves ward, it should not be based on timeframe or length of stay

- There will be no dedicated high dependency unit for complex challenging patients

- The current physical infrastructure of the environment should not be majorly modified

- All patients are to be admitted to an admission and assessment ward, but can be discharged from any ward

- Newly admitted Intellectual Disability (ID) patients will all go to the ID ward(s). In any clinical option with only one ID ward, the ward will need to meet needs of all ID patients at all stages in their admission. This is unlikely to be achievable all of the time, due to patient mix difficulties. Considerations should include how ID patient needs would be met, patient mix, and also staff with specialist skills.

- Based on Clinical Effectiveness data on seclusion, on occasion TSH may need to utilise up to 4 seclusion suites at any one time. Some of the options may not have sufficient seclusion suites directly aligned to the ward function.

- All models are, as far as possible, based on the available data regarding patient numbers and profiles. It will be necessary to have a pragmatic outlook as the reality of admissions, discharges and patient need will not be static. At times, there may be a need for a bed within an area and there is not one empty. The implementation phase should consider what contingency plans would be put in place when teams have to go outwith the parameters of the clinical model.

4) Option Appraisal Methodology

Option appraisal is a systematic evaluation of the relative positives and negatives of alternative options in meeting specific health objectives before resources are committed to one or more programmes. The methodology is commonly used to model clinical scenarios across NHS Scotland

4.1) Benefits Criteria

A set of benefits criteria were established, consulted and agreed on, based on the priorities and key themes that emerged from staff engagement process. Table two provides a summary of those benefits for assessing clinical model options.

All reference to Forensic Mental Health Services includes services for both Major Mental Illness and Intellectual Disability.

Table Two – Benefits Criteria

Ref	Description	Definition
A	Safety	This option should provide a safe service for all staff, patients volunteers and visitors. All clinical and environmental risks associated with the options should be assessed and managed. The option should ensure a safe environment for the delivery of care. Safety is defined in the context of physical, relational and procedural
B	Opportunity for staff specialism and development	This option should provide staff the opportunity to develop their professional skills and expertise and specialise in areas of clinical service delivery appropriate to the needs of patients and requirements of the hospital
C	Opportunity for patient engagement in activities	This option should provide adequate opportunity for patients to engage in and experience a range of activities relevant to their needs and abilities
D	Ability to reconfigure service to meet changes in external factors	The extent to which this options support sustainability of the service is important to ensure we plan for any potential changes in external environment and can adapt to these, e.g. Increase or decrease in admissions. The option should be able to accommodate changes in patterns of care and the changing needs of the population over the longer term.
E	Continuity of care	The option should support the premise that during their time in the state hospital patients can expect to have their care delivered by a substantially stable team of clinicians who develop therapeutic relationships to support the patient in their recovery.
F	Ability to individualise security measures	The option should be flexible and support individualised security approaches so that the least restrictive security is applied for each patient. Patients can expect to have a progressive and risk assessed approach to security through this option without detriment to the overall safety of the hospital.
G	Disruption to patients and staff	The degree to which this option would impact on the requirement of staff and patient moves to implement the clinical model. The extent to which clinical services can be maintained during any implementation phase and the timescale of the implementation phase should be considered.
H	Progression through hospital	The option should outline a clear pathway for progression through the hospital which is defined and understood by staff and patients.
I	Physical environment	The physical environment of patient bedrooms, wards, hubs and the Skye centre is suitable to provide safe care under the new model. Care should be provided in an environment that will maximise benefit to the individuals to aid their health and wellbeing. This includes the design and functionality of the building.

The benefits criteria were weighted at a workshop of senior clinical leads and managers in August 2019. The weighting was carried out by comparing each benefit against the other to produce an overall consensus weighting. The ranked outcomes are shown in table three:

Table Three – Weighted Benefits Criteria

Criteria	Rank
Safety	1
Ability to individualise security measures	2
Opportunity for patient activities	3=
Progression through hospital	3=
Continuity of care	5
Physical environment	6
Opportunity for staff to specialise	7
Ability to reconfigure to meet changes in external factors	8=
Disruption to patients and staff	8=

4.1.2) Scoring the Options

A further workshop was held in September 2019 attended by 45 senior leaders and clinicians. Attendees individually scored each option against the pre agreed benefits criteria. Clinical Effectiveness calculated the individual scores to assess if a preferred option could be identified.

The outcome is that Option 3 (*3 hubs with 3 wards and 2 ID*) is the 1st ranked preference. The Status Quo was the least preferred option ranked in 5th place.

Rank	Option	Score
1st	Option 3: 3 hubs with 3 wards (Ward 1 – Admission & Assessment, Ward 2 – Treatment & Recovery, Ward 3 – Transition) and 2 ID wards in separate hub	722.78
2nd	Option 5: 3 hubs with different functions (Hub 1 – 2 Admission & Assessment Wards and 1 Transition Ward; Hub 2 – 3 Treatment & Recovery Wards; Hub 3 – 2 Treatment & Recovery Wards, 1 Transition Ward; Hub 4 – 2 ID Wards)	664.72
3rd	Option 4: 3 hubs with different functions (Hub 1 -2 Admission & Assessment Wards; Hub 2 – 3 Treatment & Recovery Wards; Hub 3 – 2 Treatment & Recovery Wards; 1 ID Ward, Hub 4 – 2 Transition Wards)	651.39
4th	Option 2: 3 hubs with 3 wards (Ward 1 – Admission & Assessment, Ward 2 – Treatment & Recovery, Ward 3 – Transition) and 1 ID ward in separate hub	635.83
5th	Option 1: Status Quo	519.17

These combined exercises produced an overall ‘emerging preferred option’ for the service model within The State Hospital.

5) Testing of the Emerging Preferred Option

At the September workshop, it was agreed that that a desktop exercise would be carried out following the scoring process. The aim of the desktop exercise was to establish if the 'fit' against the 'emerging preferred option' is deliverable within the current patient population.

Forms were issued to each RMO on 24 September to be returned by 09 October, containing the name of each patient. Each RMO consulted with their clinical team and selected the most appropriate ward type by patient. Any difference of opinion was recorded. The results are contained in tables four and five below:

Table Four - Major Mental Illness

Hub	Admission & Assessment	Treatment & Recovery	Transition	Disagreement
Arran (22)	5	12	5	No
Iona (19)	0	13	6	No
Lewis (30)	5	18	7	No
Mull (19)	4	10	5	No
Total (90)	14	53	23	

NB - There were 3 admissions during the analysis period. These are included above. 2 other patients were placed on the waiting list for admission – they are not included in these figures.

Table Five - Intellectual Disability

Current ID Population	ID Ward 1	ID Ward 2	Disagreement
Iona 2 (12)	8	4	1 case*
Mull 2 (1)	0	1	No
Total (13)	8	5	

**Psychology and social work thought patient could go to ward 2 but nursing staff thought ward 1 – RMO supported ward 1.*

Table Six - Additional Analyses: Number of Admission Sept 18 to Aug 19: Proposed Ward Type
n=29. There are approximately 30 admissions per year

Admissions (33) 11/9/19–9/10/19	Admission & Assessment	Treatment & Recovery	Transition	ID 1	ID 2	Transferred
MMI (31)	12	7	0	-	-	12 (1 readmitted)
ID (2)	-	-	-	2	0	0
Total						

NB - 4 patients have been admitted under exceptional circumstances – 4 are included in the admission and assessment cohort.

A formal transfer list meeting is held on a regular basis between medical records administration and the Responsible Medical Officers. Any patient who has been referred to another service for transfer is listed. Patients on the list can be awaiting assessment, being assessed or accepted for transfer. Some patients will also have won appeals against being held under excessive security under the Mental Health (Care and Treatment) (Scotland) Act 2003 / 2015.

Table seven provides an overview of patients currently in The State Hospital who are within this criteria.

Table Seven - Transfer List and Proposed Ward Type

Transfer List – 30 Sept '19	Admission & Assessment	Treatment & Recovery	Transitions	ID 1	ID 2
MMI – won appeal against excessive security			8		
MMI – accepted by local service			7		
MMI – assessment		1	5		
Excessive Security	4				
ID – won appeal against excessive security					
ID – accepted by local service					1
ID - assessment					
Total	4	1	20		1

5.1) Clinical Model Viability

Major Mental Illness (90 patients)

From the desktop exercise, the number of patients allocated to each proposed speciality ward at this point in time is:

- Admissions and Assessment n=14
- Treatment and Recovery n=53
- Transition n=23*

*(*26 patients were listed for transition ward but 3 did not have full grounds access as required for the model and were recalculated to treatment & recovery wards)*

The numbers fit none of the options precisely. Based on the desktop assessment outcome, there is a demand for:

- Admissions and Assessment 2 wards (24 beds)
- Treatment and Recovery 5 wards (60 beds)
- Transition 2 wards (24 beds)

Intellectual Disabilities (13 patients)

- 2 wards are viable comprising of 8 and 5 patients
- 1 single ward does not allow all ID patients to 'fit' into one ID service

5.1.2) Consideration and Factors

The occupancy of The State Hospital in October 2019 is 103 patients, with a capacity for 120 patients, whilst operating on a 10 ward model. This gives an occupancy level of 86%. There is sufficient capacity overall to manage the number of patients across a ten ward operational model.

The overall pace of movement for patients in The State Hospital does not necessitate a rapid throughput of clinical speciality functions. Risk management and assessment of patients is carefully planned to minimise adverse events.

The current average length of stay is six years, with individual lengths of stay ranging from less than one month to over 30 years. It is likely that predictability of patient movement will allow sufficient planning time to ensure that patients progress to the appropriate specialty ward within an acceptable timeframe and without detriment to their overall care and treatment pathway. Clinical Teams are known to be more optimistic about patients' rehabilitation and future setting than occurs in reality, therefore regular reviews of patient numbers against ward types should be introduced going forward.

The patient population varies over time and will continue to do so. An expansion in medium or low secure beds would remove the need for exceptional circumstances admissions and allow patients to transfer in a timely manner. There is no imminent planning in place for this at the present time however the Review of Forensic Mental Health Estate may change that position over the next 12 - 24 months.

The LD and Autism Mental Health Act consultation proposes to remove ID beds from a secure hospital setting.

Given the specialist nature of The State Hospital it is recommended that a quarterly multi-professional review takes place to assess and recommend modifications to the clinical model as specialty needs alter and clinical need fluctuates.

5.1.3) Adaptation of Emerging Preferred Option: 10 Ward Proposal (8 MMI plus 2 ID)

In order to model the nearest available fit against the principles of the 'emerging preferred option' it is recommended that the following model is established:

Sample Model*	Ward 1	Ward 2	Ward 3
Hub 1	Admission & Assessment	Treatment & Recovery	Treatment & Recovery
Hub 2	Admission & Assessment	Treatment & Recovery	Treatment & Recovery
Hub 3	Intellectual Disabilities	Intellectual Disabilities	
Hub 4	Transition	Transition	

*For modelling purposes only

a) Intellectual Disability Provision

There is strong clinical support for the establishment of two ID wards. Under the current operating model (Status Quo), the ID patient cohort are not managed from one single location. This enables patient disassociations and improves the overall therapeutic milieu of the service. As recorded in the safety report, there is a disproportionate level of incidents and assaults when compared with the MMI patient cohort. Given that a fundamental principle of the review process was to address the safety features, it would appear counter-intuitive to revert back to a single ID ward potentially increasing the risk factors for staff and patients.

The two ward model, based on the current patient cohort would have an overall occupancy level of 54% (13 / 24 beds allocated to ID).

b) Major Mental Illness Provision

One Admission and Assessment ward would be insufficient to safely and effectively manage the admission function.

The number of patients at this time would exceed the available beds (14 / 12). The Admission and Assessment ward running on >100% occupancy would prove challenging with patient mix, disassociation, the management of risk, and the use of seclusion when necessary. It would be preferable to establish two Admission and Assessment wards to safely manage new admissions into The State Hospital.

The two ward Admission and Assessment model, based on the current patient cohort, would have an overall occupancy level of 58% (14 / 24 beds allocated to MMI Admission and Assessment). The surplus capacity could enable sufficient flexibility to retain patients under review for transfer to the Treatment and Recovery wards. This would however require careful consideration and form part of the contingency options as endorsed by the Clinical Forum.

The majority of current patients would fit with the proposed Treatment and Recovery wards (53 patients).

A five ward Treatment and Recovery option would be optimal. However it is not immediately viable from both a staffing or resource perspective to create 60 beds for the Treatment and Recovery function.

It is proposed that four wards are allocated to Treatment and Recovery totalling 48 beds. It is likely that this area will have the most fluidity associated with patient movement to and from

the other ward functions. The Treatment and Recovery Wards would be staffed to a higher compliment.

6) Financial Analysis

The NHS England NHS Benchmarking team have been contacted to discuss benchmark nurse staffing levels within medium and high secure services in England. They have verbally shared high level staffing data which is based on an average of nursing staff per 10 beds. Within both medium and high secure services, there is an average nurse staffing of 33 WTEs per 10 beds.

As a requirement of safe staffing legislation, workload tools and professional judgement will be run in all wards as part of the delivery of the 'common staffing method.' To date a full 6 week run has been completed in Lewis 1. The workload tool output was for 32.5 WTEs in this ward, with the professional judgement tool being 33.5 WTEs.

It is reassuring that the workload tools, professional judgement and NHS England Benchmarking are all broadly consistent with the planning assumptions of the Clinical Model.

The last identified process for nurse staffing levels in The State Hospital created a base establishment of:

Day Shift: 4 staff per ward
Back Shift: 4 staff per ward
Night Shift: 2 staff per ward

It is clear from the recurring financial challenges that this base number does not adequately align with the actual clinical needs of the service. This creates difficulties with allocation of staff, financial control and forecasting.

In the costing assumptions for the Clinical Model, the modelling has been undertaken on revised establishment numbers:

Function	Day Shift	Back Shift	Night Shift
Transitions	4	4	2
I.D. (Based on <70% occupancy)*	5	5	3 (+2)
Admission & Assessment**	6	5	2
Treatment & Recovery**	7	6	3

* If the two ID wards are grouped in the same Hub, the night shift total would be 5 staff (3+2).

** If Admission & Assessment plus two Treatment & Recovery wards are in the one hub, the night shift total would be 8 staff (3+2+3)

6.1) Provision Cost Profile:

Two models have been developed for the purpose of costing the Clinical Model:

Model One is based on the current shift pattern (Treatment & Recovery having 7 staff working the day shift pattern 0700-1445)

Model Two is based on using an alternative shift pattern (Treatment & Recovery having 6 staff working the day shift pattern 0700-1445, plus one member of staff working 0900-1700)

a) 11 Ward Model

Provisional financial modelling has looked at the affordability of 11 wards, i.e. the 'emerging preferred option'. The revised indicative cost of operating an eleven ward model is:

- **£15,880,163** This cost is **(£561,000)** p.a. greater than the current revenue allocation (based on current shift model)
- **£15,669,474** This cost is **(£351,000)** p.a. greater that the current revenue allocation (modelling 9am – 5pm shifts)

Furthermore, eleven wards cannot be safely staffed at this time due to vacancies in the nursing workforce, in spite of multiple attempts to recruit. This reflects challenges elsewhere in NHS Scotland.

An eleven ward option would necessitate a reduction and possible dis-establishment of posts elsewhere to bridge the affordability gap. From a financial perspective, it is unattractive and would pose significant constraints elsewhere across the organisation if this option was recommended.

b) 10 Ward Model

Provisional financial modelling has looked at the affordability of 10 wards. The revised cost of operating a ten ward model is:

- **£15,124,433** This cost is **£194,500** p.a. less than the current revenue allocation (based on current shift model)
- **£14,784,940** This costs is **£534,000** p.a. less that the current revenue allocation (modelling 9am – 5pm shifts)

The ten ward model is affordable within the existing recurring revenue allocation.

7) Recommendation

The Board is asked to:

i. endorse the method applied to reaching the 'emerging preferred option'
ii. acknowledge the significant contribution of the Clinical Forum
iii. note the multi-professional and stakeholder engagement in the process to date
iv. be aware of the variable factors associated with the forensic mental health estate overall which could alter the known planning assumptions at this point in time
v. accept that the affordability of providing an eleven ward model would create significant financial pressures across the organisation
vi. endorse a detailed planning and implementation process allowing The State Hospital to move towards a ten ward model based on eight MMI wards and two ID wards (6.1.b)
vii. Support the establishment of a quarterly review process to assess the effectiveness and challenges of operating on the ten ward model

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Review of Clinical Service Delivery model as detailed in paper.
Workforce Implications	Fully outlined in paper
Financial Implications	Fully detailed in paper
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested paper
Risk Assessment (Outline any significant risks and associated mitigation)	As outline din paper
Assessment of Impact on Stakeholder Experience	As outlined in paper
Equality Impact Assessment	Not indicated
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 X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2019
Agenda Reference:	Item No: 8
Sponsoring Director:	Medical Director
Author(s):	Associate Medical Director
Title of Report:	Overseas Travel Request
Purpose of Report:	For Decision

1 SITUATION

Requests for overseas travel require to be submitted to the Board for their approval. This request relates to work currently being undertaken by Dr Khuram Khan in Pakistan to assist with the development of mental health services. This is in keeping with the NHS Global Citizenship initiative.

2 BACKGROUND

The following request has been received. Line management approval has been given and there are limited financial costs to The State Hospital as detailed.

Travel costs will be at Dr Khan's expense.

EVENT/LOCATION	*DATE*	*STAFF INVOLVED*	*COST*
Protecting Human and Legal Rights of Mentally Disordered People and Offenders in Pakistan.	03- 04 October 2019	Dr Khuram Khan	£300 (all cost can be met through the appropriate departmental budget)

3 ASSESSMENT

Many of the Hospital's staff are asked to present at Conferences and this is an opportunity to share best practice with colleagues from other organisations and to raise the profile of the work carried out within The State Hospital and within the Forensic Network.

Dr Khan has been actively involved in assisting mental health professionals in Pakistan in improving mental health services. Through this work he has been invited to provide an educational presentation on the rights of patients and offenders with mental health problems in Pakistan. This work is in keeping with the NHS Scotland Global Citizenship initiative.

Attendance at this event is regarded as a positive opportunity to raise the profile of the Forensic Network and State Hospital initiatives.

4 RECOMMENDATION

Members are asked to approve the request received for the costs for Dr Khan to attend this event.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of spend of staff requests for International Travel related to sharing of best practice, training and development.
Workforce Implications	Cover by Consultant Colleagues for study leave
Financial Implications	None – organisers are covering the costs
Route To Board Which groups were involved in contributing to the paper and recommendations.	Request received by Chief Executive. Board Members to consider at their next meeting thereafter.
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholders	Learning shared across the organisation for the benefit of patient care. Awareness of international developments in service provision and research.
Equality Impact Assessment	No issues
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
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:	24 October 2019
Agenda Reference:	Item No: 9
Sponsoring Director:	Medical Director
Author(s):	PA to Medical & Associate Medical Directors
Title of Report:	Medical Appraisal and Revalidation Annual Report
Purpose of the 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 2018-19: 7 May and 5 November 2018.

- Revalidation Policy
  The Revalidation and Appraisal Policy was approved by the Senior Management Team on 3 August 2016 and is available on the Intranet. The Policy was due for review in August 2019 and this will be undertaken at the next Revalidation Steering Group meeting on 7 November 2019.

- Responsible Officer
  The Medical Director has undertaken Responsible Officer training and attends Responsible Officer Network meetings.

- Revalidation System
  Revalidation system has been used for 12 Consultants and 2 speciality doctors in 2018-19. This includes one doctor on secondment to Scottish Government. One Consultant is appraised and revalidated through the Chief Medical Officer.

Revalidation system for former / retired colleagues with honorary contracts is in place (n=1).

- Appraisals
  From 1 April 2018 to 31 March 2019, of the 13 medical staff at The State Hospital 12 were appraised during this period.

- Revalidation
  One speciality doctor was revalidated during the specified period. 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
  Due to the number of questionnaires patients have been asked to complete in recent months, it was agreed that these would be issued bi-annually.

- SOAR Appointment System
  SOAR appointment system has been introduced 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. A system has been designed and implemented to have CBDs on a weekly basis. These are minuted.

The TSH Self-Assessment paperwork for 2018-19 was submitted NHS Education for Scotland in 16 April 2019.

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- Annual Audit

Consultants	Last Date for Recommending Revalidation	Date of Revalidation	360 Degree Appraisal Date	Appraisal 01/04/17-31/03/18	CARE Questionnaire Return	Form 4 Completed	Appraisal 01/04/18-31/03/19		Appraisal 01/04/19-31/03/20
	20/11/2023	22/11/2016		22/02/2018	Aug 2018	Yes	07/02/2019		
	16/10/2021	17/10/2016		28/08/2017	Aug 2018	Yes	30/08/2018		24/09/2019
	02/09/2020	03/09/2015		29/03/2018	Aug 2018	Yes	21/02/2019		
	12/02/2020	12/02/2015				Yes	29/11/2018		
	21/12/2019	21/12/2014		13/04/2018					20/09/2019
	02/08/2021	02/08/2016		18/07/2018	Aug 2018	Yes	15/03/2019		
	27/12/2022	27/12/2017		06/12/2017	Aug 2018	Yes	06/12/2018		04/09/2019
	28/03/2024	28/03/2014		27/12/2018	Aug 2018	Yes	28/02/2019		
	21/12/2020	21/12/2015		07/02/2019	Aug 2018	Yes	20/12/2018		
	29/07/2020	29/07/2015		01/02/2018		Yes	28/01/2019		
	21/03/20	23/03/2015		13/06/2018	Aug 2018	Yes	25/04/2019		
	27/10/2019	28/10/2014		19/06/2017	Aug 2018	Yes	14/01/2019		
Specialty Doctors									
						Yes	31/02/2019		
	29/06/2024	05/06/2019		16/06/2017		Yes	29/11/18		
Appraised by Other Organisations									
	15/12/2023	15/12/2018			Aug 2018				30/04/2019
Retired Consultants									
	08/04/20	09/04/15	25/03/14	15/06/2018	Aug 2018 (locum cover)		15/02/2018		09/09/2019

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 the Board (Committee) 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).	None identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2019
Agenda Reference:	Item No: 10
Sponsoring Director:	Director of Nursing and Allied Health Professions
Author(s):	Person Centred Improvement Lead
Title of Report:	Person Centred Improvement Service Twelve Month Report 2018/19
Purpose of Report:	For Noting

1 SITUATION

The remit of the 'Person Centred Improvement Service' (PCIS) includes work streams emerging from:

- Person-centred improvement projects.
- Stakeholder involvement.
- Volunteer Services.
- Carer support.
- Spiritual and Pastoral Care.
- Equality Agenda.
- Supporting the role of the Patients' Advocacy Service (PAS).

2 BACKGROUND

The State Hospital's Person Centred Improvement Service Delivery Plan builds on the national commitment to provide services developed through "mutually beneficial partnerships between patients, their families and those delivering healthcare services, which respect individual needs and values and which demonstrates compassion, continuity, clear communication and shared decision-making" (Scottish Government, 2010).

This report relates to the period November 2018 to October 2019 and reflects another productive year, during which the service continues to support wider disciplines including nursing and medical colleagues in terms of national drivers, including 'Realistic Medicine' and 'Excellence in Care' (Scottish Government, 2015), which make explicit the need to ensure that stakeholder feedback is embedded within the design of services.

This report provides an update in respect of the above work streams under the umbrella of 'person-centred care', in relation to contributing to the delivery of high quality care and treatment which is based on individual need.

This year has seen extensive partnership working with external stakeholder groups, including the Scottish Government Person Centred Stakeholder Group, Scottish Health Council, Volunteer Scotland and Carers' Trust Scotland to ensure that the Board continues to discharge its duties, where appropriate, adopting a tailored approach, mindful of pressure on resources in relation to the number of patients in its care.

3 ASSESSMENT

The data illustrates progress to key performance indicators, demonstrating achievement of 11 of the 16 indicators.

The report highlights key achievements including:

- Developed new improved feedback database to support more effective approach to identifying themes and trends and a more robust monitoring approach.
- Delivered person-centred 'What Matters to You?' (WMTY) initiative.
- Facilitated patient engagement in the Clinical Care Model Consultation process.
- Developed process to enable patients to engage in Staff and Volunteer Excellence Awards process.
- Supported patient engagement in TSH3030.
- Introduced 'Building Thoughts, Connecting Blocks' feedback mechanism to the patient feedback toolkit.
- Facilitated carers' event as part of the national 'Getting Carers Connected in their Communities' initiative.
- Facilitated volunteers' event as part of the national 'Time to Celebrate' initiative.
- Increased the opportunity for the Board to hear stakeholder feedback through use of 'Emotional Touchpoint' presentations.

Actions for the next twelve months including:

- Refresh of TSH Volunteering policy and Procedure.
- Tailor national 'Interpretation and Translation Policy' for implementation locally.
- Develop Carers' Policy.
- Introduce 'carer link' roles in each ward.
- Adapt VIA to incorporate national volunteering framework.
- Develop guidance to support solution based QI approach to respond to feedback.
- Spread EQIA skills.
- Provide mentoring for patients to engage meaningfully in TSH3030 project.

4 RECOMMENDATION

The Board is invited to*:*

- Note the progress outlined in the Report.
- Note the emerging issues, learning opportunities and key actions for the next twelve months.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Supports delivery of the Person Centred Improvement Service Delivery Plan and person-centred deliverables within TSH Local Delivery Plan.
Workforce Implications	None
Financial Implications	None
Route to the Committee Which groups were involved in contributing to the paper and recommendations?	Person Centred Improvement Steering Group Patient Partnership Group Carers' Support Group Volunteer Service Group Scottish Health Council
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	Captures feedback relating to stakeholder experience and provides opportunities to develop systems / processes through which learning from feedback informs service design. Supports Board's commitment to assessing the impact of service delivery on stakeholder experience.
Equality Impact Assessment	N/A
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 Equality Impact Assessment process highlights potential inequalities and support development of plans to mitigate against such practice.
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

PERSON CENTRED IMPROVEMENT SERVICE

TWELVE MONTH UPDATE REPORT

NOVEMBER 2018 - OCTOBER 2019

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1. Introduction

The 'Person Centred Improvement Service' (PCIS) supports services across The State Hospital (TSH) through its diverse work streams contributing to the achievement of strategic objectives within the scope of the service, namely:

- Person-centred improvement projects (Person-centred Health Care Programme (ref 1)).
- Meaningful stakeholder involvement: patients, carers, volunteers, and the public (limited to external regulatory/supporting bodies and third sector partners).
- Volunteer Services.
- Carer / Named Person / visitor support.
- Spiritual and Pastoral Care.
- Equality Agenda.
- Supporting the role of the Patient Advocacy Service (PAS).

TSH Person Centred Delivery Plan (2018-21) builds on the national commitment to provide services developed through "mutually beneficial partnerships between patients, their families and those delivering healthcare services, which respect individual needs and values and which demonstrates compassion, continuity, clear communication and shared decision-making" (Scottish Government, 2010 (ref 2)).

This report relates to the period *November 2018 to October 2019, reflecting on another productive year, during which the service continues to support wider disciplines including nursing and medical colleagues in terms of a range of national drivers e.g. 'Realistic Medicine' (Scottish Government, 2016) (ref 3) and 'Excellence in Care' (Scottish Government, 2015) (ref 4), which make explicit the need to ensure that stakeholder feedback is embedded within service design.

**The previous twelve month report covered the period 1 January 2018 – 31 December 2018. Due to the timing of this paper, the reporting period no longer relates to the calendar year.*

The State Hospital's Board (the Board) is committed to continuously improving systems and processes which support safe, effective, person-centred care, adopting a balanced and proportionate response to legislative and national drivers including:

- Mental Health Strategy (2017-2027) (ref 5).
- Health and Social Care Delivery Plan (2016) (ref 6).
- Rights in Mind (2017) (ref 7).
- Safety and Protection of Patients, Staff and Volunteers in NHSScotland (2017) (ref 8).
- Public Sector Equality Duty (2016) (ref 9).
- British Sign Language (BSL) National Plan (2017-2023) (ref 10).
- Equality Act (2010) (Specific Duties) (Scotland) (ref 11).
- Patient Rights (Scotland) Act (2011, updated 2019) (ref 12).
- Carers (Scotland) Act (2016) (ref 13).
- Fairer Scotland Duty (2018) (ref 14).
- Volunteering for All: Our National Framework (2019) (ref 15)

This year has seen extensive partnership working with external stakeholder groups, including the Scottish Government Person Centred Stakeholder Group, Volunteer Scotland, Scottish Health Council, Health Improvement Scotland and Scottish Carers' Trust to support the Board to discharge its duties, adopting a tailored approach, mindful of pressure on resources in relation to the number of patients in its care.

2. Governance arrangements

The Person Centred Improvement Steering Group (PCISG), chaired by the Director of Nursing and Allied Health Professions, meet monthly to monitor progress in respect of the mainstreaming of processes supporting delivery of the above remit. This multi-disciplinary group ensures the organisation is compliant with legislative requirements and supports the service to respond to national drivers and support local practice relating to the above portfolio. The patient Chair of the Patient Partnership Group (PPG), members of the Carers' Forum and Volunteer Service Group are included within the core membership, in addition to a representative from the Scottish Health Council and the Patient Advocacy Service (PAS).

The group discuss a wide range of quarterly monitoring reports including:

- Patient and Visitor Experience.
- Volunteering input.
- Spiritual and Pastoral Care input.
- Progress to TSH Equality Outcomes (2017-21).
- Progress to TSH British Sign Language (BSL) Action Plan (2018-24).
- Advocacy input.
- Protected Characteristic groups equality monitoring
- Learning from Complaints and Feedback.
- Person Centred Improvement Projects.

In recognition of the value of maximising opportunities to embed patient and carer experience in service design, the 'Learning from Feedback' Report is also included within quarterly monitoring reports presented to the Clinical Governance Group (CGG) and Clinical Governance Committee (CGC).

3. Key pieces of work undertaken

- Service review informing successful recruitment to vacant post.
- Developed new improved feedback database to support more effective approach to identifying themes and trends and a more robust monitoring approach.
- Delivered person-centred 'What Matters to You?' (WMTY) initiative (appendix 1).
- Facilitated patient engagement in the Clinical Care Model Consultation process.
- Developed process to enable patients to engage in Staff and Volunteer Excellence Awards process.
- Supported patient engagement in TSH3030.
- Introduced 'Building Thoughts, Connecting Blocks' feedback mechanism to the patient feedback toolkit.
- Facilitated carers' event as part of the national 'Getting Carers Connected in their Communities' initiative.
- Facilitated volunteers' event as part of the national 'Time to Celebrate' initiative.
- Increased the opportunity for the Board to hear stakeholder feedback through use of 'Emotional Touchpoint' presentations.
- Supported completion of Advocacy service tendering process.

4. Wider input

TSH Strategic Objectives 2017-22: Quality Ambition No. 9: Effective
"Create conditions for supporting quality assurance, quality improvement and change".

The Person Centred Improvement Lead (PCIL) is a member of TSH Quality Improvement (QI) Forum whose role supports the spread of QI skills across the Hospital. The PCIL uses formal QI qualifications and experiential learning to provide mentoring input across the Hospital directly relating to improvement initiatives including:

- WMTY outcomes.
- Patient Active Day project.
- TSH 3030 initiative.
- Equality of access e.g. Intellectual Disability/non-English speaking patients.
- Carer engagement in the Care Programme Approach (CPA) process.
- Supporting Healthy Choices work streams.
- Visiting experience.

These skills are also used to support external QI projects including:

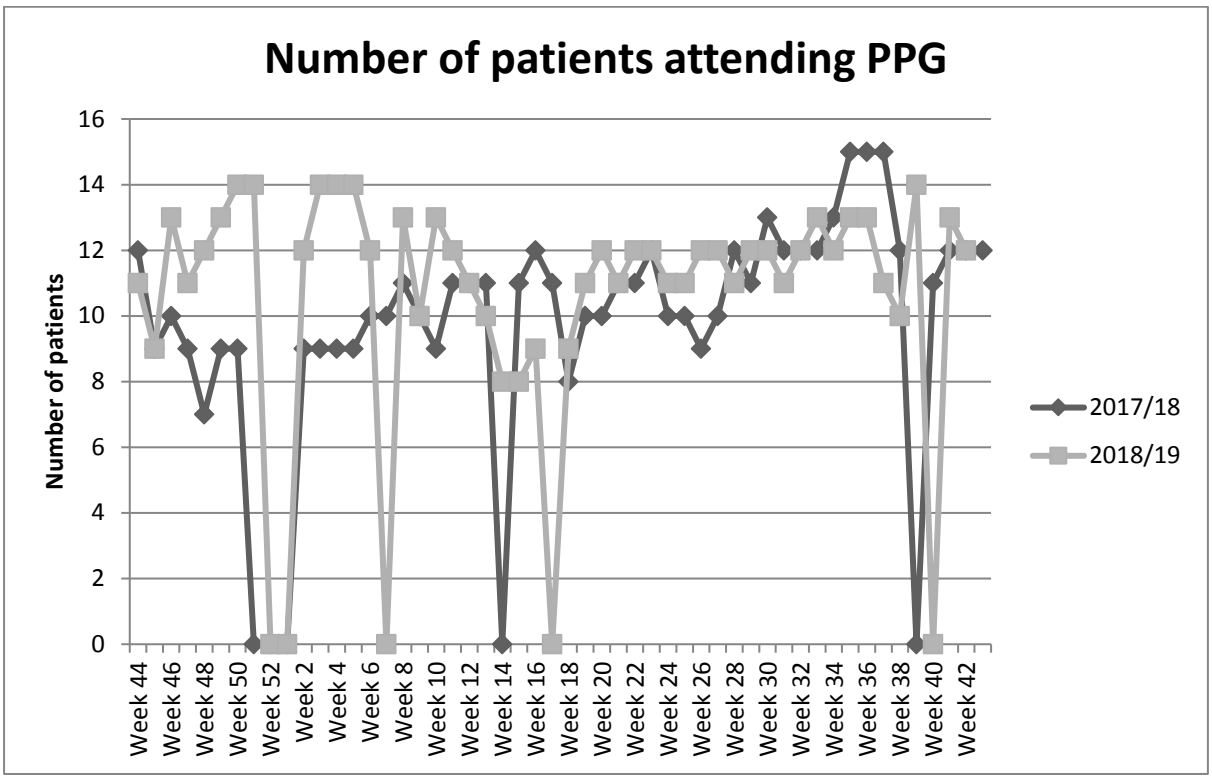
- Refresh of Investing in Volunteering Award.
- Assessing the impact of volunteering.
- Review of NHS Spiritual and Pastoral Care standards.
- NHS Interpretation and Translation Processes.

The PCIL was invited to join the International Forum: 2019 Quality & Safety in Healthcare organising committee, resulting in 6 TSH staff receiving fully funded delegate places for the three day conference in Glasgow in March 2019. This collaboration continues with the PCIL providing input to screening abstracts for the 2020 conference in Copenhagen, through which TSH input in this respect will be formally acknowledged.

5. Key performance indicators

	Improvement Indicator	**Outcome Measures**
1.	Patients from all areas of the Hospital are meaningfully engaged in contributing to service design.	a) Patient Partnership Group (PPG) is facilitated 48/52 weeks. b) PPG membership includes representation from all hubs. c) An average of 10 patients attend PPG each week. d) PPG engage with a wide range of internal and external partners.
2.	More patients have the opportunity to receive visits.	a) 10% increase in volunteer visitor referrals when compared to 2018. b) Conversion rate of 70% (from referral to visits commencing).
3.	Evidence impact of volunteering programme.	a) Undertake baseline assessment using locally tailored Volunteer Impact Assessment. b) 'Green' level achieved for 80% of indicators.
4.	Progress to TSH BSL Action Plan (2018-24)	a) 6 of total of 18 indicators achieved
5.	Carers are enabled to contribute meaningfully to patient outcomes.	a) Complete baseline Triangle of Care assessment (ref 16). b) 'Green' level achieved for 50% of indicators. c) Undertake cycle 2 assessment. d) 'Green' level achieved for 55% of indicators.
6.	Quality of Equality Impact Assessments undertaken	a) 25% increase in quality compliance scores when compared to 2017.
7.	Progress to achieving the three published TSH Equality Outcomes by April 2020.	*Outcome 1 – already complete.* a) Outcome 2 - 5 of 7 indicators completed b) Outcome 3 – 7 of 9 indicators completed.

1) Patients from all areas of the Hospital are meaningfully engaged in contributing to service design



Planned closures
2017/18 – Weeks 51, 52, 1, 14, 39
2018/19 - Weeks 52, 1, 17, 40

Unplanned closures
2018/19 - Week 7 = staffing issues.

a) Patient Partnership Group (PPG) ***facilitated 48 weeks during the year*** (target of less than 52 weeks accounts for 4 weeks public holidays).

Delivery to outcome measure a): Unachieved. 47 weeks. Some challenges around resourcing, specifically to cover leave, with support from other disciplines on four occasions and direct input from PCIL on a regular basis to ensure continuity of service delivery.

b) ***PPG membership includes representation from all 4 hubs***

Delivery to outcome measure b): Achieved. 100% of hubs represented at all meetings, succession plan in place to ensure continuity of involvement as patients transfer to step down services.

c) ***An average of 10 patients attend PPG each week***

Delivery to outcome measure c): Achieved. Target of ten patients influenced by total number of people in the group, including staff and visitors in conjunction with environmental Health and Safety restrictions, safety and security when working with large patient groups and ensuring all patients have the opportunity to engage meaningfully. Attendance at meetings fluctuates depending on the meeting agenda, mental health presentation of group members and requirement to attend tribunals and external clinical appointments which cannot be scheduled around the group timetable. The average attendance in 2018/19 was 11 patients.

"At first I was nervous about taking on the role but with staff support I soon felt OK with it. Part of the job is keeping order in the group, it can be a bit noisy at times. Nobody falls out though as we are all friends. Another part of my job is taking a report to another group where I give them an update on what's been happening in PPG in the last month or so. I've settled into it now and don't feel out of place at all. Because of my role I have had the opportunity to meet and talk to the Chief Executive and Nursing and AHP Director. One of the big discussions we have had was looking at the options for the way the Hospital will run in the future. We had a whole morning to discuss this and it's great that we are being asked to be involved in our care and treatment."

PPG Chair, September 2019

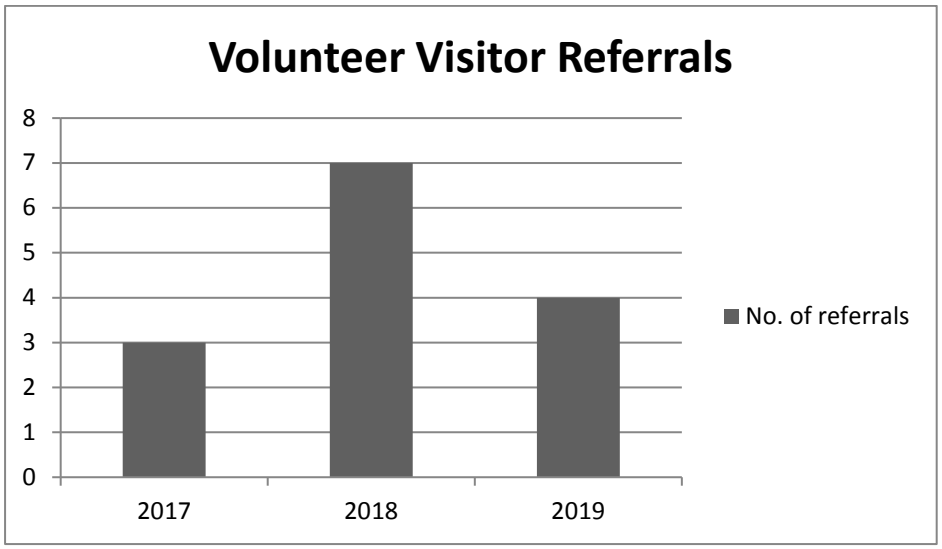
d) ***PPG engage with a wide range of professionals and external partners***

Delivery to outcome measure d:) Achieved. In addition to monthly input from Catering staff, Scottish Health Council, and PAS, a wide range of stakeholders have engaged with PPG during the year, including: Chief Executive, Chair, Director of Nursing and AHP, Medical Director, Director and Deputy Director of Security, Occupational Therapy, Lead AHP, Dietetics, Speech and Language Therapist, Higher Trainee Psychiatrist, Nursing staff, Professional Nurse Advisor, Infection Control Practitioner, Skye Centre staff, Scottish Government Person-centred Team and Chair of the Review of Scotland's Mental Health Services.

2) More patients have the opportunity to receive visits

a) ***10% increase in volunteer visitor referrals when compared to 2017/18***

Delivery to outcome measure a): Unachieved. Clinical outcomes monitoring continues to highlight the number of patients who receive no visits. Clinical Teams receive regular reminders to consider use of the volunteer visitor referral scheme. Data from the most recent monitoring report (Jul 2019) indicates that 42 of the 107 (45%) patients in the hospital at that time did not receive any non-professional visits. Data will be recorded moving forward to support a better understanding of the rationale e.g. mental health presentation, patient preference.



b) *Conversion rate of 70% (from referral to visits commencing)*
Delivery to outcome measure b): Achieved. Three of the four patients referred are now receiving visits, equating to a 75% conversion rate against the target of 70%. One of the patients involved experienced a significant decline in metal health during the process and was therefore unable to engage at that point. The referral is reviewed regularly by the Clinical Team who will resubmit when appropriate.

"We had a social event in the hub and I was able to invite my volunteer visitor so I had my own 'family' there like other patients".

TSH patient August, 2019

"I feel part of the Hospital community. I'm kept well informed about what's going on which helps me to understand about challenges staff have working in this setting. Staff are very welcoming and make sure that the patient is able to enjoy his visit with me".

TSH Volunteer Visitor, September 2019

3) Evidence impact of volunteering programme

a) *Undertake baseline assessment using locally tailored Volunteer Impact Assessment (VIA)*
Delivery to outcome measure a): Achieved.

b) *Green' level achieved for 80% of indicators*
Delivery to outcome measure b): Achieved.

4) Progress to TSH BSL Action Plan (2018-24)

a) 6 of total of 18 indicators = 33% achieved
Delivery to outcome measure a): Achieved.

5) Carers are enabled to contribute meaningfully to patient outcomes

a) *Undertake baseline Triangle of Care assessment (43 indicators)*
Delivery to outcome measure a): Achieved.

b) *Green' level achieved for 50% of indicators*
Delivery to outcome measure b): Unachieved. 28% = 12 indicators
The initial baseline assessment highlighted some issues relating to practice which is in place however not supported by evidence and therefore scored within the 'amber' category. Agreement reached with all stakeholders to remove one indicator which is not pertinent to this environment and merge one other to support a cohesive approach to achieving a robust outcome.

c) Undertake cycle 2 assessment
Delivery to outcome measure c): Achieved.

d) 'Green' level achieved for 55% of indicators (41 indicators)
Delivery to outcome measure d): Unachieved. 44% = 18 indicators

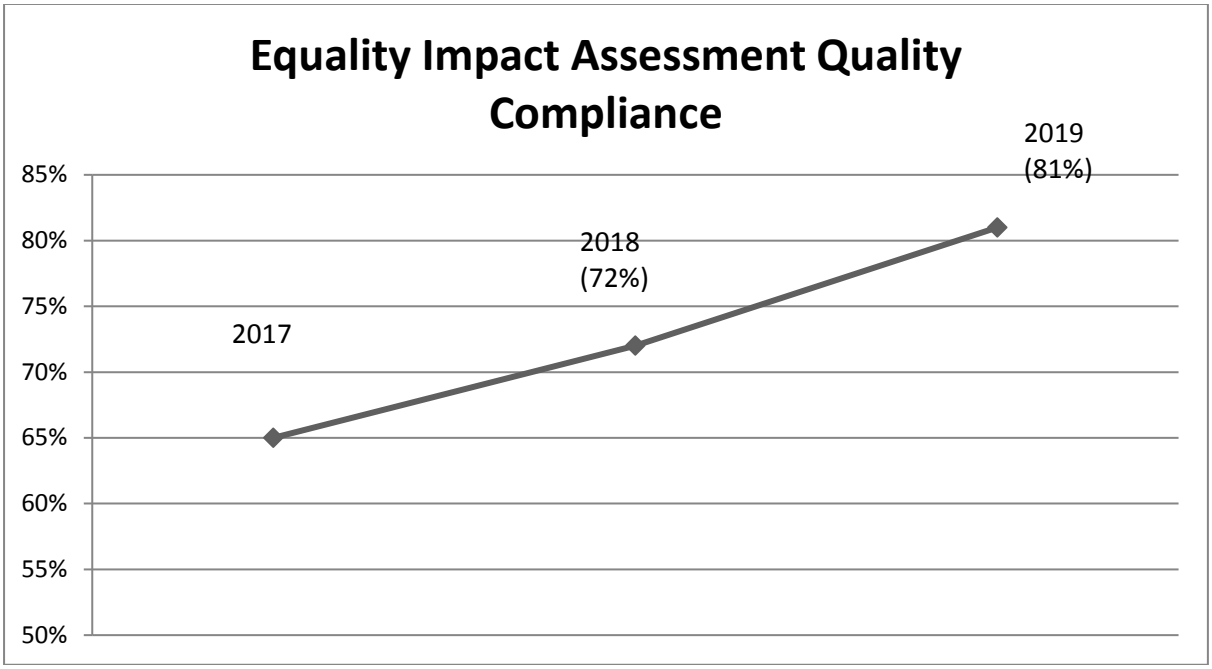
Standard	Red	Amber	Green	Total No. of Indicators
No. 1	2 (5)	3 (3)	3 (0)	8
No. 2	1 (1)	1 (1)	1 (1)	3
No. 3	2 (2)	2 (2)	4 (4)	8
No. 4	1 (1)	2 (2)	2 (2)	5
No. 5	3 (6)	3 (2)	6 (5)	*12 (13)
No. 6	3 (6)	1 (0)	2 (0)	**5 (6)
Total	**11 (21)**	**12 (10)**	**18 (12)**	**41 (43)**

Figures in brackets relate to outcome of baseline assessment.

*2 indicators merged
**1 indicator removed following consultation with external partners

6) Quality of Equality Impact Assessments Undertaken

a) *25% increase in quality compliance scores when compared to 2018*
Delivery to outcome measure a): Unachieved. Although quality compliance has increased by 12% since 2018, there is still work to be done to enhance the quality of Equality Impact Assessments (EQIA) undertaken.



TSH currently has a suite of 132 policies, 40 of which have not undergone the local EQIA process. 18 of which are owned by Human Resources, the majority 'Once for Scotland' policies which will not require a local EQIA. 12 of the outstanding polices require a new EQIA as the policies were implemented prior to the new EQIA being introduced in 2015.

The quality of EQIAs produced has improved again this year, potentially directly linked to additional 1:1 support provided to the majority of policy authors. Due to the dynamic nature of resourcing, responsibility for writing policies regularly changes, resulting in the need for delivery of an annual training session supported by tailored input thereafter. Service leads have been asked to ensure that staff required to develop policies have been appropriately trained.

The data continues to indicate a lack of awareness around the impact of policies / protocols, specifically in relation to the Protected Characteristic groups**.** The characteristics relating to 'disability', 'age' and 'race' are of particular relevance to the organisation in the context of future-proofing clinical service delivery, particularly relevant to current discussions relating to the configuration of clinical services moving forward.

Local expertise supporting the EQIA process is an area for consideration as the PCIL is currently responsible for providing support, in addition to screening all completed EQIAs prior to submission to SMT. Due to resourcing issues within the service it has not been possible to spread this skill set within the team to support wider spread across all services.

7) Progress to achieving TSH Equality Outcomes by April 2020

a) Outcome 2 - Implementation of individually tailored healthy lifestyle plans which support the physical health and well being of all patients within the Hospital: *5 of 7 indicators complete*

Delivery to outcome measure a): Achieved.

b) Outcome 3 - Service delivery will enable all patients within the Hospital to benefit from equitable access to care and treatment: *7 of 9 indicators complete*

Delivery to outcome measure b): Achieved.

Key performance indicator overall performance

11 of 16 indicators achieved – within 10 months of the original 12 month period – 1 January 2019 – 31 December 2019.

6. Wider service specific performance objectives

Delivery of Mandatory Equality and Diversity Training

This area of our training suite continues to be delivered via the mandatory online module, which was updated this year, in addition to attendance at a half day interactive workshop. In common with other mandatory training, we continue to experience challenges, in terms of nursing attendance, particularly valuable in terms of the opportunity to engage in multi-disciplinary values based discussions, based on local case studies.

Enabling Patients to share Feedback which Contributes to Service Design

Patient and carer feedback has previously been reported within the 'Learning from Complaints and Feedback' Report. Following a review of the functions of the two services involved in compiling this report, it was agreed that feedback would form part of a dedicated report as of April 2019.

A new recording system has been developed (appendix 2) to ensure that feedback data is disseminated to support service improvement, which results in an enhanced experience for patients and carers.

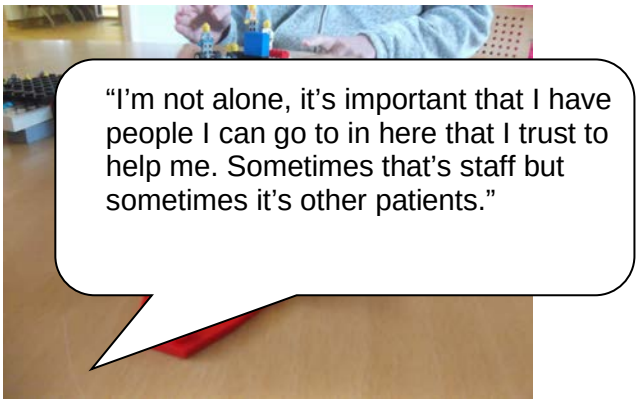
Data shared identifies the area to which it relates in order to enable local teams to understand the impact of practice on patient / carer experience. Local teams are empowered to take ownership for developing actions in collaboration with stakeholders, which support the organisation to share best practice and learn about opportunities to improve service delivery from colleagues who have tested and implemented improvement ideas.

Use of this new system enables the organisation to respond to benchmarking relating to specific national programmes including 'Realistic Medicine', specifically around shared decision making, 'Excellence in Care' and 'What Matters To You?'.

Engaging in the national 'What Matters to You?' initiative continues to provide a wealth of opportunities for service improvement incorporating stakeholder feedback.

All hubs and the Skye Centre participated in this year's WMTY event which was facilitated across the Hospital on 6 June, 2019. A variety of methods were adopted to support patients to share their feedback including creative medium, feedback questionnaires, 1:1 conversations and group discussion.

The Art and Music Therapists supported this year's Skye Centre event enabling patients who experience significant barriers to communication to participate. Patients were also encouraged to use 'Lego', adopting the concept of 'Building Thoughts: connecting blocks' to support those with limited vocabulary to share their views in a less stressful way.



Teams were asked to review the feedback shared and agree on a maximum of three actions for their area in collaboration with patients. In order to manage aspirations, they were reminded that emerging actions should be realistic in terms of timeframes and cost neutral unless a revenue source has been identified. All areas submitted their outcomes and action plans, which are updated on a quarterly basis through Hub / Skye Centre Leadership Team Meetings and monitored by the Person Centred Improvement Steering Group.

PPG suggested that an award be presented to recognise an output emerging from WMTY feedback which has the most positive impact on patient experience. Patients will agree on a shortlist and vote for the winning action to be presented in the spring of 2020.

A session was facilitated in February 2019 through which patients were supported to contribute their feedback to the wider consultation process relating to the Clinical Care Model delivery options.

The *'River' Model was used (appendix 3) to record responses (appendix 4) to three questions:

- What do you think works well with this model?
- What do you think might not work so well with this model?
- What else do you think we need to think about, such as a completely different model?

"You could use the rehab wards to test patients to see if they're ready to move on instead of sending them outside for shopping outings when the papers take photos of them.
Being able to use hot water and tools and showing you have coped with moving through different hubs and worked with lots of different clinical teams is a good test to see how you would cope with being in Rowanbank. It's not just about whether you've had any security problems like you've hit someone or shouted at someone. People say that this isn't a good idea cos you don't get to do these things when you first move on but that's a problem to do with how they manage medium secure places, not ours"

"We should have a ward for folk who need more help, not for their mental health – for guys who are older or need to use things to help them walk or can't speak English or see/hear properly or when they ask staff about the same thing all the time cos they forget what they're doing".
"I'm older than most of the guys in my ward and I can't be bothered having to listen to their loud chat and what they want to watch on the TV or them wanting to listen to the music channels for young folk."
"You're always going on about person-centred care when you tell, us this is about treating us as individuals. But this doesn't happen here – outside, there's different units for young people and older folk."

As a member of a number of internal groups, the PCIL ensures the views of stakeholders are shared within discussions informing service design:

- Senior Management Team (SMT).
- Clinical Governance Group.
- Skye Centre Leadership Team.
- Patient Active Day Project Group.
- Mental Health Practice Steering Group.
- Clinical Forum.
- QI Forum.
- Security Governance Group.
- Service change consultation / Short Life Working Groups.

The PCIL also ensures the unique needs of TSH stakeholders are shared in respect of influencing the national person-centred landscape, through membership of external groups including:

- NHS Person-centred Leads.
- NHS Equality Leads.
- Scottish Government Person Centred Stakeholder Forum.
- NHS/Third Sector Volunteer Leads.
- Scottish Government Cross-Party Volunteering Forum.
- NHS Spiritual and Pastoral Care Leads.

The Chief Executive has attended PPG on a number of occasions since his appointment in April. PPG welcome his presence and the opportunity to share what matters to them. Directly as a result of this engagement, in response to feedback, a small budget has been allocated to the group to support improvement initiatives.

<u>Patient Engagement in Spiritual and Pastoral Care Activities</u>
The number of patients regularly engaged in spiritual and pastoral care activities, including weekly denominational services of worship, Christian Fellowship and 1:1 ward based input, remains consistent at an average of 14.

Input	No of closures	Rationale	
Mass	9	**Planned closure** 3 x Public Holidays *4 x Chaplain's Annual Leave,	**Unplanned closure** *2 x unanticipated parish commitments
Church	12	**Planned closure** 4 x Chaplain's Annual Leave **6 x International Placement	**Unplanned closure** 1 x unanticipated parish commitment 1 x no patient movement
Christian Fellowship	1		**Unplanned closure** 1 x no patient movement
Total	**22**		

*4 of 8 patients opted to attend church and Christian Fellowship and therefore had access to spiritual and pastoral care during those weeks.

**3 sessions covered by another Minister

Volunteer Service Development

There are currently 17 volunteers (20 in 2017/18) providing a wide range of input to complement service delivery across the Hospital. In response to Stakeholder feedback volunteer recruitment is now a targeted approach in collaboration with services who are encouraged to identify specific roles which compliment gaps in patient activity. This practice supports a mutually beneficial outcome in terms of ensuring volunteers have the skills/interests required for the area in which they are placed.

The Scottish Government National Volunteering Framework, developed over a number of years, was published in April 2019. A gap analysis was undertaken, highlighting amendments required to the VIA in order to support a nationally agreed approach. The Volunteer Service Group are currently informing discussions to update the VIA.

Volunteers were presented with gifts made by patients at an event in June hosted by the Board as part of National Volunteer Week: 'Time to Celebrate'.

A number of volunteers were nominated by staff and patients in TSH Staff and Volunteer Excellence Awards. Two individual volunteers and the Christian Fellowship Group have been short-listed as finalists in the awards process culminating with the awards ceremony on 24 October, 2019.

The role of Volunteer Fundraiser has been advertised for some time however we have recently commenced the recruitment process with a view to having the applicant in place early in 2020. This role will facilitate Hospital wide support to identify external funding opportunities which will contribute to improvement projects which aim to improve patient experience.

Carer Support

The Board hosted an event in August 2019 as part of National Carers' Week: Getting Carers Connected in their Communities. For the first time, the event was facilitated in the Family Centre, providing an opportunity for carers and patients who do not normally access this environment to enjoy a new experience, including access to the outdoor area.

Feedback relating to the visit experience continues to highlight ongoing challenges in relation to delays in transporting visitors to the wards, frustrations around access for food and fluids, concerns relating to use of the ward dining rooms as visiting areas and a lack of

access to the outdoor environment. The Visit Experience Short Life Working group met for the first time in August 2019 to commence a scoping exercise and identify opportunities to enhance the visiting experience. Recommendations will be shared with the Senior Management Team for further discussion.

Carers continue to benefit from financial support towards the cost of travelling to and from the Hospital. A full review of home locations was undertaken in February 2019, resulting in amendments to existing complimentary transport arrangements. This realigning of the budget has enabled opportunities to provide additional travel support for carers wishing to visit more regularly / attend social events, in addition to encouraging attendance at care review meetings.

Patient Advocacy Service (PAS)

The PCIS continue to support the role of PAS, ensuring that the PAS Patient Board member is able to attend regular meetings and participate fully in the PAS AGM, held externally, via video link, along with the PPG.

The PCIL meets regularly with the PAS Manager to discuss forthcoming Mental Welfare Commission visits, and general feedback shared, maximising opportunities for learning.

The Person Centred Improvement Advisor, PAS Manager and Complaints Officer meet every month to share feedback from patients, identify trends / themes and use a triangulated approach to analysing the data included within the quarterly 'Learning from Feedback' Report.

The Advocacy Service tendering process has been undertaken, with the existing provider the preferred bidder, ensuring continuity of input for patients. Key Performance Indicators have been refreshed within the Service Led Agreement Contract to reflect changes in practice during the time in situ.

7. Contribution to organisational objectives

In addition to working towards service KPIs and objectives, the PCIS has been proactive in terms of supporting progress to a number of organisational objectives within the Local Delivery Plan 2017-2020:

Clinical Model Principle 2 Patient Focussed Care	**Action**	**Outputs**
Local Delivery Plan 7.2 Patient Experience "As outlined in the National Services Framework, we will place patients and their carers at the centre of all service planning and delivery".	Meaningfully engage patients and carers in the Supporting Healthy Choices (SHC) project implementation work streams.	• PPG engaged in supervised online shopping pilot project and short life working group. • PPG involved in group exploring increased access to fruit. • PPG have established the 'Oot and Aboot' Active Group as part of their group structure. • Visitor Information Pack updated to support healthier choices of gifts of food / fluids.
	Respond to anecdotal feedback from patients and carers in respect of challenges around meaningfully contributing to the Care Programme Approach (CPA) process including: • time of meeting; • duration of meeting; • complex paperwork; • numbers present; • language (jargon); • support to contribute to the process.	Semi-structured feedback tool introduced in 2018 to elicit data relating to attendance at discharge/transfer CPA Meetings. As a result of insufficient responses it has not been possible to identify learning opportunities. Agreement that this process will now be undertaken by the PCIA. A suite of feedback pro-formas has now been developed as part of ToC workstreams which will support a holistic approach to learning about all aspects of the CPA process.
	Respond to patient and carer feedback relating to challenges around the clinical model of service delivery, specifically in respect of access to activity and being confined to bedrooms periodically as part of the organisational response to resourcing challenges.	Feedback shared through quarterly 'Learning from Feedback' Report. Feedback incorporated within wider piece of work commissioned by the Board in relation to reviewing Clinical Service Delivery Model.

	Support patients to engage in the national 'WMTY?' initiative (June 2019).	Dedicated Skye Centre stakeholder event involving patients, staff and volunteers, from which action plans have been developed from feedback shared. Quarterly progress updates reviewed by teams involved informing service development. All hubs participated, developing action plans which are monitored by Hub Leadership Teams. Quarterly update reporting to PCISG, Clinical Governance Committee and SMT WMTY initiative outputs shared nationally as an exemplar of 'best practice' by Health Improvement Scotland via the Person-centred Health and Care Programme.
Ensure the patient and carer 'voice' is heard at a senior level within the organisation.		Leadership walk rounds continue, facilitated by senior managers, during which time patients are encouraged to share their experience. Throughout this year, TSH Board Meetings have regularly commenced with a patient / carer story, shared through a range of medium including Emotional Touchpoints, the River Model and WMTY creative feedback outputs.

Engage with external partner stakeholders to ensure the unique needs of TSH patients / carers are understood and opportunities to influence national service / policy design are maximised.	The Scottish Health Council attends PPG regularly and form part of the membership of the PCISG. The PCIL meets with the Mental Welfare Commission (MWC) as part of their regular visit process. Contact throughout the year is ongoing in response to patient feedback shared directly with the MWC. The Person-centred Health Improvement Scotland Team has attended PPG this year and provide feedback in response to national submissions relating to the WMTY initiative. The Scottish Government (SG) Person-centred Lead has attended PPG this year and engages with the PCIL through the quarterly SG Person-centred Stakeholder Group meetings. Carers' Trust Scotland are supporting the Triangle of Care assessment process, providing valuable input from a wider perspective. Patients and carers contributed to TSH Annual Review process in January, 2019, through direct engagement with the Board / Minister as part of the Stakeholder Engagement Session.

Progress to key actions identified within 2018 twelve month report

Action	**Outcome**
Develop 'Supporting Patient Communication Policy'	Complete.
Undertake service review to inform resourcing structure.	Complete.
Recruitment to vacant post.	Complete.
Develop Hospital wide feedback processes.	Complete.
Facilitate WMTY initiative.	Complete.
Facilitate TSH Annual Review Stakeholder forum.	Complete.
Present outcomes emerging from Triangle of Care.	Complete.
Spread skills relating to EQIA.	Deferred to 2020 until new staff in post.
Complete Equality Outcomes	Partially complete. Remain on target.
Extend VIA to include staff feedback.	Deferred to 2020 pending refresh of VIA.
Make recommendations to enhance patient / carer engagement in CPA process.	Deferred to 2020. Insufficient data.
Contribute to the spread of QI skills across the Hospital.	Ongoing.
Contribute to development of person centred Key Performance Indicators informing organisational performance monitoring and reporting framework.	Ongoing.

8. Progress to key actions identified within 2018 twelve month report

Challenges	Solutions / Development Opportunities
Stakeholder Feedback Inconsistent systems in place to support a QI approach which adopts evidence based approaches to acting on learning opportunities and sharing best practice.	• Develop guidance to support solution based QI approach which enables services to demonstrate collaborative service design.
Carer Input Maximising the opportunity to actively engage carers.	• Develop TSH' Involving Carers' Policy'. • Develop online Carer Awareness Module. • Introduce Ward Carer Link roles.
Equality Impact Assessments Spread the knowledge and skills relating to this process to ensure that the organisation adopts a resilient approach and is able to demonstrate a consistent, robust approach which satisfies scrutiny in relation to equality of service delivery to *Protected Characteristic groups: *Age, disability, gender, gender reassignment, marriage and civil partnership, maternity and pregnancy, race/ethnicity, religion and/or belief, sexual orientation.	• Work with service leads to develop expertise within their areas, including delivery of supplementary training. • Identify policies which still require EQIAs, analyse to highlight where there may be training needs which could be met through a group workshop session.
Visit Experience Consistent feedback in relation to issues around the quality of the visiting experience.	• Support Hospital wide working group to identify and explore options to enhance the visiting experience.

9. Implications

Staffing

Despite significant progress again this year, the increased workload in relation to supporting a more robust quality improvement approach has had some implications in terms of completing the full complement of key actions.

The Patient Involvement Facilitator (PIF) role has been vacant since December 2015. This gap in clinical staffing impacted significantly on facilitation of front line groups and the ward outreach programme, specifically around spiritual and pastoral care and the patient involvement agenda. Since 2016, the service has been fortunate to benefit from the input of an experienced staff nurse registered with the Nursing Pool, who has consistently provided two/three full days input. The PIF post has a full-time remit within the establishment of this area of service delivery. This contingency part-time resourcing has proved to be insufficient in terms of meeting the service objectives relating to follow-up work streams supporting improvement of the patient / carer / volunteer experience.

Maintaining facilitation of front line groups has, on many occasions, this year relied on support from a wide range of colleagues across the Hospital whose input is acknowledged and commended, given their own responsibilities.

In addition to undertaking a busy remit, the PCIS regularly support the work of the Skye Centre Team to ensure patient placements remain open.

Recruitment to fill the vacant post was approved in the spring of 2019. An initial recruitment process proved to be unsuccessful in respect of appointing a candidate with appropriate experience. Following re-advertisement of the post in June 2019, interviews took place in September 2019. Two very experienced internal nursing candidates, (due to retire at the end of this year) have been appointed on a job share basis, to the role of Patient Experience Improvement Advisor (the new designation to replace that of Patient Experience Facilitator).

Finance

All elements of the service were delivered within budget during the year. As a result of the resourcing shortfall, significant savings have been made within the workforce element of the PCIS budget, contributing to the Nursing and AHP directorate budget.

10. Key actions for the next twelve months

- Refresh of TSH Volunteering policy and Procedure.
- Tailor national ‘Interpretation and Translation Policy’ for implementation locally.
- Develop Carers’ Policy.
- Introduce ‘carer link’ roles in each ward.
- Adapt VIA to incorporate national volunteering framework.
- Develop guidance to support solution based QI approach to respond to feedback.
- Spread EQIA skills.
- Provide mentoring for patients to engage meaningfully in TSH3030 project.

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Appendix 1

‘What Matters to You’? 2019 Outcomes

Area	Actions Agreed	Timescale
Arran Hub	Increased access to fresh air: more walking groups, patio open when possible.	Jul 19
	Increased opportunities for exercise: open hub gym when possible, walking groups, look into pedometers, exercise bike for Arran 1.	Aug 19
	Healthy eating: more fruit on ward, healthy eating programme as part of Hub education.	Sep 19
Iona Hub	Prioritise access to fresh air by support from wider disciplines to maintain walking groups.	Jul 19
	Support more regular 1:1 conversations with Key / Associate Key Worker.	Oct 19
	Develop processes to support visiting within the hub area.	Jan 20
Lewis Hub	*Awaiting Actions*	
Mull Hub	Increase range of Hub activities, ensuring they are fit for purpose.	Dec 19
	Alternative arrangements to ensure patients are occupied when placements are cancelled.	Mar 20
	Develop information for patients which details projected pathway through / out of the Hospital.	Mar 20
Crafts	More themed sessions e.g. 1 day workshops	Nov 19
	Pop up shop to sell items produced	Nov 19
	Exhibition of patient work: rotate cabinet items regularly	Nov 19
Gardens	Ensure access to gardens placements are maximised over summer period	Jul 19
	Consider potential external funding opportunities for projects e.g. allotments	Sep 19
	Explore possibility of patients using fruit and veg in therapeutic cooking sessions	Jul 19
Atrium	Recruit patient café volunteer	Oct 19
	Xbox to be more regularly available during Patient Day sessions	Jul 19
	Facilitate a minimum of two evening social activity events	Aug 19
Sports	Tea / coffee available within sports area	Jun 19
	Recruit patient volunteers / mentors	Oct 19
	Consider weekend / evening activities	Dec 19
PLC	Water cooler / dispenser	Jul 19
	Reduce noise levels within a number of sessions	Dec 19
	Offer new interactive learning opportunities	Oct 19
PPG	More robust succession planning process	Dec 19

	Ensure patient representation from every ward	Aug 19
	Influence progress to supervised internet shopping project	Jul 19

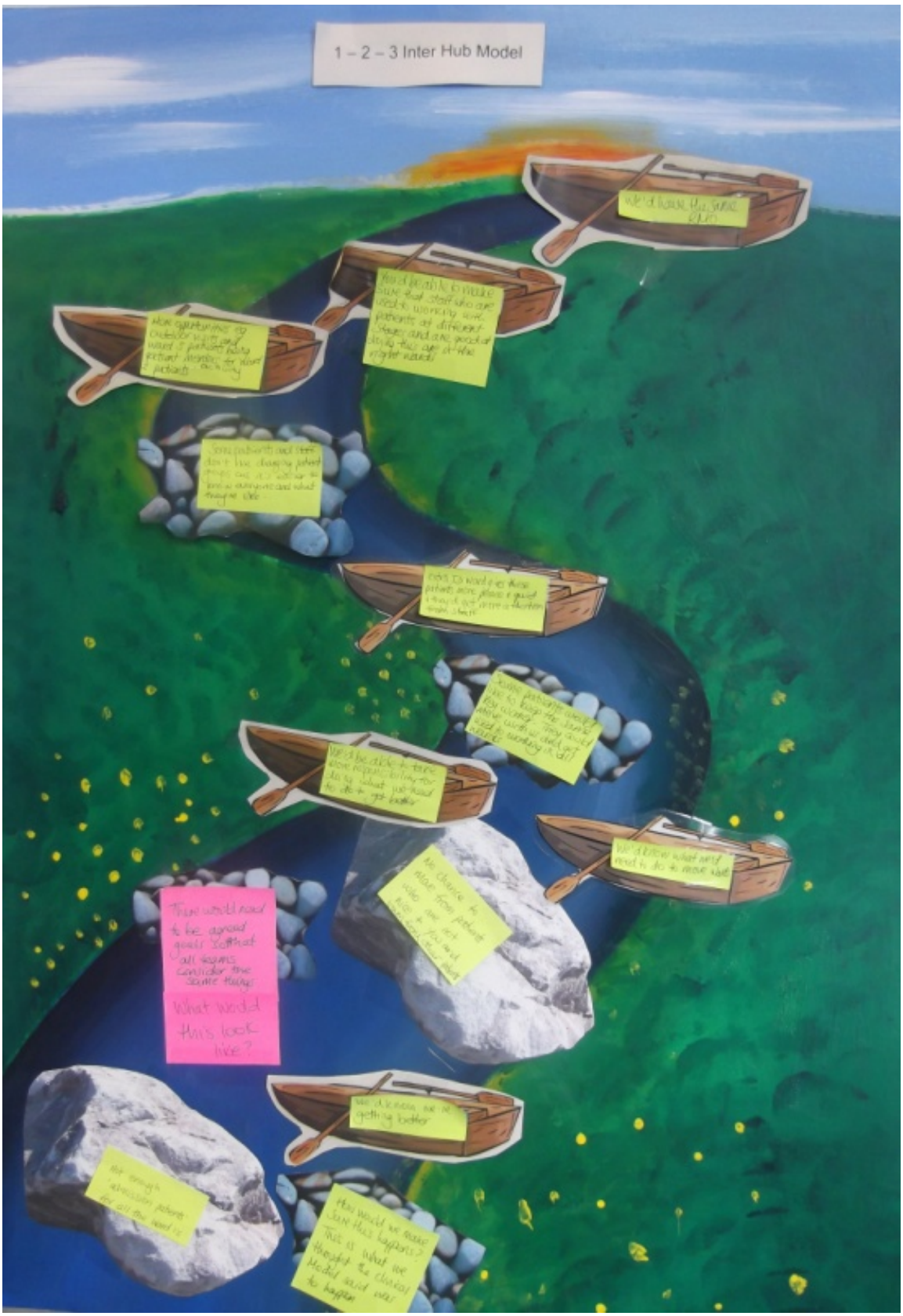
Appendix 2

Learning from Feedback – Coding system

Level 1 coding	Level 2 coding
Person Centred Values (PCV)	PCV - Cultural and faith related matters
Consistency and Continuity of Care (CCC)	PCV - Spirtituality
Efective Communication (EC)	PCV - Dignity and Respect
Physical Comfort (PC)	PCV - Discrimination
Emotional Support (ES)	PCV - Vistimisation and Harassment
Effective Relationships (ER)	PCV - Quality of Life matters
Access to Care (AC)	PCV - Shared Decision Making
	EC - Diagnosis
	EC - Medication
	EC - Therapuetic Intervention
	EC - Physical Health Promotion
	EC - Individual communication needs
	PC - Daily living activities
	PC - Catering Service
	PC - Shopping
	PC - Clean and Comfortable Surroundings
	ES - Safety and Security
	ES - Physical and Verbal Aggression
	ES - Clinical Status
	ES - Grounds Access
	ER - Decision making
	ER - Meaningful involvement of carers
	ER - Accommodation of individual needs
	ER - Access to Hospital Environment
	ER - Interactions with staff
	AC - Step down/alternative sevices/transfer to prison
	AC - Internal/External services waiting times
	AC - Outings
	AC - Equality and Opportunity

Appendix 3

River feedback model – Clinical Care Model Consultation



Appendix 4 Clinical Care Model Consultation responses

Option 1	Boats (opportunities)	Pebbles (challenges)	Boulders (obstacles)
1-2-3 Inter Hub Model plus 2 Intellectual Disability Wards	You'd be able to make sure that staff who are used to working with patients at different stages and are good at doing this are in the right wards.	How would we make sure this happens? This is what the Clinical Model says should be happening now.	No chance to move from patients who are not nice to you and have the chance to live with other patients who can teach you things.
	More opportunities e.g. outdoor visits, activity, ward 3 patients being patient mentors for ward 2 patients.	Some patients would like to keep the same key worker. They could move with us and get used to working in all wards.	Not enough admission patients to make three wards so you'd have lots of staff spread out.
	Extra ID ward gives these patients more peace and quiet and they'd get more attention from staff.	Some patients and staff don't like changing patient groups cos it's easier to know everyone and what they're like.	
	We'd have the same RMO		
	We'd be able to take more responsibility for doing what we need to do to get better.		
	We'd know we're getting better.		
	We'd know what's needed to move hubs.		

Option 2	Boats (opportunities)	Pebbles (challenges)	Boulders (obstacles)
Ward Configuration Model **2 x Admission,** **2 x Intellectual Disability,** **4/5 x Continuing Care,** **2 x Discharge**	If you're not very well, you know that staff looking after you know what they're doing.	Anxious about living with different patients and being looked after by different staff.	
	Getting to know other patients who can talk to you about the same things you're going through.	Coping with moving back to the 'admissions' ward if you have a problem – like taking a step back, being punished.	
	Patients at the same stage.		
	Patients able to help other patients.		
	Staff can let you help out more in the ward cos everyone is the same risk.		
	Able to do more together.		
	Extra Intellectual Disability ward would be good for these patients who need less patients round about them.		

	Change of Clinical Team – this might be good because you'd have to change teams when you move to another ward. Some doctors are better than others at helping patients to get to Medium Secure. But it might be difficult for other patients depending on what stage they're at because of how you begin to trust each other.

Option 3	Boats (opportunities)	Pebbles (challenges)	Boulders (obstacles)
Status Quo Model	Same RMO (doctor).	Feels safe because we know this model but we know it's not right.	Staff moving about between wards a lot.
		You've got new staff working with patients who aren't very well who they don't know how to care for them.	Ward routine depends on how well patients are – often all about one or two patients who are very sick so that means everyone else can't do things.
		Most wards are noisy when new patients come in and it means you can't relax.	People don't know what needs to happen to make progress. Patients often a long time in the 'admission' stage.
		Depending who's on shift, depends on how the ward runs and what you get to do. Some staff let you do things other staff say you're not allowed to do.	Staff don't have time to speak because they're having to deal with patients not very well.
		Takes too long for everything to happen like grounds access, starting to go to the Skye Centre.	Doesn't work cos we've been locked in our rooms.
			We're all treated the same – apart from the phone, mail and grounds access, restrictions are the same no matter what stage you're at.
			Because you can't open bedroom doors at night, even with patients who are ok, when your key worker is on night shift, you can only speak to them through the door.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2019
Agenda Reference:	Item: 11
Sponsoring Director:	Director of Nursing and AHPs
Author(s):	Board Secretary
Title of Report:	Patient Safety, Infection Control and Patient Flow Report
Purpose of Report:	For Noting

1 BACKGROUND

This report is presented to the Board to provide an update in relation to patient safety, healthcare associated infection and patient flow.

2 PATIENT SAFETY UPDATE

The last patient safety meeting was held on 1 October.

A brief summary of Scottish Patient Safety Programme (SPSP) activity across the Hospital in the last two months under the four workstream headings includes:

Communication
Post incident debriefs are ongoing but awaiting further input around how these will link in with the psychological first-aid proposed by the psychology department.

Weekly pre-weekend safety briefings continue to take place on a Friday afternoon to ensure multi-disciplinary awareness of any expected or potential issues that may arise, and this includes on-call Duty Director and RMO.

Least Restrictive Practice
All Hubs have now had a formal introductory session with Dr Skilling and the Clinical Pause process is now live on RiO. All four Hubs have now held Clinical Pauses. It is anticipated that the process will continue to improve with ongoing PDSA cycles and feedback.

- Improving Observation Practice (IOP) Workstream

Gap analysis updated in terms with compliance with 'From Observation to Intervention' document. Short Life Working Group (SLWG) priority to draft a new observation policy. This was discussed in detail at the October meeting. It is anticipated this policy will be formally consulted on in November.

During the month of September, there was only one report of secure holds being used across the hospital site.

Leadership and Culture
Six walkrounds have taken place so far in 2019. Areas visited are Human Resources, Lewis 3, Mull 2, Mull 1, Lewis 1 and Iona 3. Actions and owners are discussed monthly at the Chief Executive Business meeting and the Patient Safety group. One action highlighted by a Charge Nurse has resulted in an improvement project being established to introduce a ward tablet to aid with access to systems outwith the ward area.

Physical Health

- Safer Medicines Management
The electronic PRN (as required medicine) form has been implemented across all wards. In August, Arran hub had 100% compliance of both checks with PRN recording.

Links continue with the physical health steering group to ensure compliance with this workstream.

3 HEALTHCARE ASSOCIATED INFECTION (HAI)

This is a summary of the Infection Control activity from 1st August – 30th September (unless otherwise stated).

Key Points:

- The submission of the hand hygiene audits continues to be a key priority which is monitored and reported both to the Board, Infection Control Committee and Senior Ward staff routinely. The Senior Nurse for Infection Control (SNIC) will contact individual wards which are non compliant to allow a late submission.

- The compliance within the Skye Centre continues to be of concern; however with the installation of the free standing dispenser an increase has been shown for the month of September.

- DATIX incidents continue to be monitored by the SNIC and Clinical Teams, with no trends or areas identified for concern with the exception of the Safe Management of Linen. The Risk Management Team Leader, SNIC and Housekeeping & Linen Services Manager have undertaken audits during this time and fed back to SCN's directly. Improvements have been noted.

- The antimicrobial prescribing is minimal in comparison to other NHS Boards; however the prescribing that occurs within The State Hospital is being monitored by the antimicrobial pharmacist for compliance with NHS Lanarkshire Antimicrobial Prescribing Formulary. The Infection Control Committee review antimicrobial prescribing quarterly with no trends or areas identified for concern. The biennial audit is due to commence in November 2019. The SNIC is now a member of the Hospitals Medicines Committee & Medication Incident Review Group.

Audit Activity:

Hand Hygiene
During this review period, there was a drop in the number of audits submitted. Investigation shows that those responsible for undertaking the audits were either on annual leave or night shift. This reinforces that the audit submissions remain person dependent. The Senior Charge nurses have been made aware of this by the SNIC. Reminders to submit and follow up of non compliance will continue to be carried out by the SNIC.

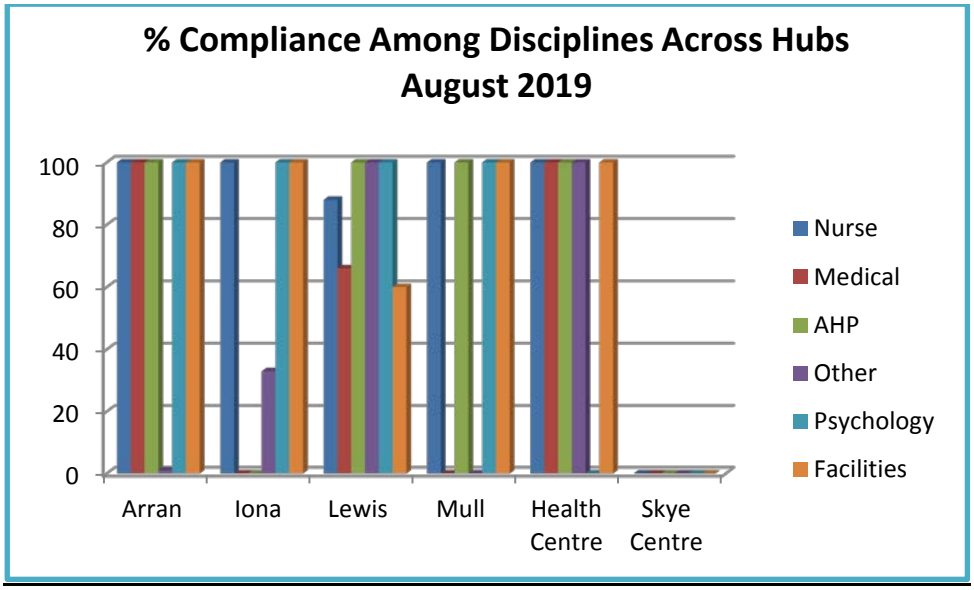
<u>August</u>
8 out of a possible 12 were submitted

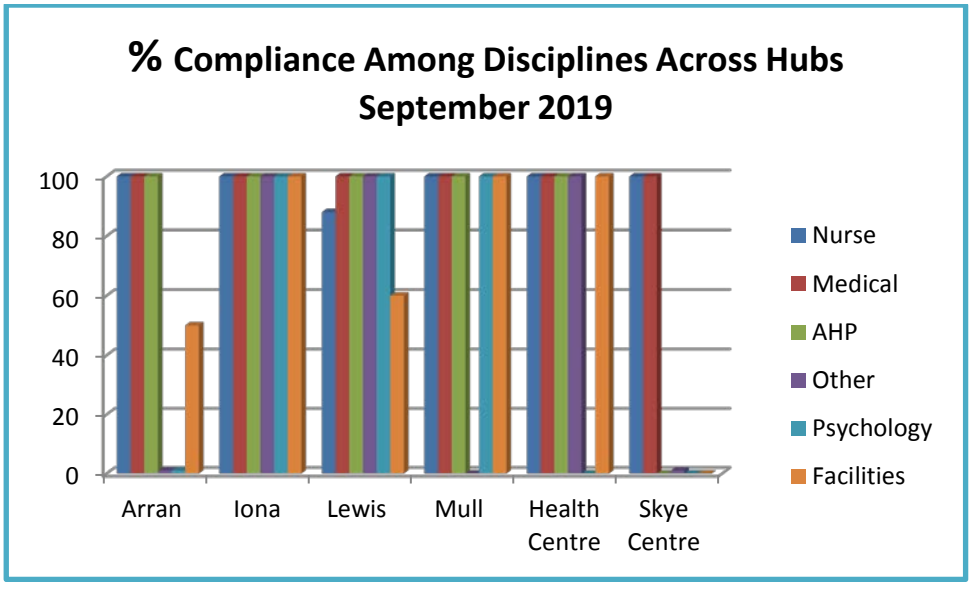
<u>September</u>
9 out of a possible 12 were submitted

The overall hand hygiene compliance within the hubs varies between 83-100%. During this audit period there has been a significant improvement noted within the psychology department, 92% across the hospital.

The Skye Centre continues to remain the lowest at 70%; however this was based on one audit being submitted during this period. The installation of a free standing dispenser at the end of the wooden screens may have contributed to this increase. As part of the TSH30:30 the Skye Centre atrium staff will be focusing on hand hygiene compliance within this area.

It should be noted that scores of 1% demonstrates non-compliance





DATIX Incidents for Infection Control

There were a total of 15 incidents for the period under the Category of Infection Control, 14 of which relate to clinical waste (safe management of linen). All 14 of these relate to the labelling of the bags. Audits were undertaken to ascertain if the laundry tags are falling off in the laundry cage, this would appear not to be the case. DATIX will continue to be completed until an improvement is noted.

1 incident related to the exposure to blood & bodily fluids.

There were 5 incidents recorded within the secondary category of Infection Control 3 of which were superficial self harming incidents. This is being reviewed by the clinical team.

The remaining 2 were not deemed to be infection control related.
All Infection Control related DATIX incidents are investigated by the Senior Nursing Staff, clinical teams (as required) and reviewed by the SNIC to ascertain if there are learning outcomes identified. In addition the Infection Control Committee is presented with this data quarterly.

Scotland's Infection Prevention and Control Education Pathway (SIPCEP) (previously Cleanliness Champions):

There is no data available at this time.

Hepatitis C Treatment

Funding has been secured for the one patient who was waiting for treatment; however he is being transferred imminently and it was deemed not appropriate to commence him on treatment at this time. All communication will be passed on to the receiving hospital (which is located in his home board) where he will receive his treatment.

Policies and Guidance

All infection control policies and procedures are being reviewed as per policy schedule and there are no outstanding policies.

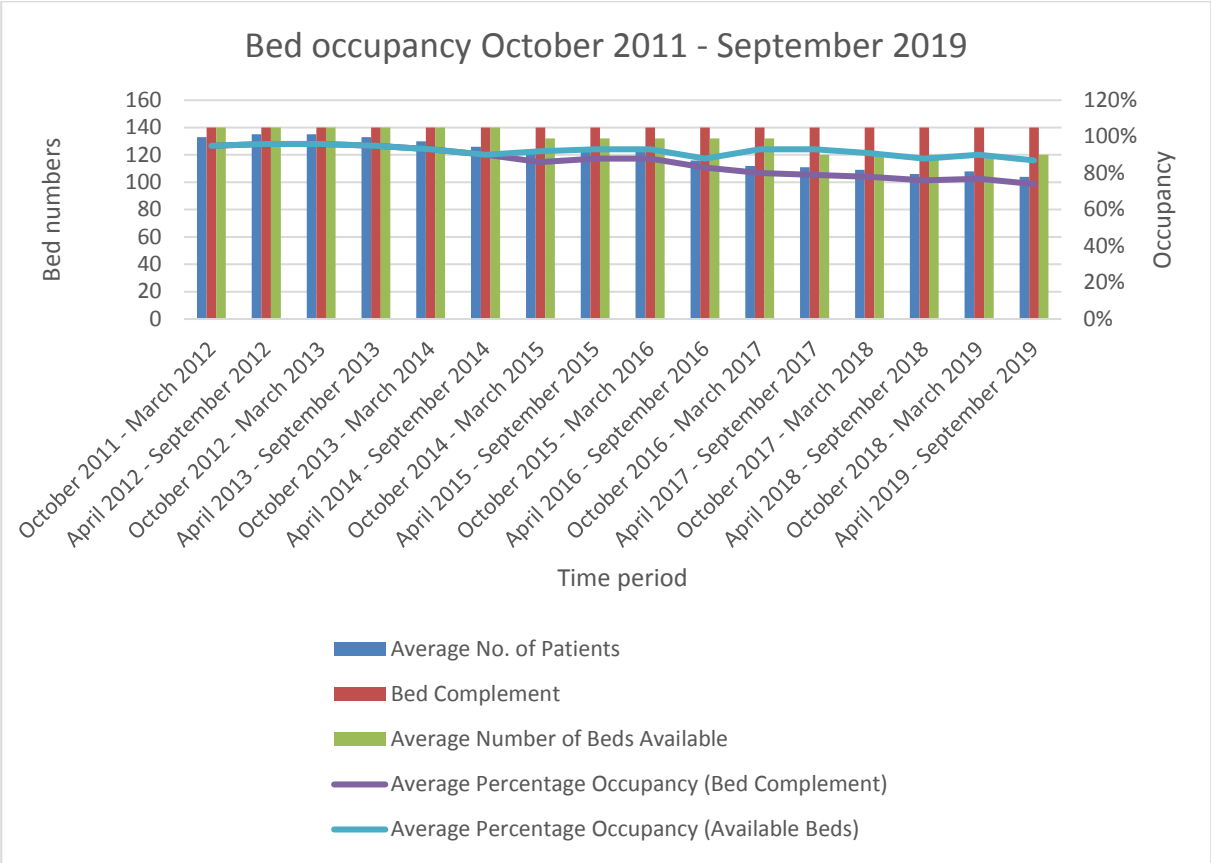
Flu vaccination Clinics

The flu vaccinations for staff will commence on 28th October. There are 5 clinics planned, all of which will be held in the family centre. It was felt that this area was most central and staff have to pass this building on route to their department. All staff have received a letter advising them of the clinics and if they are unable to attend the clinic how they can make arrangements to receive their vaccine. The Healthy Working Lives group have donated a 'misfit' fitness tracker as a raffle prize for those who have received their vaccine. Further information will be provided in the next report.

4 PATIENT ADMISSION / DISCHARGES

A detailed report on admissions and discharges is provided to the Clinical Governance Committee on a 6 monthly basis.

The NHS Board has requested further detail on bed occupancy for the period from the opening of the new hospital on site in 2011 to date. The following table outlines the high level position.



5 RECOMMENDATION

The Board is invited to note the content of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To provide the Board with specific updates on patient safety, infection control and patient admission and discharges as well as any other areas specified to be of interest to the Board.
Workforce Implications	As detailed within sections 2 and 3 of report
Financial Implications	No financial implications identified
Route To Board Which groups were involved in contributing to the paper and recommendations.	Nursing and AHP Directorate/ Health Records – Board requested information
Risk Assessment (Outline any significant risks and associated mitigation)	Not identified for this report
Assessment of Impact on Stakeholder Experience	Not identified
Equality Impact Assessment	Not formally assessed
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not identified as relevant
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND **CG(M) 19/03**

Minutes of the Clinical Governance Committee Meeting held on Thursday 15 August 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs

CHAIR:	
Non Executive Director	Nicholas Johnston
PRESENT:	
Non Executive Director	David McConnell
IN ATTENDANCE:	
Chairperson	Terry Currie
PA to Finance and Performance Management Director	Fiona Higgins (Minutes)
Chief Executive	Gary Jenkins
Head of Psychological Services	John Marshall
Head of Corporate Planning and Business Support	Monica Merson
Director of Nursing and AHP	Mark Richards
Clinical Effectiveness Team Leader	Sheila Smith
Medical Director	Lindsay Thomson
Security Director	David Walker

1 APOLOGIES AND INTRODUCTORY REMARKS

Nicholas Johnston welcomed those present to the meeting and apologies for absence were noted from Khuram Khan; Robin McNaught, Maire Whitehead and Margaret Smith

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted in respect of the business to be discussed.

3 TO APPROVE THE MINUTES / ACTON NOTE OF PREVIOUS MEETING HELD ON 9 MAY 2019

The Minutes of the previous meeting held on 9 May 2019 were approved as an accurate record.

4 PROGRESS ON ACTION NOTES

- ***CIR 18/01***

Members received and noted a report on CAT 1 Review 18/01 – Ending of Seclusion which was presented by David Walker, Security Director, who advised that the report had been considered in draft by the Senior Management Team at its meeting in October 2018 with a formal report agreement in November 2018 where it was agreed that a smaller task group would consider the recommendations made and feedback to the Senior Management Team an appropriate action plan. The purpose of this update was to inform the Committee of the progress made on the implementation of the action plan.

David Walker advised that the Task Group had focussed on the redesign of the Modified Safe Room (MSR); Personal Protective Equipment (PPE) and CCTV, seeking advice from the other high secure hospitals in England and from the Prison and Police Services.

Members noted that a “mock up” of a modified MSR would be installed in Arran 3. The major alterations were around the door design, which is now outward opening and includes a hatch, allowing better access for communication and provision of medication, food and water without the necessity of staff having to enter the room. Changes to the internal configuration include removal

of walls to make a square shaped room for maximum observation and the inclusion of a recessed sink and toilet area which will be pixilated on CCTV to ensure privacy.

The CCTV will be installed as part of the current Security refresh; modifications to the MSR will form part of a proposal to the Senior Management Team and will be reviewed after installation in one MSR prior to rolling out across the Hubs. David Walker emphasised that any changes to the Clinical Model as part of its current review will be factored into both of these proposals.

Lindsay Thomson commented on the use of a door hatch and acknowledged that this would be a useful tool; however would never replace the need to enter a MSR as the basis of the Clinical Model is engagement and there may also be occasion where medical intervention is essential.

Mark Richards concurred with Lindsay Thomson's position and highlighted the difference between the Models of Care used within the English Special Hospitals to the State Hospital's Clinical Model.

No issues were raised from members in regard to the installation of CCTV.

In relation to the recommendations around PPE and the changes to current practice that this would require, were discussed at length with the main concern being around:

- significant change to the ethos of the Clinical Model
- the use of shields, pads and helmets
- the requirement to upskill staff and the challenges in maintaining skills and confidence when the use of enhanced PPE is low
- limitations when comparing to the English Special Hospitals as the patient group and clinical model at the State Hospital is not comparable
- impact on patients when nursing staff are wearing enhanced PPE
- impact on staff having to undertake this enhanced level of PPE

David Walker noted the comments and concerns raised whilst acknowledging that the use of recognised national standard PPE when delivering PMVA techniques equates to the threat level and is designed to protect both staff and patients whilst undertaking these techniques.

Terry Currie highlighted that the Hospital Board needs to be assured from a governance perspective that the recommendations made following the independent review have been considered and responded to. The Board will require an evidenced response for each recommendation, detailing the action taken or the provision of a rationale and justification as to why a recommendation was not implemented.

David Walker agreed to have an interim discussion at the Chief Executives Business Meeting and then to prepare a report for consideration at the September meeting of the Senior Management Team. A further update will be provided to the Clinical Governance Committee at its meeting on 14 November 2019.

ACTION: DAVID WALKER

Members further noted that in relation to the communication and sharing of intelligence recommendations that David Walker is meeting with the National Head of Prison Service in September in relation to a review of national information sharing protocol.

In relation to other items on the Clinical Governance Minute Action Points members noted that these are either on the agenda or are ongoing.

5 MATTERS ARISING

There were no further matters arising.

6 PSYCHOLOGICAL THERAPIES SERVICE 12 MONTHLY REPORT

Members received and noted the Psychological Therapies Service 12 Monthly Report, which was presented by John Marshall, Head of Psychological Services. The report covered the period January to December 2018 and had previously been presented to the Clinical Governance Group. The report is centred on the six quality dimensions from the Healthcare Quality Strategy for NHS Scotland, as detailed below.

- Safe
- Effective
- Efficient
- Challenges
- Person Centred
- Equitable
- Timely

Service developments undertaken during the reporting period included:

- Changes to group work to be more trauma informed
- Delivery of healthy living and diabetic intervention groups
- QI projects supported by NHS Quality Improvement Scotland, helping to increase group therapy productivity and efficiencies, improved leadership and contribution to TSH3030 projects. Significant link with national and international academic and doctoral trainee psychologists programmes.
- Structured formulation guide and audit of formulation quality is currently underway.
- Continued involvement in local and national strategic groups.

Challenges highlighted in the report included:

- Delivering further SLA's and increasing the efficiencies of the service
- Contributing to the work of reducing staff sickness absence rates
- Increasing the quality of clinical care in keeping with scientific and technical development in psychological models of care/intervention.

Members noted that patient engagement and satisfaction is high which is significant when considering the complexity of the patient group and the challenges associated with ensuring patient readiness to move on to further therapies and the need to ensure there are other patients also ready to move on when this is group therapy. The requirement for Multi Disciplinary Working is key in relation to MAP interventions and ensuring Key Worker involvement to aid patient motivation and engagement.

Mark Richards commented on the clear detailing of the activities and impacts within the report and noted the decrease in participation within the healthy living group. John Marshall highlighted the possibility of securing funding from NES for a Trainee Health Psychologist, this is a significant gap in the current Psychology Workforce. A discussion also took place around the Psychology staff participating in the PAA rota and the subsequent impact on service provision. It was noted that this should form part of the discussion around the Clinical Model.

David McConnell commented on the usefulness of the vignettes throughout the report and John Marshall agreed to continue with their inclusion. Nicholas Johnston highlighted the interesting content of the analysis from the Risk Needs section.

ACTION: JOHN MARSHALL

Members asked that in light of the delay in presenting the annual report to the Committee, due to absence, that an update be provided to the next meeting, with the presentation date of next year's report remaining the same on the workplan.

ACTION: JOHN MARSHALL

Members **noted** and **approved** the content of the report.

7 MEDICINES COMMITTEE 9 MONTHLY REPORT

Members received and noted a 9 Monthly Report on the Medicines Committee which was presented by Morag Wright, Lead Pharmacist, who advised that the report provided an overview of the work of the Medicines Committee including key areas of work and future developments. The report presented covers a 9 month period rather than the normal 12 month period as a result of a review of the clinical Governance Workplan.

Key areas of work during the reporting period included:

- Extensive Clinical Audit Programme
- Medicines supply planning
- Medication Incident Review Group progression
- New prescribing guidance documentation

Morag Wright information members that in relation to the Clinical Audit, post injection monitoring is now electronic using the Hospital RiO system. Preparation work is ongoing in relation to Medical Supplies and Brexit. The establishment of a monthly Medication Incident Review Group, led by Mark Richards, Nursing and AHP Director and the Nursing Practice Development staff has been key in promoting wider medicines awareness and the proactive engagement from the Hospital's new GP and the newly qualified Pharmacy Prescriber have also been helpful in taking the work of this group forward. The introduction of electronic prescribing is currently with NHS Lothian who continue to await clarity around funding from the Scottish Government, without this funding there is no option to facilitate electronic prescribing.

Members noted the continued progress of the work undertaken by the Medicines Committee and in particular around Brexit planning and receiving of medication supplies. Gary Jenkins advised that he would speak with David Walker, as Chair of the Hospital's Resilience Committee to seek assurance in relation to medical supplies.

ACTION: GARY JENKINS

Morag Wright provided assurance to the Board that the Hospital has a significantly small number of Medication Incidents when you consider the number of patients and number of medications given daily, which would equate to approximately 800 potential incidents per day. Most incidents are administration errors and communication is through the Staff Bulletin; directly with the Senior Charge Nurses and is on each Hub Business Meeting agenda. An audit is programmed to take place in September through the Practice Nurse Development Team.

Members **noted** and **approved** the content of the report.

8 PATIENT SAFETY 12 MONTHLY REPORT

Members received and noted a 12 month report on the Scottish Patient Safety Programme which was presented by Mark Richards, Nursing and AHP Director, who advised that the report provided an overview of the Patient Safety Programme for the period July 2018 to June 2019. During this period, in February 2019 a relaunch of the Patient Safety Programme safety principles was undertaken, this included:

- Communication
- Leadership and Culture
- Least Restrictive Practice
- Physical Health

Mark Richards informed members that these principles fit well with the Board focus and would not require any changes to current governance arrangements, which include a bi monthly meeting of the Patient Safety Group who are taking forward work in relation to:

- Introduction of Patient Support Plans
- Leadership Walkrounds
- Observation Practice from observing to intervention, with Policy Development and practice change underway for this and a detailed case study highlighted in the report.
- Dynamic Appraisal of Situational Awareness (DASA) as part of the Tableau Project has received positive feedback and work continues on this

Mark Richard advised members that in comparison to last year where all actions were completed and areas of good practice were noted there may be capacity issues this year with the loss of 2 days per week of Clinical Effectiveness / data capture support. Terry Currie asked that this be monitored. **ACTION: MARK RICHARDS**

Lindsay Thomson advised that work on drafting the Observational Policy had been undertaken and National Guidance had now been received. Mark Richards informed members that there were no significant changes required following receipt of guidance and advised that the gap analysis had been completed and the draft policy would be issued in September for consultation with the finalised policy expected to be approved in October/November.

Nicholas Johnston asked that a clear statement in relation to avoiding unintended harm be included in the report and Mark Richards advised that this could be evidenced around the Medication Incidents Group and audit findings and agreed to provide an assurance statement within the report and to speak with Monica Merson, Head of Corporate Planning and Business Support to consider including this within Duty of Candor.

ACTION: MARK RICHARDS

Members **noted** the progress outlined in the report and **approved** the 12 month rolling report.

9 FORENSIC MEDIUM AND HIGH SECURE CARE STANDARDS ACTION PLAN

Members received and noted the annual update from the Continuous Quality Improvement Framework Action Plan which was presented by Sheila Smith, Clinical Effectiveness Team Leader, who advised that the action plan had been drafted following the Peer Review which took place in April 2018. A total of 37 actions were identified and these are split into 3 categories as detailed below:

- 11 high graded actions
- 15 medium graded actions
- 11 low graded actions

All actions are either in progress or have been completed and members noted the updates included within the action plan.

In relation to Theme 5 and considering the feedback received from carers, families and professional visitors and the peer review team regarding all aspects of the visiting experience members noted that a review of visits is currently being undertaken by Security with a proposal expected to be submitted to the Senior Management Team. Terry Currie and Nicholas Johnston both highlighted concern that the timescale for completion of this action is June 2020. Gary Jenkins informed members that there is a national focus on visitor and carer experience and as such he would speak with David Walker, Security Director to ensure this progressed at a faster pace, suggesting that a 3 month timeline would be more appropriate for this action.

ACTION: GARY JENKINS

In relation to Theme 4 on reflective practice members suggested that the timescale of September 2019 may require extending to allow completion of the consultation process and Sheila Smith agreed to speak to the action owner in relation to this.

ACTION: SHEILA SMITH

Members **noted** the updated action plan and asked that monitoring continue to ensure the positive progress made is maintained.

10 LEARNING FROM FEEDBACK

Members received and noted a report on Learning from Feedback, including "What Matters to you" 2019 Outcomes, which was presented by Mark Richards, Director of Nursing and AHP who advised that the report provided an overview of activity relating to the feedbacks received for the period 1 April to 30 June 2019 and also included outcomes emerging from the What Matters to You initiative, facilitated on 6 June 2019.

Members noted that the during the reporting period there were 56 items of feedback received, 18 of which related to patients' meal service and 29 compliments relating to the Skye Centre Event. From the feedback 5 outstanding actions remain and all outcomes are detailed within the report.

The emerging themes from the What Matters to You initiative include:

- More access to fresh air
- More access to exercise
- Increased contact from family and friends
- Access to placements
- Opportunity for social activities at weekends and evenings

These are being taken forward by Sandie Dickson, Person Centre Improvement Lead with the leadership teams across the site, a 6 month update on this will be provided to the Committee.

Members were advised that staff within Mull Hub had the opportunity to see the Emotional Touch Point feedback previously shared with the Hospital Board.

Members **noted** the new format of this report and to its ongoing development and **noted** the 2019 What Matters to You outcomes and that an update on these outcomes will be presented to the Committee in March 2020.

ACTION: MARK RICHARDS

11 LEARNING FROM COMPLAINTS

Members received and noted a report on Learning from Complaints which was presented by Lindsay Thomson, Medical Director who advised that the report provided an overview of activity of complaints, concerns and enquiries for the period 1 April to 30 June 2019. The report also provided detail on Scottish Public Service Ombudsmen (SPSO) contact and the results of the evaluation and audit of the complaints process.

Members noted that during the reporting period 16 complaints and 10 concerns/enquiries were received. From these complaints:

- 2 were withdrawn
- 13 closed
- 4 were upheld
- 2 were partially upheld
- 2 responses are being reviewed by the SPSO
- Timescales for responding met for all complaints

There is a significant reduction in the number of complaints received when compared to the same period in 2018/19 however this can be explained due to the high number of complaints received in relation to a telephone and a bedroom chair issue which created a high volume of complaints during that period. This has been concluded and lessons learnt. There are no particular issues of note or any obvious emerging trends.

Mark Richards highlighted the low number of complaints in relation to staff shortages when compared with previous years and suggested that this may provide a false assurance. Members noted that a report on Ward Closures is due to be presented to the Committee in November.

Members **noted** the content of the report.

12 INCIDENT REPORTING AND PATIENT RESTRICTIONS

Members received and noted a report on Incidents and Patient Restrictions which was presented by Lindsay Thomson and provided an overview of activity of incidents and patient restrictions for the period 1 April to 30 June 2019, there were no noticeable trends or areas of concern and members were content to **note** the report.

13 DISCUSSION ITEM

- ***Clinical Model***

Members received and noted a presentation on the Clinical Model which was delivered by Monica Merson, Head of Corporate Planning and Business Support, who advised that a Benefits Criteria Workshop is scheduled to take place on 21 August 2019 with a follow up Options Appraisal scheduled for 16 September 2019. The results of the options appraisal and weightings, including financial and human resource analysis will be presented to the Board along with this presentation at its meeting in October 2019.

Members asked that a document detailing clear definitions be provided by the Clinical Forum in advance of the benefits criteria in order that a desk top exercise can be undertaken to ensure accurate scoring can be achieved at the options appraisal.

ACTION: MONICA MERSON

14 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

There were no comments received in relation to good practice or areas of concern.
It was agreed that the log of good practice / areas of concern should be included with future meeting papers.

ACTION: SHEILA SMITH

15 WORKPLAN

Members received and noted the Workplan for 2019 and agreed that the Discussion Item for November would be either the Clinical Model or Policy Work for Improving Observational Practice.

ACTION: SHEILA SMITH

16 ANY OTHER BUSINESS

There was no other business.

17 DAY, DATE, TIME AND VENUE FOR NEXT MEETING

The next meeting will be held on 14 November 2019 at 9.45am in the Boardroom.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2019
Agenda Reference:	Item No: 13
Sponsoring Director:	Interim HR Director
Author(s):	Interim HR Director
Title of Report:	Attendance Management Report
Purpose of Report:	For Noting

1 SITUATION

The State Hospital (TSH) sickness absence level in-month figure for August 2019 was 6.10%; with an average rolling 12 month figure of 6.54% for September 2018 to August 2019. The rolling 12 month figure is 2.44% lower than the September 17 to August 2018 figure (8.98%).

The Board should note the local target level is 5%.

2 BACKGROUND

Over the last 3 years, TSH monthly absence levels have frequently been between 8% and 10%. Consequently absence management and monitoring have been areas of particular focus.

Absence data reported is extracted from both the SWISS, the national source and SSTS local information system to provide this report.

3 ANALYSIS

The August 2019 sickness level of 6.10% is the lowest August figure recorded by TSH in the last 4 years. However, this does exceed the 5.0% target and the NHS Scotland level of 5.21% for the same period (Appendix IV).

Long/short term absence split is 4.45% and 1.65% respectively. These figures were recently recalibrated and therefore make comparison with historic data irrelevant. (Appendix II).

The in-month absence level equates to a loss of 4517.45 hrs / 27.75 WTE.

The current average rolling 12 month sickness figure is 6.54% for the period 1 September 2018 to 31 August 2019. This represents a 2.44% lower figure than 2017/18 (8.98%). The current national target is to achieve a 0.5% reduction in sickness absence per annum over 3 years.

The main reasons for absence continue to be Anxiety/Stress/ Depression/Other Psychiatric Disorders (36%), Musculoskeletal (10%) and Fractures (9%) (Appendix I).

4 RECOMMENDATION

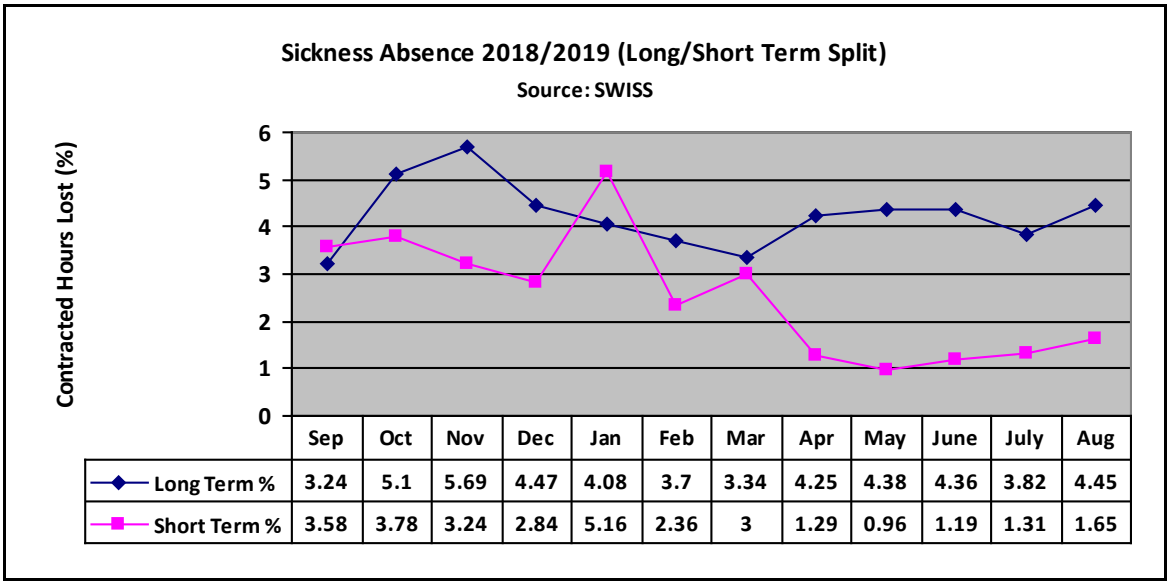
The Board is asked to **note** the content of the report.

Appendix I : Absence Reasons 1st June 2018 to 31st May2019

Absence Reason Description 1 September 2018 to 31 August 2019 Source: SSTS	Short Term Sick %	Long Term Sick %	Total (SL+II) Working Hours Lost	Total & inc Industrial Injury
Anxiety/stress/depression/other psychiatric illnesses	8.26 %	47.13 %	33018.13	36.47 %
Other musculoskeletal problems	6.54 %	6.67 %	9482.96	10.47 %
Injury, fracture	5.03 %	8.36 %	8119.67	8.97 %
Gastro-intestinal problems	20.99 %	5.75 %	7523.05	8.31 %
Cold, cough, flu - influenza	19.00 %	1.86 %	4606.13	5.09 %
Heart, cardiac & circulatory problems	1.40 %	6.56 %	4564.70	5.04 %
Back problems	8.54 %	3.54 %	4274.17	4.72 %
Other known causes - not otherwise classified	4.46 %	4.32 %	3871.58	4.28 %
Genitourinary & gynecological disorders - exclude pregnancy related disorders	2.12 %	4.15 %	3109.58	3.43 %

Details all absences amounting to greater than 2%. Source: SSTS

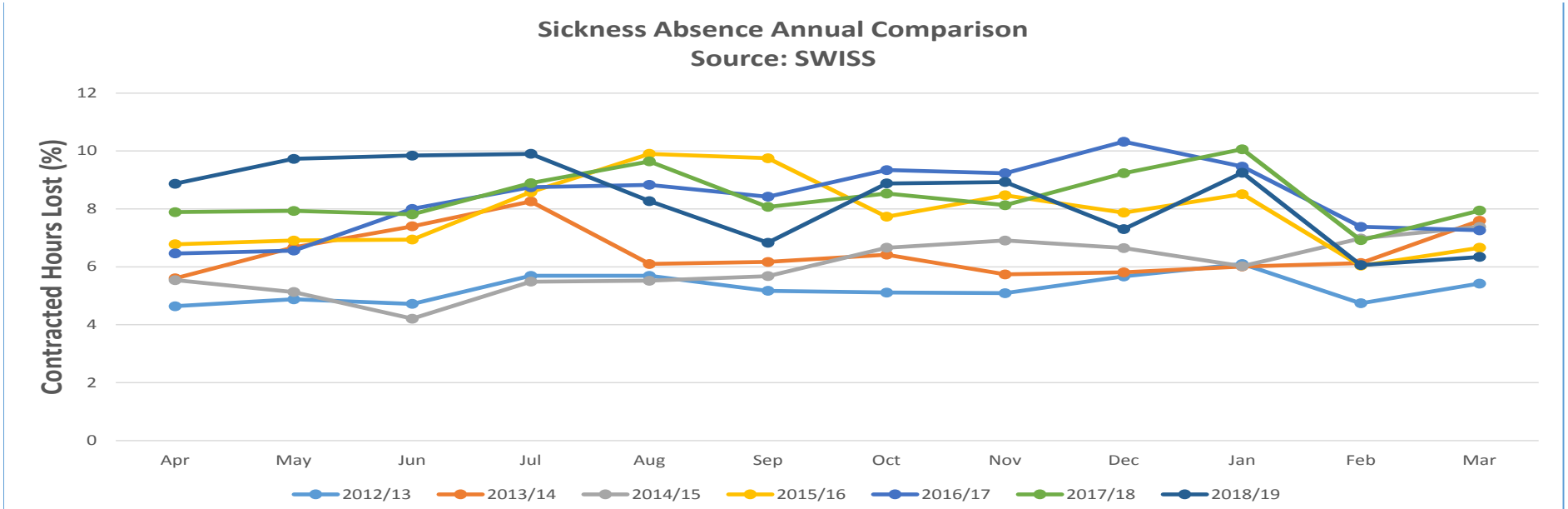
Appendix II : LONG / SHORT TERM ABSENCE BREAKDOWN – NATIONAL DATA (SWISS)



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug
Long Term %	3.24	5.1	5.69	4.47	4.08	3.7	3.34	4.25	4.38	4.36	3.82	4.45
Short Term %	3.58	3.78	3.24	2.84	5.16	2.36	3	1.29	0.96	1.19	1.31	1.65

Chart 1 provides a rolling monthly comparison of long and short-term absence from SWISS for the State Hospital only.

Appendix III : YEARLY AND MONTHLY COMPARISON - details the breakdown in percentage of sickness absence for the financial years 2012/13, 2013/14, 2014/15, 2015/16, 2016/17, 2017/18, 2018/19. This data is derived from SWISS.



Year/Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	4.64	4.88	4.72	5.69	5.69	5.17	5.11	5.09	5.67	6.1	4.74	5.42
2013/14	5.6	6.67	7.4	8.26	6.1	6.17	6.42	5.74	5.81	6.01	6.13	7.59
2014/15	5.54	5.13	4.21	5.49	5.52	5.68	6.66	6.91	6.65	6.02	6.98	7.38
2015/16	6.78	6.91	6.94	8.58	9.9	9.75	7.73	8.47	7.87	8.51	6.04	6.66
2016/17	6.46	6.56	8	8.75	8.83	8.42	9.34	9.23	10.32	9.46	7.38	7.26
2017/18	7.89	7.93	7.81	8.89	9.64	8.07	8.53	8.13	9.23	10.06	6.92	7.94
2018/19	8.87	9.73	9.84	9.9	8.27	6.83	8.88	8.93	7.3	9.25	6.06	6.34
2019/20	5.55	5.34	5.56	5.13	6.1							

Appendix IV : National Comparison with NHS Scotland and The State Hospital - August 2019

	Absence Rate			Instances			Absence Reason	
	Total	Long Term [1]	Short Term [2]	Total	Long Term [1]	Short Term [2]	Yes	No [3]
Scotland	**5.21**	**3.49**	**1.72**	**24,244**	**7,762**	**16,482**	**21,214**	**3,030**
NHS Ayrshire & Arran	4.88	3.36	1.52	1,346	464	882	1,210	136
NHS Borders	4.39	2.78	1.61	495	136	359	418	77
NHS National Services Scotland	4.52	3.26	1.26	450	145	305	431	19
NHS 24	7.50	4.73	2.77	456	139	317	392	64
NHS Education For Scotland	1.67	1.15	0.52	78	22	56	46	32
NHS Healthcare Improvement Scotland	4.06	2.85	1.21	51	18	33	49	2
NHS Health Scotland	2.05	0.70	1.35	30	5	25	24	6
Scottish Ambulance Service	8.98	6.49	2.49	893	379	514	831	62
The State Hospital	6.10	4.45	1.65	94	47	47	87	7
National Waiting Times Centre	4.38	2.85	1.53	251	74	177	212	39
NHS Fife	5.50	3.92	1.58	1,213	478	735	1,110	103
NHS Greater Glasgow & Clyde	5.55	3.92	1.62	5,871	2,191	3,680	5,375	496
NHS Highland	5.16	3.41	1.74	1,505	432	1,073	1,027	478
NHS Lanarkshire	5.58	4.09	1.49	1,617	652	965	1,419	198
NHS Grampian	4.42	2.68	1.74	2,261	558	1,703	1,786	475
NHS Orkney	4.46	2.40	2.06	103	19	84	102	1
NHS Lothian	4.81	2.69	2.12	4,008	906	3,102	3,539	469
NHS Tayside	5.01	3.42	1.59	1,782	568	1,214	1,566	216
NHS Forth Valley	5.52	3.79	1.73	864	308	556	806	58
NHS Western Isles	5.04	2.91	2.13	179	40	139	151	28
NHS Dumfries & Galloway	4.54	2.76	1.79	610	166	444	551	59
NHS Shetland	3.31	1.68	1.64	87	15	72	82	5

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Links to the Attendance Management Policy and aids monitoring of 5% attendance target set by the Scottish Government
Workforce Implications	Failure to achieve 5% target will impact ability to efficiently resource organisation.
Financial Implications	Failure to achieve 5% target results in additional spend to ensure continued safe staffing levels
Route To BOARD Which groups were involved in contributing to the paper and recommendations.	SMT, Partnership Forum
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	Failure to achieve the 5% target will impact on stakeholder experience
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Board Paper 19/80

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2019
Agenda Reference:	Item No: 14
Sponsoring Director:	Interim Director of Human Resources
Author(s):	Interim Director of Human Resources
Title of Report:	Attendance management task Group
Purpose of Report:	For noting

1 SITUATION

The Attendance Management Task Group (AMTG) was reconvened in August 2018, at the request of the Staff Governance Committee / Board, due to a concerning increase in sickness absence levels in QI & II of 2018/19 (levels ranging from 8.27% to 9.9%). The group developed and implemented an Action Plan to achieve a 3% reduction from the June 2018 level of 9.8% to 6.8% by March 2019.

This target was achieved with a 5.55% absence level reported in March 2019. Levels have been maintained at or below 6% throughout QI and II to date.

2 BACKGROUND

Over the last 3 years, TSH monthly absence levels have frequently been high. However, throughout QI & II in 2018/19 levels peaked to between 8-10%. The Attendance Management Task Group resumed and developed an Action Plan to enhance

- **Leadership**
  Ensure full engagement of senior managers and staff on the improvement target.
- **Training & Support**
  Ensure staff were well informed on sickness absence policy
  Support Line Managers to implement policy
- **Policy Compliance**
  Achieve full compliance with implementation of TSH sickness absence policy
- **Monitoring of outcomes**

The group led the implementation of the plan with the support of Partnership Forum and the Senior Management Team.

3 ASSESSMENT

The engagement of HR, Managers and Partnership with employees in the implementation of this plan has resulted in a significant improvement in sickness absence levels. There is a recognised on-going need to continue with this approach and actions initiated in the AMTG Action Plan are continuing to be embedded into practice.

The group acknowledge that wider consideration to factors of culture, values & behaviour, etc may further enhance staff attendance but as a programme of work is underway through the TSH Sturrock review, the AMTG should be stood down in the short term. The Staff Governance Committee support this proposal.

4 RECOMMENDATION

The Board is invited to note the content of this report and the support of the Staff Governance Committee for the suspension of the AMTG.

Board Paper 19/80

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Continues to support management of attendance but allows focus to shift to impact of culture / values and behaviours.
Workforce Implications	Supports ongoing monitoring of absence and potential to reconvene AMTG as required if absence starts to increase.
Financial Implications	Lower absence levels reduce cost on supplementary staffing.
Route To Board Which groups were involved in contributing to the paper and recommendations.	AMTG SGC
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	None identified
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.

Paper No. 19/81

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2019
Agenda Reference:	Item No: 15
Sponsoring Director:	Director of Nursing and AHPs
Author(s):	Director of Nursing and AHPs
Title of Report:	Health and Care Staffing Bill
Purpose of Report:	For noting

1 SITUATION

The Health and Care (Staffing) (Scotland) Bill was unanimously passed by parliament on 2 May 2019 and received Royal Assent on the 6th June 2019. Statutory guidance is currently under development, and enactment of the legislation is anticipated in mid-2020. It remains likely that there will be a phased approach to the implementation of the requirements of the Bill.

The purpose of this paper is to ensure that the Board remains sighted on the overall requirements of this legislation, the role of the Board, and specific actions that need to be progressed to ensure readiness for enactment of the legislation. This paper also sets out the work undertaken this year to ensure we are prepared to meet our requirements in response to the Act.

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 supporting 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. It will:

- provide assurance that staffing is appropriate to support high quality care, identify where improvements in quality are required and determine where staffing has impacted on quality of care

- support an open and honest culture where clinical/professional staff are engaged in relevant processes and informed about decisions relating to staffing requirements

- enable further improvements in workforce planning by strengthening and enhancing arrangements already in place to support transparency in staffing and employment practice across Scotland and through the use of, and outputs from, the Common Staffing Method and associated decision making processes

- ensure the clinical voice is heard at all levels by ensuring arrangements are in place to seek and take appropriate clinical advice in making decisions and putting in place arrangements in relation to staffing including: identification of any risks; mitigation of any such risks, so far as possible; notification of decisions and the reasons why and a procedure to record any disagreement with the decision made

3 ASSESSMENT

All territorial Health Boards and those Special Health Boards delivering patient facing clinical services are covered by the legislation, which is underpinned by guiding principles and duties.

These have been set out in a previous paper to the Board, but in summary, 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.

The duties on Health Boards which are described in the Act are:

1. Ensure appropriate staffing
2. Ensure appropriate staffing: agency workers.
3. Have real-time staffing assessment in place
4. Have risk escalation process in place
5. Have arrangements to address severe and recurrent risk
6. Seek clinical advice on staffing
7. Ensure adequate time given to clinical leaders
8. Ensure appropriate staffing: training of staff
9. Follow the Common Staffing Method

Reporting
The Board will be required to publish and submit to Scottish Ministers an annual report which details how we have complied with the duties in the Act.

Scottish Ministers must collate these reports and produce a statement detailing how they have or will use the information in their policies for staffing in the Health Service.

At this point in time, the Act is not enacted, so there is no formal reporting requirement for the Board.

Progress to date
In preparation for the legislation coming into force, the Board is receiving funding until September 2020 to employee a 0.5 WTE Senior Nurse – Workforce Planning to take forward this work.

The Senior Nurse is working closely with a Healthcare Staffing Programme (HSP) Advisor to prepare for meeting the requirements set out in the Bill, particularly the Common Staffing Method.

The HSP Advisor aligned to the State Hospital provides the necessary support required to build capacity and capability within the Board to ensure:

- Effective application of the workload tools, common staffing method and roster management

- Robust analysis of reports and workforce information for the organisation
- Identification and or development of approaches and strategies for effective risk assessment, mitigation, escalation and prioritisation of nursing workload and workforce planning concerns

In addition, the Programme Advisor will provide education and training and specific advice to ensure:

- Frontline clinical staff, clinical leaders and managers have an understanding of the mental health workload tool and common staffing methodology
- The mental health workload tool and common staffing methodology is embedded in practice
- Frontline clinical staff, clinical leaders and managers have an understanding of effective roster management and impact of this on staffing requirements
- Frontline clinical staff, clinical leaders and managers have an understanding of how to access and analyse information in standard Healthcare Staffing reports
- Frontline clinical staff, clinical leaders and managers have an understanding of how to identify, mitigate, escalate and prioritise risk, and systems and process are in place which enables transparent decision making based on this risk assessment
- Frontline clinical staff are engaged in the process, know how to escalate concerns and are informed of decisions made following application of the common staffing method

A quality improvement approach is being used in preparation for the Health and Care Staffing Legislation. An action plan has been developed with the Senior Nurse and Programme Advisor with 5 headline actions as set out below. A progress report against each action is offered.

1. **Effective application of the workload tools, common staffing method and roster management:**

- Workload tool test of change and spread plan throughout the State Hospital by end of December 2019, to ensure tools are reflective of workload including peaks and troughs of activity. These will be used continuously over the next 6 months in all wards. There are initial outputs from Lewis Hub.
- Common staffing triangulation adopted although requires further work to incorporate the Excellence in Care (EiC) assurance and workforce measures.
- Substantial work has been undertaken in establishing baseline staffing levels within each ward. Reporting templates have been established for the predicted absence allowance, staff in post, supplementary staffing used and borrows from the nursing pool. Next steps include inclusion of the EiC workforce and assurance measures.
- The Senior Nurse is working with SSTS West of Scotland Region SSTS Systems Manager. Rostering is a key feature within improving current systems and is an ideal platform for starting discussions around workforce change. There has been a focus on current rostering practice and in particular planned leave within the Predicted Absence Allowance (PAA) Rostering practice is under review with an aim to standardize and maintain planned leave within the PAA.
- Mull 2 has been identified to test out the new developments currently available within SSTS interactive rostering. This will commence in October.
- The State Hospital has been identified as an early adopter and test site for eRostering.
- Work is underway in developing underpinning rostering policies
- Reporting is through the Clinical Operations Manager, Nurse Director and Partnership.

2. **Robust analysis of reports and workforce information for the organisation:**

- Reporting and monitoring templates have been developed
- The reports are shared with the Clinical Operational Manager and Nurse Director as well as Senior Charge Nurses and ward teams
- Reporting will be via the recommendation of a Forum (guiding coalition) which will report to the Partnership Forum and the Board.

3. **Identification and /or development of approaches and strategies for effective risk assessment, mitigation, escalation and prioritisation of nursing workload and workforce planning concerns:**

- Work has progressed well against actions 1 and 2 as part of the scoping and establishing baseline information identifying the challenges, risks, levers and areas for improvement.
- Monthly meetings established between Senior Nurse, HSP advisor, Clinical Operations Manager and Nurse Director. The Head of HSP will attend these meetings when required
- Further work to be undertaken with transparency and governance around leave management and use of supplementary staff.
- Further work to be done matching workforce demand to staff. This will include workforce demographics.
- Staff work fixed shift patterns of unequal lengths. This removes flexibility and is difficult to manage the variances
- To develop a strategy in line with the areas within the common staffing method as a template for the board.
- Embed QI approaches to managing workforce change and develop feedback mechanism for clinical staff to raise concerns
- Continue to build knowledge, capability and confidence around workforce planning with all staff groups.

4. **Education and training for staff:**

- Significant work undertaken engaging staff in both preparation for the legislation and application of workload and professional judgement tools.
- Encouraging Senior Charge Nurses to understand workload activity, rostering and the PAA and how this links to the quality of care and wellbeing of patients and staff
- Feedback on the outputs of the tools established in the test wards.
- Develop mechanisms for staff to raise concerns or improvement ideas.

5. **Ensuring representation at local and national forums, to influence, shape and contribute to the National Policy Agenda:**

- The Senior Nurse – Workforce Planning is a member of the Healthcare Staffing Programme group which meets formally with workforce leads across the NHS Boards.
- Links have been forged with NHS Ayrshire and Arran and NHS Forth Valley to develop robust templates for data collecting and reporting.
- The Senior Nurse – Workforce Planning represents the Hospital at the developmental build meetings for SSTS interactive rostering.

As part of the assessment of the Board's readiness for the requirements of the Act, RSM UK will undertake an audit in this area in January 2020. This audit will run from 6 to 10 January 2020, the finding of which and associated recommendations will be reported through the Audit Committee of the Board in due course.

4 RECOMMENDATION

The Board is invited to **note** this update on safe staffing legislation, and invite a further update at the February meeting of the Board.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Sets out the Board's legal duty as it relates to safe staffing.
Workforce Implications	The common staffing method will be applied which may have implication for the size and shape of the clinical workforce.
Financial Implications	Outputs from the common staffing method and subsequent advice to Board may have financial implications. These are not fully quantified at this point in time.
Route To Board Which groups were involved in contributing to the paper and recommendations.	N/A.
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified in terms of readiness for legislation being enacted. Financial risk unquantified as will be informed by outputs from safe staffing method and subsequent advice to the Board.
Assessment of Impact on Stakeholder Experience	Not formally assessed.
Equality Impact Assessment	Not formally assessed.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None identified to date.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ✓ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Board Paper 19/82

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2019
Agenda Reference:	Item No: 16
Sponsoring Director:	Interim Director of Human Resources
Author(s):	Interim Director of Human Resources
Title of Report:	The State Hospital Workforce Planning
Purpose of Report:	For noting

1 SITUATION

The State Hospital Board in February 2019 anticipated that a new workforce plan would be produced by September 2019; taking into account the revised clinical model and the outcomes from the Common Staffing Method. This assumed completion of the TSH revised clinical model in May 2019 and availability of outcomes from TSH application of the Common Staffing Methods in July 2019.

Time delays in both the clinical model / Common Staffing Method will delay the production of the Workforce Plan to December 2019.

2 BACKGROUND

TSHs workforce plan 2017/2022 was produced in June 2017 in accordance with Scottish Government "Revised Workforce Planning Guidance", CEL 32 (Scottish Government, 2011).

The plan identified the anticipated internal and external drivers influencing the shape of TSH workforce over a 5 year time period and projected a reduction of 8 WTE staff by 2018; equating to 587.9 WTE.

The First Minister announced the Scottish Government's intention to enshrine safe staffing in law in 2016. In its Programme for Government 2017/18 it indicated its intent to deliver on the commitment starting with the nursing and midwifery workforce. These commitments led to the Health and Care (Staffing) (Scotland) Bill being produced to enable safe and high quality care by making the provision of appropriate staffing in health and care statutory, resulting in better outcomes for service users.

As a direct result of this action, TSH are obligated to run the Nursing and Midwifery Workload and Workforce Planning Tools as part of a 'Common Staffing Method' on an annual basis taking cognisance of the outcome and determining the best means to risk manage any identified shortfalls.

3 ASSESSMENT

It is acknowledged that workforce planning is an iterative process and TSH Workforce Plan requires to be updated in line with the:

- Revised clinical model and
- Common Staffing method defined by the Health and Care (Staffing) (Scotland) Bill.

The interdependency of the three work streams; Clinical Model, Common Staffing Method and Workforce Plan, is recognised and consequently the delay in the Workforce Plan production until December 2019 is unavoidable.

4 RECOMMENDATION

The Board is invited to note the content of this report.

Board Paper 19/82

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Ensures projection of appropriate staff for future needs are aligned to Clinical Model
Workforce Implications	Ensures projection of appropriate staff for future needs
Financial Implications	Accurate workforce projections reduce demand on more costly staffing solutions e.g. overtime. Locums, etc
Route To Board Which groups were involved in contributing to the paper and recommendations.	N/A
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	None identified
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 ***SG(M)19/03***

Minutes of the meeting of the Staff Governance Committee held on Thursday 29 August 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

Present:

Non-Executive Director	Bill Brackenridge ***(Chair)***
Employee Director	Tom Hair

In attendance:

Board Chair	Terry Currie
Chief Executive	Gary Jenkins
Unison Representative	Anthony McFarlane
Head of Corporate Planning & Business Support	Monica Merson
Clinical Operations Manager	Brian Paterson
Interim HR Director	Kay Sandilands
Organisational Development & Learning Advisor	Gayle Scott
Board Secretary	Margaret Smith

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Brackenridge welcomed everyone to the meeting and noted apologies from Mr Nicholas Johnston and Mrs Maire Whitehead.

NOTED

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted in respect of the business to be discussed.

NOTED

3 MINUTES OF THE PREVIOUS MEETING HELD ON 23 MAY 2019

The Committee approved the Minutes of the previous meeting held on 23 May 2019 as an accurate record.

APPROVED

4 ACTION POINTS AND MATTERS ARISING FROM THE PREVIOUS MEETING

Members noted that each item either had been completed or was on the agenda for today's meeting.

In addition in reference to action point one, Ms Sandilands advised that further training sessions were planned and that the key themes from these sessions would be collated to produce a

Frequently Asked Questions document by way of further support for line managers. She also advised that work was progressing to interrogate the data produced through EASY reporting.

NOTED

5 ATTENDANCE MANAGEMENT REPORT

The Committee received the latest Attendance Management Report (for June 2019) and Ms Sandilands summarised the key issues. The absence rate was 5.56%, which represented a continued fall in the overall rate of absence.

The Committee received the report positively, and noted the continued improvement in this area. This was reflective of the efforts made across The State Hospital (TSH). Mr Brackenridge underlined that this was a welcome improvement and meant that TSH compared more favourably to other NHS Boards in the national context. Mr Hair added praise for the Human Resources department.

Mr Hair also asked a question around what it was in particular that had helped to being about the improvement is sickness absence figures. He asked particularly about the support given to staff when they return to work following an absence. Ms Sandilands noted that there would need to be further review of the data over time to get a clear view on this but that it was likely to be multi-factorial. She acknowledged that staff could be particularly vulnerable when returning to work following an absence. Mr McFarlane agreed with this particularly from a nursing perspective in terms of it familiarity with a ward environment. Mr Jenkins added that it was important to put in a tailored package of measures for each individual upon their return to work.

The Committee noted the content of the report, and asked for their thanks to be passed to heads of service as well as partnership colleagues for the continued improvement in this area.

NOTED

6 ATTENDANCE MANAGEMENT IMPROVEMENT WORKING GROUP

Ms Sandilands provided a verbal update to the Committee, noting that it was timely to reflect upon the work progressed to date by the Attendance Management Improvement Working Group (AMIWG) within the context of improvement in attendance management performance for TSH.

The original action plan had focussed on the leadership and skill set of line managers within TSH. A broader focus was now required to include influencing the culture and values and behaviours of the organisation, and this was linked to the work being progressed in the response to the Sturrock report.

On this basis, the Committee was asked if it agreed that the AMIWG should be paused at this point, although noting that there should be continued focus on attendance management to ensure that the improvement experience could be sustained.

The Committee was supportive of this course of action, and it was agreed that a paper should be submitted to the Board at its meeting in October on this basis to note this direction of travel.

Action – Ms Sandilands

AGREED

7 HR PERFORMANCE – EMPLOYEE RELATIONS ACTIVITY

The Committee received a report, which provided an update on employee relations activity up to and

including 30 June 2019. Ms Sandilands provided Members with a summary of the key data from the report. She underlined the continuing emphasis on timescale to complete cases, and asked the Committee to note improvement in the number of cases outstanding for over six months since the paper was finalised. Going forward, a monthly report would be produced, which should help to shed light on any potential obstacles to progress and to manage these effectively. The aim was to reach a positon where no cases were outstanding for longer than six months. The Committee considered that any such case should be exceptional and that every step should be considered to progress these cases. Discussion should be progressed in partnership to consider this more fully, including the possibility that a case may be heard in the absence of the employee, depending on the individual circumstances. Members noted, in particular, the detrimental effect that long timeline to complete cases could have for staff.

The Committee noted the content of the report.

NOTED

8 PERSONAL DEVELOPMENT PLAN REPORT

A paper was submitted to the Committee to provide a progress update in relation to personal development planning and review (PDPR) staff governance standards and associated compliance. Ms Dunlop asked Members to note the upward trajectory of performance in this area, which compared well to other NHS Boards in the national context.

Mr Brackenridge asked a question about the rate of completion of reviews and how the quality of the discussions had was evaluated. Ms Dunlop confirmed that the department took forward evaluation with staff and to date the general picture was positive with agreement that the TURAS system did support active involvement by staff with more meaningful conversations during reviews.

The Committee was content to note the continued progress made in this area.

NOTED

9 STATUTORY AND MANDATORY TRAINING COMPLIANCE

The Committee received an update report on organisational compliance levels for statutory and mandatory training, which focused on assurance that mechanisms were in place to promote completion and address non-compliance for core training. Ms Dunlop led Members through the detail in the report outlining the Core Training Matrix as well as arrangements in place to ensure that all staff members, across different roles in the hospital, understand and have access to the statutory and mandatory training for their role. In addition, monthly reports were issued to line managers as an update of performance within their departments.

In addition, a benchmarking exercise was carried out to compare TSH to other NHS Boards in Scotland. Mr Currie noted that no it appeared that there was no specific training in place across NHS Boards to tackle bullying and harassment in the workplace. Ms Dunlop advised that it was likely that this type of training was delivered as part of other modules e.g. Dignity at Work. Ms Sandilands noted that the direction of travel in the national context would be toward standardised core modules, as part of the 'Once for Scotland' workforce approach.

In answer to a question from Mr Brackenridge on how performance in the area was managed, it was confirmed that this was through line managers. Ms Sandilands noted the possibility existed of restrictions to professional practice if there was a failure to complete statutory training.

Mr Hair added that informal staff feedback received highlighted the helpful and supportive nature of the service provided to staff by the Learning Centre Team.

The Committee noted the content of the report.

NOTED

10 HEALTHY WORKING LIVES (HWL) ANNUAL UPDATE 2018/2019

The Committee received a paper, to provide an annual update on the work progressed by the HWL Group for 2018/19. Since 2008, TSH had achieved and continued to maintain the HWL Gold Award.

Ms Scott was in attendance at the Committee to summarise the detail of the report for Members. She noted the key achievements including the three year strategy, as well as some of the benefits delivered to staff within the organisation. Ms Scott also advised that in the coming year, the HWL Group would benchmark activity by recording and comparing attendance at events as well as iMatter results to help evaluate the benefits to staff.

Mr Brackenridge asked if the HWL Group could provide further input as to the healthiness of staff. Ms Scott noted good involvement rates by staff in schemes to help improve their health such as smoking cessation and weight loss programmes.

The Committee agreed that the work of the HWL Group was exceptional and compared well to other NHS Boards – particularly in the achievement of Gold Award status since 2008. Continued funding was seen as being important in supporting the HWL Group; and also that the benefit to staff should also be considered in conjunction with support provided through the Occupational Health Service.

The Committee noted the content of the report.

NOTED

11 PRINCIPLES OF THE STURROCK REVIEW

The Committee received a presentation from Mr Jenkins to outline progress of work at TSH in response to the Sturrock Report, which had provided an opportunity within TSH to review staff feedback through a number of routes including recent iMatter reporting and the engagement process undertaken as part of the review of the clinical model.

In addition, an engagement process had been launched to seek staff feedback through a questionnaire. This work was progressed in partnership by the Chief Executive, the Interim Director of Human Resources and the Employee Director to draw out the emergent themes. Mr Jenkins acknowledged that the response rate to the exercise had been low and the need to engage widely throughout the organisation.

The following themes had emerged:- Communications and Engagement, Leadership and Management, Human Resources, Culture and Behaviours, Staff Support and Governance. Feedback on this process and these themes was being led through the committee and forum structure throughout TSH including the Partnership Forum. Further staff engagement would follow which would help formulate a structured plan for the organisation.

Mr Brackenridge welcomed this update and noted the initiatives takin place across TSH to influence culture, and offered the view that these should be taken forward as a broad front. Mr Jenkins agreed with this type of approach and added that this could help to take forward more meaningful discussion with staff across the organisation. This should be through circular, engaged communication and collaborative in nature. This partnership approach would support discussion, and provide valuable feedback from staff on what they felt about TSH as an employer. Mr Currie also noted the different strands of work on culture and values and behaviours, most notably through Sturrock as well as the

Review of the Clinical Model and the Corporate Governance Blueprint. He agreed that this work should be linked. The Committee also noted the need to continue to engage with Scottish Government.

Mr Jenkins confirmed that the approach would be to map these components against each other to help produce a comprehensive and sustainable TSH action plan, which would be reported to the Board.

The Committee was content to note this approach.

Action – Mr Jenkins

NOTED

12 SCOTTISH GOVERNMENT CIRCULARS – UPDATE

A paper was received to note Scottish Government circulars on organisational change pay protection arrangements, pay during annual leave and the management of sickness absence.

The Committee noted this update.

NOTED

13 ONCE FOR SCOTLAND – BRIEFING NOTE AUGUST 2019

A paper was received to provide an update on progress of 'Once for Scotland' Workforce policies within NHS Scotland. The draft workforce polices would be reviewed at the Scottish Workforce and Staff Governance (SWAG) Committee Meeting on 23 October 2019. Following approval of core policies, there would be a move towards implementation.

The Committee noted this update.

NOTED

14 EQUALITY DIVERSITY AND HUMAN RIGHTS – WWORKFORCE ANNUAL MONITORING REPORT 2018/19

The updated report – with one minor change was received and noted by the Committee.

NOTED

15 HEALTH, SAFETY AND WELFARE COMMITTEE - DRAFT MINUTES OF MEETING HELD 28 MAY 2019

Members received and noted the draft minutes of the Health, Safety and Welfare Committee, which had taken place on 28 May 2019.

NOTED

16 PARTNERSHIP FORUM – MINUTES OF MEETING HELD 16 JULY 2019

Members received and noted the minutes from the meeting of the Partnership Forum held on 16

July 2019.

NOTED

17 CATEGORY 1 AND 2 TIMESCALE REPORT (AREA OF INTEREST FROM CLINICAL GOVERNANCE COMMITTEE)

The Clinical Governance Committee had highlighted performance within adverse event review reporting as an area of concern for consideration by the Staff Governance Committee

A paper was received to outline the key issues, and Ms Merson provided a summary of this for Members, particularly on capacity within the department due to staff absences and vacancy. Ms Merson also underlined the importance of completing adverse event reviews within timescales, and that this would an area of key focus going forward.

Mr Brackenridge underlined the need to complete reviews quickly in order to take on board any learning and change in process or practice where appropriate. Mr Jenkins added his agreement and noted that should reviews not be completed in a timely way, this could leave the organisation open to the risk of recurrence of the original event. It was incumbent on the organisation to develop a resilience framework to meet any possible challenge to completing reviews such as staff absence.

The Committee expressed their concern in this area, and asked for an update report in six months time to demonstrate improvement in this regard. This should include an average timescale to complete reviews at that point, compared to the position reported to the Committee today.

Action – Ms Merson

NOTED

18 ANY OTHER BUSINESS

There were no other items of business for consideration.

19 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 28 November 2019 at 9.45am in the boardroom, The State Hospital, Carstairs.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2019
Agenda Reference:	Item No: 18
Sponsoring Director:	Finance & Performance Management Director
Author(s):	Finance & Performance Management Director
Title of Report:	Internal Audit – service provision
Purpose of Report:	For Decision

1 SITUATION

The purpose of this report is to enable members to consider and make a recommendation to the Board with regard to the ongoing internal audit service provision.

2 BACKGROUND

Following a competitive tender process in early 2017, RSM were appointed as Internal Auditor to the State Hospital. Under the terms of the tender, their appointment – effective 1st April 2017 – was on the basis of "3 years with the possibility of 2 further 1 year extensions on a one plus one basis".

3 ASSESSMENT

Since their appointment, RSM have completed two full years as our internal audit providers, and are underway with their third year, which will expire on 31st March 2020.

At this point, the Board have the option either to extend the appointment under the terms noted above, or to issue a new tender for the service provision effective 1st April 2020.

Further to discussion at the Audit Committee on 10th October 2019, it is the Audit Committee's recommendation that the option is taken to extend RSM's engagement by one year to 31st March 2021.

4 RECOMMENDATION

It is proposed that, under the terms of the 2017 tender and their subsequent appointment and acceptance thereof, the Board invites RSM to accept an extension of one year to that appointment – effectively extending their period of service provision to 31st March 2021. This will be due for further review in autumn 2020, when there will remain the option of extension by one more year.

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Essential provision of a quality internal audit service
Workforce Implications	None
Financial Implications	None – in line with current budget
Route to the Committee Which groups were involved in contributing to the paper and recommendations?	Audit Committee Chair of the Audit Committee and Finance & Performance Management Director
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No identified implications.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No identified implications
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITAL BOARD FOR SCOTLAND

Date of Meeting:	24 October 2019
Agenda Reference:	Item No: 19
Sponsoring Director:	Finance and Performance Management Director
Author(s):	Head of Management Accounts
Title of Report:	Financial Position as at 30 September 2019
Purpose of Report:	For noting

1 SITUATION

1.1 The Senior Team and the Board consider the Revenue and Capital plans, and financial monitoring. This report provides information on the financial performance to 30 September 2019, which is also included in the Partnership Forum agenda, the Board agenda and sent monthly to Scottish Government (SG), with the financial template.

1.2 Scottish Government are provided with an annual Operational Plan (narrative plan – with a financial template forecast submitted for a 3-year period) which was confirmed at the 20 June 2019 Board meeting.

1.3 This Plan sets out a balanced budget for 2019/20 based on achieving £2.103m efficiency savings, as referred to in the tables in section 4. There is, however, a significant savings gap.
Authorisation by email was given from SG to capitalise the perimeter fence project facilitation / support staff, which is in the process of being confirmed and will help relieve the unidentified savings / pressure.
We have also assumed the reversal of the £0.127m tranche 2 saving for the territorial boards, which then reduced the unidentified savings.

2 BACKGROUND

2.1 Revenue Resource Limit Outturn

The annual budget of £37.619m is primarily the Scottish Government Revenue Resource Limit / allocation, now including PAIAW. A thorough review of Ehealth strategic monies is ongoing.

The Board is reporting an under spend position of £0.165m to 30 September 2019, the table below shows analysis by expenditure type.

In month favourable movement of £0.053m. Nursing staffing is under establishment, which affects overtime levels, however this is similar to earlier months.
Legal fees pressure. Research projection favourable movement, due to delays in projects.

Spend Type	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 6	Budget WTE	Actual WTE (volume)
Other Operating Income	(582)	(291)	(307)	16	(2.00)	(2.00)
Pay	31,567	15,563	15,517	46	621.32	623.21
Savings	(1,375)	(73)	0	(73)	0.20	0.00
Purchase Of Healthcare	792	381	360	21	0.05	0.00
Non Pay	4,964	2,446	2,287	159	0.00	0.00
Hch Income	(603)	(365)	(355)	(10)	(9.07)	(9.22)
Capital Charges	2,857	1,429	1,423	5	0.00	0.00
	37,619	**19,090**	**18,925**	**165**	**610.50**	**611.99**

2.2 The table below highlights areas of key pressures / expected benefits to be received.

PRESSURES	Risk	Best estimate £'k
Holiday Pay - Lock v British Gas - PAIAW - Full Year 19/20 (have also anticipated RRL of £141k for 17/18 retrospection)	High	210
Rebandings arrears	High	tbc
Clinical Model Review	High	tbc
Legal Fees	High	103
EU Exit (may get guidance from sub group)	Low	tbc
Perimeter Fence - FBC - Additional Staff (Capital funding pending)	Low	193
3 yr up for opt out sup'an Nov 19 (approx 100 staff not sup'an)	Med	tbc
BENEFITS	**Risk**	
Exceptional Circumstance Patients (new - recharging host Board)	Med	290
VAT element on Utilities in our favour (v HMRC)	Low	120

2.3 **Forecast Outturn**

The forecast outturn trajectory was an over spend of £0.230m, however the position is £0.165m underspent, therefore a favourable movement of £0.395m.
Comparing the Nursing overspend to the same period last year shows a £0.396m improvement, this explains the large variation in forecast outturn trajectory and actual position.
Unidentified savings are phased to month 12; therefore, there is the requirement to recognise an apportionment for the year to date, a small amount has been addressed September 2019.

HMRC has settled in our favour to reduce VAT on utilities to 5% from 20%, this windfall will benefit TSH in 2019/20 – for which the Electricity is nearly concluded (issues with invoices and credit notes), and we are still awaiting details on Oil and Gas.

PAIAW - funding is set aside for the payment due December 2019 for 19/20 arrears, unsure whether this is enough, thereafter the payment will be made monthly. Got the anticipated RRL through in the September allocation letter.

A year-end breakeven position was forecast in the Operational Plan, pending outcomes on a number of pressures (most significant noted in the above table at 2.2).

3 ASSESSMENT

3.1 YEAR TO DATE POSITION – BOARD FUNCTIONS

Directorates	Annual Budget 19/20 £'k	YTD Budget Sept 19 £'k	YTD Actuals Sept 19 £'k	YTD Variance (budget - actual) (adverse) / favourable Sept 19 £'k	Budget wte	Actual WTE
Cap Charges	2,857	1,429	1,423	5	0.00	0.00
Central Reserves	(30)	19	21	(1)	0.00	0.00
Chief Exec	1,849	922	904	18	22.45	22.36
Finance	2,970	1,575	1,573	2	37.53	34.27
Human Resources Directorate	836	419	414	5	13.38	13.38
Medical	3,764	1,822	1,725	97	36.08	29.09
Misc Income	(294)	(147)	(25)	(122)	0.00	0.00
Nursing And Ahp's	19,710	10,010	9,946	64	378.53	387.79
Security And Facilities	5,958	3,041	2,945	97	123.63	119.18
Under / (over) spend	**37,619**	**19,090**	**18,925**	**165**	**611.60**	**606.07**

Key Highlights

Central Reserves – Charges are for non-AFC pay awards pending.

Finance – legal fees pressure, invoices exceptionally high this year (re specific cases), offset with projected underspend in Research.

HR – Occupational Health – pressure from backdated invoicing for 18/19, and pressure in year for additional physio sessions (funding now released September). Learning Centre underspend in course fees.

Medical – Pressure in invoices from other Boards for Senior Trainee Doctors, offset with **Psychology** – continuing vacancies (due to continued closure of two wards).

Miscellaneous Income – targeted saving for VAT benefit on Utilities, not yet realised.

3.2 Further detail on Nursing & AHP's

Nursing & AHP's	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 6	Budget WTE	Actual WTE
Advocacy	147	74	73	1	0	0
AHP's & Dietetics & SLA'S	647	324	293	31	13	12
Hub & Cluster Admin & Clinical Operations	812	408	389	19	23	19
PCI & Pastoral	220	110	81	29	3	2
NPD & Infection Control & Clin Gov	416	208	192	16	6	5
Skye Centre	1,735	875	772	102	38	36
Ward Nursing	15,733	8,012	8,146	(134)	295	313
Total Nursing and AHP's	**19,710**	**10,010**	**9,946**	**64**	**378.53**	**387.79**

Key Highlights

AHP's, Skye Centre, Hub Admin, PCI – are all generating underspends from vacancies.

Ward Nursing – Further detail in table below.

Ward Nursing	2019/2020						
Ledger Nursing	Annual Budget £'k	In month / Year to Date Budget £'k	In month / Year to date Actuals £'k	YTD Variance (budget less actuals) £'k	Budget WTE	Actual WTE	Contracted/ conditioned wte's
Total April 19		**1,286**	**1,350**	**(65)**	**295.00**	**318.77**	**289.30**
Total May 19		**1,286**	**1,343**	**(58)**	**295.00**	**315.33**	**289.30**
Total June 19		**1,286**	**1,282**	**3**	**295.00**	**309.54**	**286.30**
Total July 19		**1,286**	**1,286**	**(1)**	**295.00**	**303.18**	**288.28**
Total Aug 19		**1,577**	**1,583**	**(6)**	**295.00**	**309.99**	**281.72**
Total Sept 19		**1,293**	**1,301**	**(8)**	**295.00**	**312.86**	**291.55**
Cum Sept 19	**15,733**	**8,012**	**8,146**	**(134)**			
Variance analysis:							
Overtime for vacancies backfill				(200)			
Phased savings (not yet realised)				(75)			
'Nursing Resource' to analyse			*	141	New control measures in place		
				(134)			

3.3 Further detail on Security and Facilities

Security & Facilities	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 6	Budget WTE	Actual WTE
Facilities	4,264	2,161	2,045	116	84	76
Security	1,637	823	842	(19)	40	39
Perimeter Security	57	57	58	(0)	0	4
Total Security & Facilities	**5,958**	**3,041**	**2,945**	**97**	**123.63**	**119.18**

Key Highlights

Facilities – Vacancies in Estates & Housekeeping. Utilities underspends.

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Security – Backfill pressure and acting post.

Perimeter Fence - revenue staff have been 'funded' by increasing the unidentified savings gap, pending capital funding.

4 Savings

The target column of the table is an extract from the Operational Plan, further information shows savings achieved to date and remaining balance to be achieved by the year-end.

Savings Annual Target LDP	Savings Annual Target LDP 2019-20 Rec £'k	Non-Rec £'k	Total £'k	Savings (Achieved), as at Sept 19 2019-20 Rec £'k	Non-Rec £'k	Total £'k	Savings still to be achieved by year end 2019-20 Rec £'k	Non-Rec £'k	Total £'k
Efficiency & Productivity Workstreams:									
Service redesign (Clinical)	(22)	(95)	(116)	0	30	30	(22)	(65)	(86)
Drugs & Prescribing	0	(20)	(20)	0	26	26	0	6	6
Workforce	(57)	(481)	(538)	15	421	436	(42)	(60)	(102)
Procurement	0	0	0	0	0	0	0	0	0
Infrastructure *(e.g.facilities mgt, IT, other support services)*	(56)	(309)	(365)	0	65	65	(56)	(244)	(300)
Other	0	(100)	(100)	0	0	0	0	(100)	(100)
Financial Management / Corporate Initiatives	0	0	0	0	0	0	0	0	0
Unidentified Savings	0	(965)	(965)	0	171	171	0	(794)	(794)
Total In-Year Efficiency Savings	**(134)**	**(1,969)**	**(2,103)**	**15**	**713**	**728**	**(119)**	**(1,256)**	**(1,375)**
Trajectory (1/12ths of LDP)				**67**	**985**	**1,052**			
(under) / over achieved against trajectory				**(52)**	**(271)**	**(323)**			

The following table, by Directorate, provides further clarification on savings.

Cumulative Savings	Savings - Annual Target	Achieved to date	(Still to be achieved) / over achieved
Directorate	**£'k**	**£'k**	**£'k**
Chief Executive	(162)	80	(82)
Finance	(99)	47	(52)
Nursing & AHP's	(261)	187	(74)
Human Resources	(33)	10	(23)
Medical	(117)	133	16
Security & Facilities	(367)	100	(267)
Unidentified (offset contingency reserve?)	(100)	0	(100)
Unidentified	(965)	171	(794)
Total	**(2,103)**	**728**	**(1,375)**

Targeted saving 50%, actual saving 35%, underachieved 15%.

5 CAPITAL RESOURCE LIMIT

Capital allocation from Scottish Government is £0.269m.

It is expected we will get Perimeter Fence TSH revenue-staffing costs included in the FBC funding; this would significantly reduce the unidentified savings/pressure in revenue. There is a delay in the project.

	Annual Plan £'k	YTD Plan £'k	YTD Actual £'k	YTD Variance £'k
Estates	165	30	30	-
IM&T	104	104	104	-
Vehicles	-	-	-	-
Other equipment	-	-	-	-
Security Fence Dvpt	-	30	30	-
TOTAL	**269**	**164**	**164**	**-**

6 RECOMMENDATION

6.1 **Revenue: Under spend of £0.165m year to date. Year-end projection: Breakeven.**

Overtime in Nursing is still higher than budget year to date, however in comparison to previous years there is much improvement, and with many measures in place it is hoped to stabilise over the remaining months.

Quarterly Financial Review meetings, over and above the monthly Management Accounts meetings, help eliminate any surprises in the accounts and aids forecasting the year-end outturn.

The Board is asked to note the content of this report.

6.2 **Capital: Breakeven year to date. Year-end projection: Breakeven**

The Board is asked to note the content of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of Financial Position
Workforce Implications	No workforce implications – for information only
Financial Implications	No workforce implications – for information only
Route to SG/Board/SMT/Partnership Forum Which groups were involved in contributing to the paper and recommendations.	Head of Management Accounts
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ☑ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed. ☐ There are privacy implications, full DPIA included.

Paper No: 19/85

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2019
Agenda Reference:	Item No: 20
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Corporate Governance Improvement Action Plan
Purpose of Report:	For noting

1 SITUATION

Following Board self-assessment, an improvement plan was developed to support key corporate governance priorities as part of the Corporate Governance Blueprint.

The Board submitted its improvement plan to Scottish Government in April 2019.

2 BACKGROUND

The five key areas of the improvement plan are outlined as follows:

- Setting the Direction
- Holding to Account
- Assessing Risk
- Engaging Stakeholders
- Influencing Culture

3 ASSESSMENT

The improvement plan has been updated to indicate progress against each item (Appendix A) and the Board is asked to note the content of the updated plan, as well as the assurance mechanism through which progress will continue to be monitored.

In particular, the Board is asked to note the work progressed on the development of more robust processes to compare planned and actual spend and to account for any variance (Point 3). In particular, that **a** summary of any significant or material variances will be collated to be reported as appropriate.

Further, progress has been made in the development of risk management with focus on risk register to ensure this is clearly defined with set of mitigating measures against each risk, which also have a focus on improvement actions (Point 9). This is being taken forward through closer risk register monitoring and review process led through the Risk Team Leader.

The Board is asked to note that work on influencing culture and staff engagement has been linked to the work being progressed through the response to the Sturrock report, and that a report will be brought back to the Board at its December meeting.

4 RECOMMENDATION

The Board is asked to note progress in implementation of the improvement plan.

A further update will be brought to the next meeting of the Board in December 2019.

Paper No: 19/85

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Corporate Governance Blueprint
Workforce Implications	None identified to date
Financial Implications	None identified to date
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board Standing Committees/ SMT
Risk Assessment (Outline any significant risks and associated mitigation)	None identified to date
Assessment of Impact on Stakeholder Experience	Implementation will benefit stakeholder engagement through the workstreams indicated in the improvement plan
Equality Impact Assessment	Not formally assessed
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No impact identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND - IMPROVEMENT PLAN **Appendix A**

BLUEPRINT FUNCTION		ACTION	LEAD	ASSURANCE SYSTEM	TIMESCALE	PROGRESS
SETTING THE DIRECTION	1	Reconfirm the Board's strategic direction, and communicate this through the Strategy Map and development of strapline statement for corporate documents.	CEO	CEBM	June 2019	**Completed:** Strapline finalised following hospital wide competition. Strategy Map reviewed as part of review of Corporate Objectives.
	2	Review of effective rostering system within nursing as component of focus on effective workforce utilization and safe staffing legislation.	Director of Nursing and AHPs	SMT	March 2020	**On Track**. Review In progress.
	3	Development of more robust processes to compare planned and actual spend and to account for any variance.	Director of Finance & PM	SMT /Board	September 2019	**Update:** Planned and actual £ spend per budget line being reviewed with each individual budget holder on a line-by-line basis from the 2019/20 mid-year 6-month reviews (30/9/19) – a summary of any significant or material variances will be collated to be reported as appropriate.
HOLDING TO ACCOUNT	4	Ensure compliance with new national guidelines in management of Executive pay and performance through remuneration Committee approval for annual ESM pay and performance cycle.	Chair /Interim HR Director	Remuneration Committee	Ongoing	**On Track**
	5	Ensure implementation of attendance management policy through support from HR to line managers help identify and act upon patterns of absence.	Interim HR Director	AMITG/ SMT	October 2019	**On Track.** Training for Line Managers and HR Managers implemented in June and July, with further sessions ongoing.

		Continued implementation of the action plan developed through the Attendance Management Improvement Task Group (AMITG).				Update presented on attendance management to each Board Meeting.
	6	Implementation and compliance with Once for Scotland HR policies within TSH. Focus on policy awareness through completion of metacompliance / staff bulletins/ staff training in Single Investigatory process.	Interim HR Director	Partnership Forum/SMT	December 2019	**On Track** – following roll out of the national guidance.
	7	Review performance framework and assurance information systems to support review of performance.	CEO	CEBM	July 2019	**On Track** - Update provided to August 2019 Board Meeting.
	8	Blueprint Improvement Plan to be placed on Board Workplan for review at each Board Meeting.	Chair	Board	June 2019	**Completed**
ASSESSING RISK	9	Further development of risk management with focus on risk register to ensure this is clearly defined with set of mitigating measures against each risk which also have a focus on improvement actions.	Director of Finance	Audit Committee / Board	December 2019	**Update:** -Underway through closer Risk Register monitoring and review process (managed by Risk Team Leader) and reporting to Risk Finance and Performance Group – All risk register items either now with action plan in place or underway.
ENGAGING STAKEHOLDERS	10	Review and develop the Communications Strategy to include	CEO	Board	March 2020	**Review in progress:** with regular updates to the Board.

		proactive engagement with aim of addressing dissonance between strategic aims of the hospital and public perception of these aims.				
	11	Promotion of The State Hospital as an employer in the local area. Increase number of modern apprenticeships. Participate in local school careers events, local and university recruitment fairs	Interim HR Director	SMT	March 2020	**Ongoing** – engagement commenced in university recruitment fairs. Recruitment Fair at TSH in October 2019 (Outwith secure area to enable public engagement).
	12	Encourage carers / volunteers /staff / local population to attend public Board Meetings through additional promotion and links with local community.	Board Secretary	Board	September 2019	**In progress** – through promoting external Board Meetings and Annual Review session in 2020.
	13	Hold two Board Meeting each year at external locations to promote role as national Board.	Board Secretary	Board	April 2020	**Update:** December Board Meeting to be outwith TSH.
	14	Annual Review - Public Meeting to be held outside of the hospital to help engage public engagement and attendance.	Board Secretary	Board	April 2020	Plan to be progressed as part of Annual Review planned expected summer 2020.
INFLUENCING CULTURE	15	Define culture in The State Hospital in terms of key strengths and weaknesses - take forward through development sessions	CEO	Board	December 2019	**Review in progress** – progressed in conjunction with response to Sturrock and update to December Board.
	16	Implement a Staff Recognition Scheme for long service as well as individual contribution to the organisation.	Interim HR Director	SMT	September 2019	**Completed**- first ceremony 24 October 2019.

	17	Embed a culture of quality across the organisation through initiatives such as TSH3030, Quality Forum and sharing our work more widely.	CEO	SMT	March 2020	**On Track** - QI Forum initiatives underway. TSH 3030 launched successfully for November 2019
	18	Senior Management visibility through regular front line staff engagement meetings with CEO / Directors' Group - plan a calendar of events to ensure regular engagement.	CEO	SMT	July 2019	**On Track** - CEO Business Meetings venue held weekly across site, for visibility. CEO attending staff groups across site. OD Lead supporting wider engagement plan across TSH – progressed in conjunction with response to Sturrock.
	19	Senior Team / RMO presence at key events in hospital calendar e.g. patient learning awards/ sportsman dinner. Promote this through management structures.	CEO / Medical Director	SMT	September 2019	**On Track** -Coordination of central diary of events to help facilitate attendance.
	20	Link in with Scottish Government once appointment of the Independent National Whistleblowing Champion has been appointed.	CEO	Board	April 2020	**On Track** National Recruitment process underway.
	21	Plan a schedule of Non-Executive Director informal visits across TSH to help promote the values and behaviours of the organisation.	Chair	Board	August 2019	**On Track** -Approval at August Board, for planned schedule including walkrounds, staff induction and patient engagement.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2019
Agenda Reference:	Item No: 22
Sponsoring Director:	Board Chair
Author(s):	Board Secretary
Title of Report:	Annual Schedule of Board and Sub Board Meetings – 2020
Purpose of Report:	For noting

1 SITUATION

The Board considered the draft schedule of meetings for 2020, at its meeting on 22 August 2019.

2 BACKGROUND

It was agreed that there should be no changes to the usual pattern of the schedule for Board and Committee Meetings in 2020. Some minor amendments were proposed to the draft schedule.

3 ASSESSMENT

The updated Board and Committee schedule is now attached.

4 RECOMMENDATION

Members are asked to note the attached Annual Schedule of Meetings for 2020, which will be published on the NHS Board website.

The State Hospital

ANNUAL SCHEDULE OF MEETINGS - 2020
BOARD AND SUB-BOARD

MEETING	Chair/ Members	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
BOARD	**Terry Currie*** B Brackenridge T Hair N Johnston D McConnell M Whitehead		Thursday 27.02.20 9.45am Boardroom		Thursday 23.04.20 9.45am Boardroom		Thursday 18.06.20 12.30pm Boardroom		Thursday 27.08.20 9.45am Boardroom		Thursday 22.10.20 9.45am Boardroom		Thursday 17.12.20 9.45am Boardroom
AUDIT COMMITTEE	**D McConnell*** B Brackenridge T Hair M Whitehead	Thursday 23.01.20 9.45am Boardroom		Thursday 26.03.20 9.45am Boardroom			Thursday 18.06.20 9.45am Boardroom				Thursday 08.10.20 9.45am Boardroom		
CLINICAL GOVERNANCE COMMITTEE	**N Johnston*** D McConnell M Whitehead		Thursday 13.02.20 9.45am Boardroom			Thursday 14.05.20 9.45am Boardroom			Thursday 13.08.20 9.45am Boardroom			Thursday 12.11.20 9.45am Boardroom	
STAFF GOVERNANCE COMMITTEE	**B Brackenridge*** T Hair N Johnston M Whitehead		Thursday 20.02.20 9.45am Boardroom			Thursday 28.05.20 9.45am Boardroom			Thursday 20.08.20 9.45am Boardroom			Thursday 19.11.20 9.45am Boardroom	
RENUMERATION COMMITTEE **	**T Currie*** B Brackenridge T Hair N Johnston D McConnell M Whitehead		Thursday 27.02.20 2.00pm Boardroom				Thursday 18.06.20 3.30pm Boardroom				Thursday 22.10.20 2.00pm Boardroom		

* Chair of Committee
** Remuneration Committee also meets as and when required

2020

PUBLIC HOLIDAYS:
New Year : Wednesday 1 January & Thursday 2 January
Christmas : Friday 25 December & Monday 28 December
Easter : Friday 10 April & Monday 13 April
Autumn Holiday : Friday 25 September & Monday 28 September

THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 19 DECEMBER 2019
9.45am

The Boardroom, The State Hospital, Carstairs, ML11 8RP

A G E N D A

1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 24 October 2019	For Approval	TSH(M)19/11
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 19/91
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
	CLINICAL GOVERNANCE		
7.	**Patient Story** Report by the Director of Nursing and AHPs	For Discussion	Presentation
8.	**Clinical Service Delivery Model - Incorporating update on Sturrock Response** Report by the Chief Executive	For Decision	Paper No. 19/92
9.	**Approved Medical Practitioner – Request** Report by the Medical Director	For Decision	Paper No. 19/93
10.	**Patient Safety, Infection Control and Patient Flow Report** Report by the Director of Nursing and AHPs	For Noting	Paper No 19/94
11.	**TSH3030 - 2019** Report by the Head of Corporate Planning and Business Support	For Noting	Verbal
12.	**Clinical Governance Committee** Committee Chair's Update - meeting held 14 November 2019	For Noting	Verbal
13.	**Clinical Forum** Approved Minutes of meeting held 15 August 2019	For Noting	CF(M)19/03
	STAFF GOVERNANCE		

14.	**Workforce Plan – Update** Report by the Interim Director of HR	For Noting	Paper No. 19/95
15.	**Attendance Management – Board Update** Report by the Interim Director of HR	For Noting	Paper No. 19/96
16.	**Staff Governance Committee** Committee Chair's Update - meeting held 29 November 2019	For Noting	Verbal

CORPORATE GOVERNANCE

17.	**Finance Report to 30 November 2019** Report by the Finance & Performance Management Director	For Noting	Paper No. 19/97
18.	**Performance Report – Quarter 2 2019/20** Report by the Finance & Performance Management Director	For Noting	Paper No. 19/98
19.	**Corporate Governance – Improvement Plan Update** Report by the Board Secretary	For Noting	Paper No. 19/99
20.	**Corporate Leadership** Report by the Board Secretary	For Noting	Paper No. 19/100
21.	**Board Workplan – 2020** Report by the Board Secretary	For Decision	Paper No. 19/101
22.	**Audit Committee** Draft Minutes of meeting held 10 October 2019	For Noting	A(M) 19/04
23.	**Any Other Business**		
24.	**Date and Time of next meeting** 27 February 2020, 9.45am		

25. EXCLUSION OF PUBLIC AND PRESS

To consider whether to approve a motion to exclude the Public and press during consideration of the items listed as Part II of the Agenda in view of the confidential nature of the business to be transacted.

THE STATE HOSPITALS BOARD FOR SCOTLAND TSH (M) 19/11

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 24 October 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

Chair:	Terry Currie
Present:	
Non-Executive Director	Bill Brackenridge
Employee Director	Tom Hair
Chief Executive	Gary Jenkins
Non-Executive Director	David McConnell
Director of Finance and Performance Management	Robin McNaught
Director of Nursing and AHPs	Mark Richards
Medical Director	Lindsay Thomson
In attendance:	
Person Centred Improvement Lead	Sandie Dickson [Item 10]
Head of Communications	Carline McCarron
Head of Corporate Planning and Business Support	Monica Merson
Interim HR Director	Kay Sandilands
Board Secretary	Margaret Smith
Director of Security, Estates and Facilities	David Walker

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Currie welcomed everyone to the meeting, and apologies were noted from Mr Nicholas Johnston and Mrs Maire Whitehead, as well as from Ms Aileen Burnett, Chair of the Clinical Forum.

2 CONFLICTS OF INTEREST

There were no declarations of conflicts of interests from Members in respect of the business to be discussed at this meeting.

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 22 August 2019 were noted to be an accurate record of the meeting.

The Board:

1. Approved the minute of the meeting held on 22 August 2019.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board noted progress on the action points from the last meeting – each item either had been

completed or formed part of the agenda of today's meeting.

The Board:

1. Noted that the action list was up to date.

5 CHAIR'S REPORT

Mr Currie reported on the meeting of the NHS Chairs' group, which took place on 26 August 2019. He advised that the Cabinet Secretary had referred to Brexit and noted that the likeliest outcome now looked to be withdrawal from the E.U. without a deal. NHS Boards had been asked to resubmit the checklist on progress against key issues such as impact on staffing and availability of medicines. As well as the impact on employment and the provision of health and social care services, the Cabinet Secretary had also asked that NHS Boards consider the effects of the no deal scenario on innovation, research and clinical practice.

The Cabinet Secretary had expressed concern about the wide variation across NHS Boards regarding the decision to trigger an Adverse Event process and advised that this was currently being examined. She had advised that the results of the consultation on the decision to establish a new body, Public Health Scotland, had received broad support. It was noted that Mr Jim McGoldrick had been appointed Chair to the Shadow Board. Ms Angela Leitch, currently Chief Executive of East Lothian Council, had been appointed Chief Executive of the new body.

At the meeting, Chairs were asked to note the establishment of a new Directorate at Scottish Government, the Directorate for Community Health and Social Care, and that Ms Elinor Mitchel had been appointed Director. There was a substantial programme of reform underway in primary care, adult social care support and integration with a fundamental consistent purpose of ensuring that more people could enjoy health and care services at home or in a community setting. The new Directorate would provide an opportunity to join up this reform and achieve a shift in the balance of care.

The Cabinet Secretary highlighted access and performance issues within NHS Boards, with performance around elective activity and unscheduled care pre-eminent. The increased levels of attendance at emergency departments was also discussed. She also asked Chairs to note that the Annual Operational Plan process would be moved forward by around six months in the coming year.

Finally, it was noted that a new non-executive website had been activated. Initially this would include details of local and national induction; on-line interactive training; policy into practice videos; integration of health and social care; mentoring and coaching. Further additions would occur between September 2019 and March 2020 including eLearning modules on Finance and Audit and Risk.

Mr Currie asked Board Members to note that a mid-year review session would take place on 8 November 2019 in St Andrews House and would be chaired by Ms Donna Bell, Director of Mental Health. The Chair and Chief Executive had been asked to attend. Further, that Ministers would conduct Annual Reviews for all Health Boards in the summer of 2020.

Mr Currie confirmed that The Health and Sport Committee at the Scottish Parliament were conducting a series of evidence sessions with Health Boards and had invited The State Hospital to attend to give evidence on 3 December 2019 at 10am. He noted that 14 NHS Boards had already attended.

He highlighted that the inaugural Staff and Volunteer Excellence Awards Presentation for The State Hospital would be taking place today in the Skye Centre at 1.30pm and encouraged Board Members to attend to give strong Board representation and support. He also noted that the Moderator of the Church of Scotland would be visiting the hospital on 30 October 2019.

The Board:

1. Noted the update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins provided the Board with an update of his activities since the date of the last Board meeting.

He had attended the Health and Social Care in Prisons Board in August and had hosted a visit from Ms Alison Taylor, Deputy Director of health and Social Care Integration at Scottish Government. She had been impressed by the work being taken forward at The State Hospital (TSH). He had arranged to visit Barlinnie Prison with colleagues from Scottish Government on 31 October which presented a valuable opportunity to promote the work of TSH in a wider arena.

The Board would today consider a paper in relation to the Review of the Clinical Model, and work on this had been highly focussed during the past two months.

Mr Jenkins highlighted the detailed preparatory work for EU Withdrawal, led by Mr Walker. A Statement of Assurance had been submitted to and accepted by Scottish Government in respect to planning in place at TSH, as events unfolded at a political level.

Mr Jenkins had met with colleagues in the Mental Health Directorate for a quarterly of the Annual Operational Plan for 2019/20 during September, and reported that this had been positive under each heading of the plan.

Mr Jenkins advised Board Members that a fortnightly Executive Team Meeting had been established and that work was progressing through Ms Smith as Board Secretary to benchmark arrangements for corporate leadership teams across NHSScotland for good governance practice.

He referenced the Independent Review into the Delivery of Forensic Mental Health Services, and confirmed that he would be submitting evidence to this on behalf of TSH in November.

As Chief Executive, he had attended a workshop for newly appointed Accountable Officers and had also taken up the role of Chair of the National Boards Estates Strategy. In his role as Chair of the Police Care Network, he was leading in a remodelling and benchmark exercise to re-establish this work; and through this he would continue to promote the profile of TSH.

Mr Jenkins noted that an update would be provided to the Board on the security re-fresh project at TSH during the private session scheduled to take place today following the public session.

Finally, he noted that he would be attending the Mid-Year review with Ms Donna Bell, Director of Mental Health Directorate alongside the Board Chair.

The Board:

1. Noted the update from the Chief Executive Officer.

7 REVIEW OF THE CLINICAL SERVICE DELIVERY MODEL

A paper was received from the Medical Director, which provided the Board with a detailed update on the progress of the review of the clinical model and outlined a preferred option for the Board's consideration and decision.

Professor Thomson provided the Board with a summary of the key developments progressed since the date of the last Board meeting in August 2019. Mr Jenkins then took Members through the key points of the paper in detail covering the life of the review in each stage as it was progressed. He highlighted the empowered role of colleagues from the Clinical Forum who provided professional input. The review had been taken forward through an options appraisal process, well established throughout NHS Scotland, and involving a wide range of leaders and clinicians from across the organisation and which led to ranking of the options and identification of a preferred option for the configuration of clinical services.

Following this, further detailed work was taken forward on viability taking into account fit with the patient cohort: studying patient numbers, characteristics and movement over the previous four years. This noted the stability of patient numbers overall with an increase in the numbers of patients with Intellectual Disability. This placed within the context of findings of the patient safety report led by Professor Thomson on the potential assaultive challenge from this patient cohort.

Each option had been subject to financial costing in terms of the service configuration presented in each, and the number of wards required. Mr Jenkins led the Board through the potential costs of different ward configurations focussing on the cost of the nursing that would be required in each as the key indicator and highlighted the need to be an efficient organisation He outlined the parameters of the configuration of services required, confirmed that this work had established an emergent preferred option, based upon and adapted from the preferred option identified by the options appraisal process

Mr McConnell welcomed the paper, and noted the movement in the recommended option from the preferred option which arose from the options appraisal process. This was clear to understand through the work carried out on the patient cohort. He asked in particular how this adapted model would have fared within the options appraisal process. Professor Thomson acknowledged that none of the options had been found to fully fit the patient cohort, and that therefore focus had been on the principles of the preferred option especially for continuity of care and to adapt the model with this in mind. This would allow medical staff to retain care across hubs for patients. Mr Jenkins also underlined that although transition ward could have been established within hubs, the movement of patients to this ward was seen as being an integral part of their progress. Professor Thomson noted that it must also be accepted clinically that patients who were not able to cope may require to be moved back from the transitions ward.

Mr Richards added that for nursing staff, this model would afford an opportunity to specialise their skills within the transition wards and to liaise with Allied Health Professional colleagues

Mr Brackenridge welcomed the report warmly as a positive piece of work involving whole system review, and which had highlighted potential for re-investment in services at TSH to improve the hospital and for patient care. Mr Jenkins agreed noting the wide range of challenges within the organisation across services. He also noted that the hospital should be ready in its reserves for contingency planning, allowing any spike in admissions or a particular clinical challenge to be met. Overall the need to demonstrate a value for money base as a public service was recognised within the context of the efficiency savings required on all NHS Boards.

Mr Hair noted that it would be essential to ensure that patient flow across wards was shown to be realistic in terms of the number of beds available in each stream, especially for patients with major mental illness, and staff would wish to be reassured on this. Professor Thomson acknowledged this saying that a 120 bed model was clearly realistic, but that the key would be the flow of patients within each stream. For example, whilst admission and assessment wards may have capacity other wards

may not. The logic of the two ID wards in one hub was accepted clinically. She emphasised the need to continuously review patient flow and the impact of this model to ensure that it was working as envisaged and to monitor the impact of change.

Mr Hair offered the view that staff were on the whole pragmatic about the need for realistic modelling and an efficient organisation and believed they would welcome this as being long term viable planning. This was being taken forward in partnership and this should continue to be the case. Professor Thomson added that staff had appeared most concerned that the result of this process may be that change was not taken forward, and Mr Richards echoed this point with positive reaction from staff to date in their participation with the options appraisal process. Staff were aware of the difficulties faced in affordability and the need to ensure the delivery of safe and effective care for patients.

On behalf of the Board, Mr Currie summarised the views around the table in support of the recommended option. He recognised the excellent work over the period of the review process which had been very thorough. He noted in particular that staff had indicated a desire for change in the delivery of clinical services, and that this had been delivered. He paid particular tribute to Ms Merson for her work in support of this review.

The Board:

1. Endorsed the method applied in reaching the emerging preferred option.
2. Acknowledged the significant contribution of the Clinical Forum
3. Noted the multi-professional and stakeholder engagement in the process to date.
4. Noted the variable factors associated with the forensic mental health estate overall which could alter the known planning assumptions at this time.
5. Agreed that the Affordability of an 11 ward model would create significant financial pressures across the organisation.
6. Endorsed a detailed planning and implementation process allowing TSH to move to a tem ward model based on eight MMI wards and two ID wards.
7. Supported the establishment of a quarterly review process to assess the effectiveness and challenges of operating the ten ward model.

8 OVERSEAS TEAVEL REQUEST

A paper was received from the Medical Director, which asked the Board to endorse an overseas travel request in connection with the Global Citizenship programme, previously seen and approved by the Board Chair.

Board Members were content to do so and also recognised the achievement of Dr Khuram Khan, Consultant Psychiatrist in being nominated as a finalist in the Scottish Health Awards for his work in this regard.

The Board:

1. Approved this travel request for costs as indicated.

9 MEDICAL APPRAISAL AND REVALIDATION - ANNUAL REPORT

A paper was received from the Medical Director, which provided the Board with a summary of work progressed within TSH to meet the requirements of revalidation for medical staff as stipulated by the General Medical Council.

There had been no issues to report and work had progressed successfully.

The Board:

1. Noted the content of the report.

10 PERSON CENTRED IMROVEMENT – 12 MONTHLY REPORT

A paper was received from the Director of Nursing and AHPs, to summarise the work take forward by the Person Centred Improvement Service (PCIS) from November 2018 until October 2019.

Ms Dickson was in attendance to highlight the key pieces of work progressed by the service, including delivery of the What Matters To You? Initiative and supported patient involvement in the TSH 3030 quality improvement programme. She also outlined the way in which the service would meet its key performance indicators and would continue to contribute to organisational objectives supported by successful recruitment within the team. Mr Richards asked the Board to note the depth of work undertaken.

The Board received this report warmly and thanked Ms Dickson and her team for continuing good work. In response to a question on what challenges the service met, Ms Dickson outlined a positive picture with the patient feedback being recognised as central to service delivery.

Mr Currie asked Ms Dickson to feedback the Board's appreciation of the work they do in their contribution to improving the patient experience at TSH.

The Board:

1. Noted the content of the report.
2. Acknowledged the excellent work progressed by the Person Centred Improvement Team.

11 PATIENT SAFETY, INFECTION CONTROL AND PATIENT FLOW REPORT

A paper was received from the Director of Nursing and AHPs, which summarised activity within the hospital in relation to patient safety, healthcare associated infection (HAI) and patient flow. Mr Richards summarised the report for the Board, which included a summary of patient flow from 2011 to date.

It was noted that the report should in future also include the monthly update on patient numbers and flow, going forward.

Action – Mr Richards

The Board:

1. Noted the content of the report.
2. Requested monthly patient flow figures be included in reporting.

12 CLINICAL GOVERNANCE COMMITTEE

The Board received the draft minutes of a meeting of the Clinical Governance Committee which took place on the 15 August 2019. The Board noted the key issues discussed including the review of the Clinical Model, and the work led by Mr Walker following Critical Incident Review 18.01 through a Task Group. The Committee had reviewed the 12 month reports from the Psychological Therapies Service and on Patient Safety, as well as reviewing the Forensic Medium and Secure Care standards Action Plan as it related to TSH.

The Board:

1. Noted the content of the draft minutes of the Clinical Governance Committee for 15 August 2019.

13 ATTENDANCE MANAGEMENT REPORT

A paper was received from the Interim Director of Human Resources, which outlined staff attendance data over the course of the latest reporting period of August 2019 and placed this within the context of the rolling 12 month figures.

Ms Sandilands advised the Board that although a slight increase had been experienced in the August figure, the rolling 12 month figure demonstrated a 2.44% reduction with the previous 12 month period. Close monitoring of the measures put in place would continue going forward to ensure that the figure stabilised.

The Board:

1. Noted the content of the report.

14 ATTENDANCE MANAGEMENT IMPROVEMENT TASK GROUP (AMITG)

A paper was received from the Interim Director of Human Resources, which outlined the progress made by the AMITG over the course of the past 12 months, and asked the Board to support the Staff Governance Committee in its view that the group should be suspended at present.

Ms Sandilands highlighted that although this request was made in respect of the work focussed in the specific areas as outlined, the actions put in place would continue. However, there was a perceived need to pause and take a wider view of culture across the organisation in light of the Sturrock report, and place this focus in a new arena.

The Board discussed this and took the view that this would be the right way forward provided that this was a pause, and that a continued deterioration in attendance data would prompt the group to be reinstated. The update to the Board should also continue to allow oversight at Board level.

The Board:

1. Supported the view of the Staff Governance Committee to pause the AMITG
2. Requested that updates should continue to be presented to every Board meeting**.**

15 HEALTH AND CARE STAFFING BILL – UPDATE

A paper was received from the Director of Nursing and AHPs, which provided an updated overview of the overall requirements of this legislation, the role of the Board, and the specific actions that need to be progressed to ensure readiness for enactment of the legislation.

Mr Richards provided a summary of the five headline areas including use of workload tools, common staffing method and roster management, robust analysis of reporting and workforce information as well as risk mitigation in this respect. He also outlined work progressed in training and education for staff and representation at local and national forums on the part of TSH. He also asked the Board to note that internal auditors would review the organisation's preparedness as part of the internal audit plan during January 2020. Guidance from Scottish Government was expected at the end of 2019 with enactment expected from 1 April 2020. Finally, the Chief Nursing Officer Office would be visiting the Board on the day of the next Board Meeting to provide an update.

Mr Jenkins added that TSH had requested to be a pilot site, and that confirmation of this was awaited.

The Board:

1. Noted the content of this report.

16 WORKFORCE PLAN

A paper was received from the Interim Director of Human Resources, which confirmed that TSH had anticipated that a new workforce plan would be produced by September 2019. However, time delays in the review of the clinical model within TSH, as well as the delivery of the common staffing method nationally meant that the workforce plan would be made available at the next meeting of the Board in December 2019.

The Board:

1. Noted the content of this report.

17 STAFF GOVERNANCE COMMITTEE

The Board noted the draft minutes of last meeting of the committee, which had taken place on 29 August 2019. Mr Brackenridge provided an overview of the key points discussed at the meeting which had included attendance management and statutory and mandatory training; as well as initiating the workstream around TSH response to Sturrock.

The Board:

1. Noted the content of the draft minutes of Staff Governance Committee on 29 August 2019.

18 INTERNAL AUDIT PROVISION

A report was received from the Finance and Performance Management Director, which asked the Board to note that the current appointment of RSM UK Ltd as internal auditors would expire in March 2020. This appointment had been made on the basis of the possibility of two further one year extensions on a one plus one basis. It was recommended that an extension period of year was offered to RSM UK Ltd to take their period of service provision to 31 March 2021.

Mr McConnell, as Chair of the Audit committee advised the Board that this proposal had been discussed in detail by the Audit Committee, who recommended this proposal to the Board.

The Board:

1. Approved the proposal to extend the appointment of RSMUK Ltd for a period of one year until 31 March 2021.

19 FINANCE REPORT AS AT 31 JULY 2019

The Finance Report to 30 September 2019 was submitted to the Board by the Director of Finance and Performance Management, and Members were asked to note the content of this report. Mr McNaught led Members through the report highlighting the key areas of focus notably that the Board was reporting an overall underspend position of £0.165m.

Mr McNaught noted that the Annual Operational Plan set out a balanced budget for 2019/20 based on achieving £2.103m efficiency savings which were set out in this paper, and that the main

challenge continued to be the gap in identified savings.

There was discussion on the pressure to identify recurring savings in particular, and in the way recurring and non-recurring savings were defined across NHSScotland. The need to reduce non-recurring savings as a proportion of identified savings was noted. Mr Jenkins also emphasised the importance of efficiency modelling and the need to performance manage on the basis of budget control across the organisation as a focussed way forward.

The Board noted that a request had been made to refresh the presentation of information in the report, and it was agreed that this would be delivered at the next meeting of the Board in December 2019.

Action – Mr McNaught

The Board:

1. Noted the content of thus report, and the ongoing work on efficiency savings.
2. Requested that a re-fresh in presentation of the report for the next Board Meeting.

20 CORPORATE GOVERNANCE IMPROVEMENT PLAN

A paper was received from the Chief Executive, which outlined progress made in relation to the Corporate Governance Improvement Action Plan since the date of the last Board Meeting.

Ms Smith provided Members with a summary of progress to date, highlighting the work on robust process changes within the Finance Department to measure variance as well as continuing development in risk management. She also highlighted the work taken forward in influencing culture and values and behaviours in the organisation by linking this work with the Board's response to the Sturrock report. Ms Smith advised Board members that benchmarking across NHSScotland indicated this as a common approach.

Mr Currie asked for further clarification on work being progressed on rostering and Mr Richards confirmed that this was being progressed in conjunction with the safe staffing work stream, with TSH having requested being a pilot for the implementation of workforce tools.

Mr Currie also asked if the December Board was to be held at an external location. Following discussion, it was decided that Mr Currie and MS Smith should consider the feasibility of holding the meeting outwith The State Hospital

The Board:

1. Noted the content of this report

21 AUDIT COMMITTEE

Mr McConnell outlined the key business undertaken at the meeting of the Audit committee on 10 October highlighting the detailed discussion on the proposed re-appointment of internal auditors, as well as an updated internal audit report into management of sickness absence which provided reasonable assurance. He also highlighted that concern had been raised within the Committee at the number of policies that were out of date and how to expedite the review and approval process. The formal minute would be available at the next Board meeting in December 2019.

Mr Currie highlighted the achievement of the Human Resources Department under Ms Sandilands' leadership in the significant improvement made.

The Board:

1. Noted this verbal update form the Chair of the Audit committee.

22 ANNUAL SCHEDULE OF BOARD AND SUB BOARD MEETINGS -2020

A paper was received on behalf of the Board Chair to propose a meeting schedule for the Board and its standing committees throughout 2020.

Ms Smith confirmed the changes made since the date of the last Board Meeting and which were approved.

The Board:

1. Noted and approved the meeting schedule.

23 ANY OTHER BUSINESS

Ms Merson asked Board Members to note that the quality improvement initiative at The State Hospital, TSH3030, would commence in November. Planning was underway and there was increased participation across the hospital from staff and from patients.

An award ceremony was planned for December. Ms Merson was planning for this to include patients as well as staff and advised that details would follow. Board Members were warmly welcomed to attend.

Board Members also asked for an update on the appointment of Whistleblowing Champions through the Public Appointments Office, and Ms Smith confirmed that recruitment was underway with the expectation was that appointment would be in place for January 2020.

The Board:

1. Noted the update on TSH3030
2. Noted the update on the appointment of a Whistleblowing Champion.

24 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 19 December 2019, with the venue to be confirmed.

25 EXCLUSION OF PUBLIC AND PRESS

Members approved a motion to exclude the public and press during consideration of the items listed at Part II of the agenda in view of the confidential nature of the business to be transacted.

ADOPTED BY THE BOARD

CHAIR _____
(Signed Mr Terry Currie)

DATE 24 October 2019

MINUTE ACTION POINTS
THE STATE HOSPITALS BOARD FOR SCOTLAND
(From October 2019)

ACTION NO	AGENDA ITEM NO	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	5	Chair's Report	Circulate Audit Scotland Report to Non-Executive Directors	Margaret Smith	December 19	**Completed**
2	11	Patient Safety, Infection Control and Patient Flow Report	Include patient flow table to demonstrate month changes in patient numbers.	Mark Richards	December 19	**Completed**
3	19	Finance Report to 30 September 2019	Review the format of report and presentation of data.	Robin McNaught	December 19	**Completed**
4	20	Corporate Governance	Confirm venue of December Board	Margaret Smith	December 19	**Completed**

Board Paper 19/92

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2019
Agenda Reference:	Item No. 8
Sponsoring Director:	Chief Executive /Medical Director
Author:	Chief Executive
Title of Report:	Transition plan for implementation to the new Clinical Service Delivery Model
Purpose of Report:	For Decision

1. SITUATION

The Board has received regular progress reports on the status of the Clinical Care Model process.

The Board endorsed the preferred option for the new Clinical Care Model at its meeting on 24 October 2019. This model outlined a 10 ward model with eight major mental illness wards and two intellectual disability wards. The Board agreed to a quarterly review process to review effectiveness and challenges of operating the new model review.

2. BACKGROUND

It was agreed at the October Board meeting that a detailed planning and implementation process would be developed for review and discussion. This paper outlines the process.

3. ASSESSMENT

This paper provides an overview of the proposed implementation process including:

- Establishment of a Clinical Model Oversight Board
- Establishment of six work stream to plan for the transition
- Commitment to continue to engage with the Clinical Forum, Partnership Forum, staff, patients and stakeholder in development of the plan for transition
- Commitment to establish a quarterly review process

4. RECOMMENDATION

The Board is asked to:

- endorse the detailed planning and implementation process allowing The State Hospital to transition into a ten ward model based on eight MMI wards and two ID wards
- note the deliverables identified in the work stream plans

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support implementation of the clinical model
Workforce Implications	As considered and detailed within report
Financial Implications	As considered and detailed within report
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested
Risk Assessment (Outline any significant risks and associated mitigation)	As detailed within report
Assessment of Impact on Stakeholder Experience	As detailed within report
Equality Impact Assessment	To be reviewed as part of process
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None identified to date
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One 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

Leading Change -The State Hospital Clinical Model Implementation

Background

The need to review the Clinical Model arose from issues raised through a staff engagement exercise focussed on readiness for change. In that exercise, issues of safety were spontaneously raised in several responses. In response to the issues raised, The State Hospital Board endorsed the need to progress with a review of the current Clinical Model in June 2018

The Review Process was divided into three key elements:

i. Review of the Clinical Model Principles

ii. Review of Safety Data

iii. Review of the Clinical Service Delivery Model

Reviews of the Clinical Model Principles and the Safety Data were carried out in 2018. The Safety Data review added weight to the need to review the clinical model. An engagement and options appraisal exercise was then carried out in 2019 to determine a range for options to consider as a new model and the benefits that movement to a new model would realise. In October 2019, The State Hospital Board approved a move to the model below in table 1. This paper sets out the plan for implementation to transition into this model.

Table 1 – New Clinical Model for The State Hospital

Sample Model	Ward 1	Ward 2	Ward 3
Hub 1	Admission and Assessment	Treatment and Recovery	Treatment and Recovery
Hub 2	Admission and Assessment	Treatment and Recovery	Treatment and Recovery
Hub 3	Intellectual Disability	Intellectual Disability	
Hub 4	Transition	Transition	

Introduction

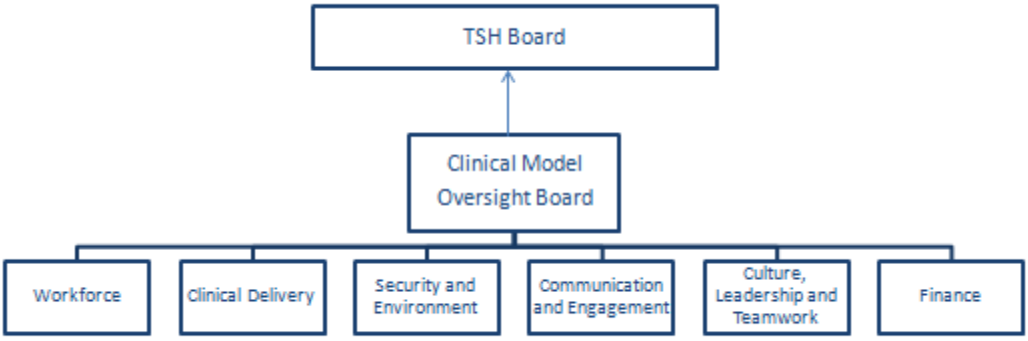
The transition to a new clinical model is complex involving multiple stakeholders and will result in changes in practice for clinical staff and placement of patients' in the hospital Hub environment. It will have executive leadership and multiple interdependent work streams delivering a range of diverse 'products'. There is an opportunity to use quality improvement approaches in the development of some aspects of work. Co design and co production will also be important aspects of developing the programmes of work required to successfully transition to the new model to support delivery of high quality care, organisational effectiveness and an open transparent culture

To support the process of change the change model below developed by NHS England provides a useful organising framework for sustainable change and transformation that delivers real benefits for patients and the public. It was created to support health and care to adopt a shared approach to leading change and transformation.

Our shared purpose – to deliver high quality, safe, effective care and treatment and transition all State Hospital Patients and Staff to the new Clinical Model from April – June 2020

Leadership and governance

The structure to support the delivery of the transition will require Executive Leadership, Gary Jenkins, Chief Executive and Professor Lindsay Thomson, Medical Director will provide joint leadership. A Clinical Model Oversight Board will be established with a role to provide strategic leadership, guidance and receive reports on the delivery of the project. Project Work Streams will also be established to take forward distinct areas of work. They will be represented on the Clinical Model Oversight Board by the Director Lead. Each work stream will have a Project Team which will be responsible for managing and reporting on the individual work streams, managing the risks and issues, milestones and timelines.



Reporting and accountability

The chart above provides an overview of the reporting and accountability structure. Reporting will be through the Clinical Model Oversight Board to the State Hospital Board. The Clinical Model Oversight Board will include representation from the Clinical Forum and Partnership Forum. Consideration will also be given to how to enable the voice of patients and carers in discussions, possibly through linking into PPG regularly as well as other routes of engagement. The Clinical Model Oversight Board will enable identification of any associations, themes or dependencies that sit across the work streams and will advise on any sequencing of activities to support preparation for transition

The work stream leads will be responsible for the quality and progress of their work stream, with overall accountability to the Executive Leads (Gary Jenkins and Lindsay Thomson). Work stream leads will be responsible for the delivery of their work stream and identification of risks, issues and interdependencies. A reporting template will be available for the project work stream groups to update the Clinical Model Oversight Board on progress and challenges.

The Clinical Model Oversight Board will meet every 4 weeks in the planning and implementation phase, this will be reviewed following implementation. When the project has reached a stage where staff and patients are transitioning to the new model a logistics group will be created to oversee the moves and ensure that moves are carried out safely, in accordance with agreed protocols and staff are supported. Any key learning from each move will be used to inform future work.

Each work stream will have input from relevant staff from across the organisation with appropriate skill, expertise and professional knowledge.

Work streams for Implementation

The following work streams will be established to leads the various aspects of implementation.

a) Workforce

Lead: Mark Richards Director of Nursing and AHP, Kay Sandilands Director of Workforce

Aims:

- Delivery of a clear strategic approach to workforce planning and development that is aligned with the delivery of the revised clinical service delivery model.
- Develop and oversee the organisational change required to align staff to the revised model
- Ensure that risk is minimised and the safety of staff and patients is maintained during transition process
- Ensure the hospital has the right staff, in the right place, at the right time, with the right skills.

Objectives:

- Sustainable, affordable, workforce plans are developed across all clinical and non-clinical functions affected by clinical model redesign.
- Our workforce that has knowledge and skills to deliver safe and effective care across all clinical service areas.
- Staff are identified and aligned to revised ward and service functions through an agreed process which will focus on minimising disruption.
- That legislative requirements are met as they relate to safe staffing legislation, and specifically the use of the Common Staffing Method.
- Work is underpinned by a strong commitment to partnership working and engagement at all levels of the organisation.

1. Why? (What is the problem or value proposition addressed by the project? Why is it being sponsored?)

- The clinical service delivery model is being refreshed, with a sharper definition of service functions. The service will be delivered within a 10 ward model, with a key change being that we have an ambition to deliver this as an 8 x mental illness ward and 2 x intellectual disability ward model.
- Safe staffing legislation will be enacted in the near future. This will be for nursing in the first instance, but covering all clinical disciplines in due course. All disciplines and functions, however, require to have an up to date workforce plan that reflects the changed shape of the clinical service delivery model.
- Use of the Common Staffing Method will be a legislative requirement.
- We need to ensure we can consistently achieve the delivery of right staff in the right place at the right time, and in doing so, help ensure safe, effective and person centred care.
- We need to consider different/new clinical roles and models of staff deployment to best ensure we meet the needs of our patients.
- The training and development of staff is important when they are being asked to work in more defined service functions. For example, we need to grow our Intellectual Disability workforce, largely within nursing.
- Our service needs to be affordable and sustainable across all departments and functions. As such, our workforce planning and development activity needs to extend across all

departments affected by the change to the clinical service delivery model, for example, housekeeping.
- The State Hospital needs to positon itself as an exemplar employer, and through this, best ensure retention of existing staff and recruitment of new staff.

2. What? (What is the work that will be performed on the project? What are the major deliverables?)

- Workforce plans will be developed for all clinical services and non-clinical services that are directly affected by the changes to the Model. These will be costed and will be affordable within 2020/21 cost base.
- For nursing, the Common Staffing Method will be used to identify safe staffing levels from an evidence based perspective.
- New roles that are focused on 9-5 working will be described, the jobs evaluated, and they will be recruited to.
- A training and development plan will be developed. Partner with local HEI to undertake a training needs analysis, and to design and deliver a training and development programme. This will be focused on ID services in the first instance, and targeted primarily at nursing staff.
- Staff will be aligned to revised ward and service functions, following a process agreed in partnership to manage this transition.
- Through the personal development planning process, staff will be encouraged to identify areas for development, linked to revised service delivery functions.
- A refreshed workforce strategy will be produced.

3. Who? (Who will be involved and what will be their responsibilities within the project? How will they be organised?)

Key departments/stake-holders who will be involved in this process are:

- Partnership
- Nursing
- Security
- Medical
- Estates and Facilities
- Administration
- Psychological Therapy Services
- Allied Health Professions
- Skye Centre
- Human Resources
- Learning & Development
- Nursing Practice Development.

4. When? (What is the project timeline and when will particularly meaningful points, referred to as milestones, be complete?)

- A refreshed workforce strategy will be produced. **December 2020.**
- Workforce plans will be developed for all clinical services and non-clinical services that are directly affected by the changes to the Model. These will be costed and will be affordable within 2020/21 cost base. **January 2020.**
- New roles that are focused on 9-5 working will be described, the jobs evaluated, and they will be recruited to. **March 2020.**
- A training and development plan will be developed. Partner with local HEI to undertake a training needs analysis, and to design and deliver a training and development programme. This will be focused on ID services in the first instance, and targeted primarily at nursing staff. **January to March 2020.**
- Staff will be aligned to revised ward and service functions, following a process agreed in partnership to manage this transition. **March 2020.**
- Through the personal development planning process, staff will be encouraged to identify areas for development, linked to revised service delivery functions. **During 2020.**
- For nursing, the Common Staffing Method will be used to identify safe staffing levels from an evidence based perspective. **Ongoing.**

b) Clinical Delivery

Lead: Lindsay Thomson, Medical Director and Mark Richards, Director of Nursing and AHP

Aims:

- To develop clinical policies and guidance for admission and assessment wards
- To develop clinical policies and guidance for treatment and recovery wards
- To develop clinical policies and guidance for transition wards, including addressing the issues of graded security and joint working with Skye Centre
- To develop clinical policies and guidance for intellectual disability service
- To develop working methods across hubs in clinical teams to transitions
- To establish clear bed management processes
- To create governance arrangements to check clinical model fidelity

Objective:

To create a sustainably improved:
- Clinical service
- Tailored security
- Increased opportunity for activity

1. Why? (What is the problem or value proposition addressed by the project? Why is it being sponsored?)

- The readiness for change review carried out in April to May 2018 uncovered staff concerns with safety. A subsequent full TSH staff and patient safety report was carried out and this highlighted information relevant to the clinical model.

- The principles of the 2009 clinical model were consulted upon and updated.

- The current review of the clinical model looks at delivery of clinical care.

- The full options appraisal process and subsequent sensitivity analysis have resulted in a preferred model that now requires to be implemented. From a clinical perspective it is essential that the policies and guidance for the different wards are delineated in advance of implementation.

- It is recognised that for the mental illness wards, the proposed model is a tight fit to allow the opening of a second intellectual disability ward. This will remain under regular review.

2. What? (What is the work that will be performed on the project? What are the major products and deliverables?)

- Four working groups should be established with clear terms of reference to deliver on the policies and guidance for the 4 types of wards, including liaison between the transition wards and the Skye Centre.

- An overall group should ensure that the policies and guidance fit together as a whole. This group should address the issues of working across a hub to the transitions hub, bed management and governance.

- The first draft of policies and guidance should be completed by 31 January 2020 to allow time for consultation and implementation.

- The implementation of the clinical model needs decided on by Clinical Model Oversight Board. This could be done incrementally or as a whole.

- Measures by which the success of the clinical model in terms of clinical care should be chosen and monitored.

3. Who? (Who will be involved and what will be their responsibilities within the project? How will they be organised?)

The project workstream will be chaired by Lindsay Thomson, Medical Director. The workstream will report to the project steering group and project team. Project workstream support will be provided by Monica Merson, Head of Performance and Business Support.

a) The key stakeholders
The stakeholders for each guidance and policy group will be made up of multidisciplinary team members

- Medical
- Nursing
- Allied Health Professionals
- Clinical Psychology
- Social Work
- Security
- Administration
- Clinical Effectiveness

b) The key stakeholders that will be involved in leadership aspect will be represented from

- Clinical Forum
- Senior Management Team
- Senior Charge Nurse Cohort
- Heads of Department
- Medical Advisory Committee

4. When? (What is the project timeline and when will particularly meaningful points, referred to as milestones, be complete?)

- First draft policies and guidance for each type of ward 31 January 2020
- Consultation – proposed 3 week period
- Amendment of policies – 1 week
- Senior Management Team – March 2020

c) Security and Environment

Lead: David Walker, Director of Security

Aims:

- Create a safe and secure working environment for staff, patients and visitors
- Identify and prioritise work streams to support the transition towards implementation of the new model within set timescales**.**

Objective:

- Ensure the environmental adaptations support the safety and security of TSH and comply with legal requirements.

1) Why

(What is the problem or value proposition addressed by the project? Why is it being sponsored?)

To support the clinical model, the Security Directorate in partnership will identify the necessary changes required to adapt or amend the physical estate.

2) What

(What is the work that will be performed on the project? What are the major products and deliverables?)

a) Define geographical layout of the site that maximises the 'safe' element of the model.
b) Establish working group to assess requirements of each clinical model component.

3) Who?

(Who will be involved and what will be their responsibilities within the project? How will they be organised?)

This aspect of the project chaired by David Walker, Director of Security. The work stream will report into the Clinical Model Oversight Group. Project work stream support will be provided by Heads of department.

The key stakeholders that will be involved will be representatives from:

- Clinical Teams
- Security
- Estates and Facilities
- Partnership
- Other as required

4) When?

(What is the project timeline and when will particularly meaningful points, referred to as milestones, be complete?)

Anticipated that early identification of the geographical layout of the hospital will require a 10-12 week lead in time for physical adaptations.

Any changes to procedural and relational security practices requires an impact assessment for each hub that outlines the proposed changes.

d) Communications and Engagement

Lead: Monica Merson, Head of Corporate Planning

Aims: To ensure effective communication and engagement regarding the transition to the clinical model with:

- Patients
- Staff
- Stakeholders

Objectives:

A communications and engagement plan will be developed to

- ensure all stakeholders including patients, carers, staff and external interested parties are kept informed of planning for change
- ensure that where appropriate, stakeholders are engaged in shaping changes.
- ensure that scope, timescale and milestones are communicated appropriately
- ensure consistency of message and transparency of development
- inform the development of an EQIA for the implementation process

1. Why? (What is the problem or value proposition addressed by the project? Why is it being sponsored?)

Communication and engagement with patients, carers and stakeholder is essential to successfully embed change. The State Hospital as an NHS Board, is required by legislation to involve people in designing, developing and delivering the health care services they provide for them. The Patient Rights (Scotland) Act 2011 has a set of principles for healthcare provision covering patient focus, quality care and treatment, patient participation, and communication. Staff, Stakeholder and Patient engagement has been a central aspect of the review of the clinical model and will be essential as we move towards planning for implementation and be part of the regular review following implementation.

2. What? (What is the work that will be performed on the project? What are the major products and deliverables?)

1. Stakeholder analysis

2. Communications and Engagement plans for the following groups
- Patients
- Staff
- Stakeholders

3. EQIA

3. Who? (Who will be involved and what will be their responsibilities within the project? How will they be organised?)

- The key stakeholders for the project are

- Staff
- Patients
- Carers
- Volunteers
- Mental Welfare Commission
- Scottish Government
- SHC

- The Person Centred Improvement Steering Group and the PPG will also be a key reference groups for this work
- The group will report into the Clinical Model Oversight Board
- The PPG will also be an important reference group

4. When? (What is the project timeline and when will particularly meaningful points, referred to as milestones, be complete?)

The Communications and Engagement work strand will run throughout the length of the project from planning through to review phase – initial assessment is that this group will run for 12 months and be reviewed in Dec 2020. Meeting will take place every 2 – 3 week for the first 3 months then fall back to 6 weekly following implementation

Feedback from implementation will be gathered to inform ongoing development of approach to ensure learning from implementing is built into process

Key milestones and time scales for the initial planning for implementation phase are detailed below:

Milestone	**Target completion date**
Stakeholder analysis	27th January 2020
Patient Communication and Engagement Plan	10th February 2020
Staff Communication and Engagement Plan	10th February 2020
Stakeholder Communication and Engagement Plan	10th February 2020
EQIA	27th February 2020

e) Finance

Lead: Robin McNaught

Aims:

- Review the team structures of, and support provided by finance, procurement, risk/CE and eHealth **a**ligned to the model implementation.
- Review any organisational change required if there is any realignment of directorate services to the revised model.

Objective:

- Consideration of directorate operational requirements which are identified at all stages from the working groups engaged in the development of the new model

1) Why *(What is the problem or value proposition addressed by the project? Why is it being sponsored?)*

- Ensure early representation from finance, procurement, Risk Team, Clinical Effectiveness and e-Health, also referring to Information Governance at all stages of the evolution of the new model – especially through prompt communication and engagement.

- Ensure any input required from, and impact on these departments is gauged in the initial stages to provide timescales of any required actions to be aligned to the overall project timescale.

2) What *(What is the work that will be performed on the project? What are the major products and deliverables?)*

- Leads of all departments within the directorate require to be engaged with the first phase of the project planning, then to gauge what level of input will be appropriate, if required, for the full implementation.

3) Who? *(Who will be involved and what will be their responsibilities within the project? How will they be organised?)*

Departmental leads, reporting to Finance and Performance Management Director.

The key stakeholders that will be involved in the cultures, values and behaviours aspect have been identified as representatives from the undernoted, which highlights the essential involvement of the directorate:
The key stakeholders are the undernoted:

- Finance
- Risk
- Clinical Effectiveness
- Procurement
- eHealth

4) When? *(What is the project timeline and when will particularly meaningful points, referred to as milestones, be complete?)*

Engagement in all initial project meetings – thereafter dependent on any issues / impacts identified.

f) Values, Cultures, Behaviours and Leadership.

Lead: Gary Jenkins, Chief Executive / Monica Merson, Head of Corporate Planning

Aims:

- Refresh the hospital wide leadership model and management structure
- Create a consistency of values, behaviours and culture embedded with the model implementation
- Team fidelity to the Clinical Model and the values of The State Hospital

Objective:

Create a sustainably improved:

- Culture
- Level of staff engagement, morale and sense of value
- Team approach and fidelity to the values of the organisation
- Sense of worth and empowerment for all staff across The State Hospital
- Leadership model for The State Hospital

1) Why *(What is the problem or value proposition addressed by the project? Why is it being sponsored?)*

The Sturrock Review (The Review) has been a focus for all NHS Board in relation to organisational cultures, behaviours and values. Scoping work, undertaken in autumn 2019, assessed which aspects from The Review were pertinent and giving the workforce at The State Hospital the greatest cause for concern and workplace dissatisfaction.

The consultative stages of the Clinical Model process identified a number of challenges from staff who were dissatisfied with aspects of the organisation; these factors were unrelated to the direct delivery of clinical care. The behavioural and cultural themes were disassociated from the Care Model structure with agreement that the issues would be addressed through an alternative process.

The outcome of the previous two years staff survey results were analysed to assess if recurrent features were being identified and remained unaddressed through the conventional action plan return.

The outcome of the three processes cited above were collated; the following themes were identified for improvement:

- Communication and Engagement
- Leadership and Management
- Human Resources
- Cultures and Behaviours
- Staff Support
- Governance

30 sub-themes were identified in each of the headings noted above (Appendix x)

The 30 identified sub-themes are likely to affect different staff groups in different ways. The method of review and potential resolution is likely to be multi factorial depending of the individual or staff group perception of value, empowerment and sense of organisational engagement.

A number of organisations have studied different way to sustainably improve culture, values, behaviour and leadership. Wrightington, Wigan & Leigh Foundation Trust (WWL) have published a paper following a successful process that took them from the bottom 20% of NHS Trusts to the top 10% in the National Staff Survey 2014 and 2015.

WWL used a technology based approach (the Go Engage) survey tool to measure the nuances of staff satisfaction across the multi-disciplinary layers of their organisation. This enabled tailored and target support to support cohorts of employees where satisfaction and morale were problematic. A set of exploratory questions were sent to staff on a quarterly basis; this enabled measurements of success and challenge to be analysed recurrently and support targeted development measures where and when issues arouse. Particular areas of focus included:

i. Working relationships – did staff feel supported?
ii. Recognition – did staff feel valued?
iii. Resources – did staff have the resources they needed to work effectively in their roles?
iv. Clarity – did staff understand what was going on in their role / team / organisation?
v. Perceived fairness – did staff feel processes and treatment was fair?
vi. Personal Development – did staff have development opportunities?
vii. Influence – did staff feel involved in change and decisions affecting them?
viii. Mindset – did staff feel confident in their jobs and optimistic about the future?
ix. Trust – are staff empowered to do their job?

2) What *(What is the work that will be performed on the project? What are the major products and deliverables?)*

a) Further scoping work will be undertaken to assess how cultural, values and behaviours based improvement can be achieved, delivered and sustained across the entire organisation.

b) A further review of the sub themes will be explored with the Senior Management Team. This will also be designed to assess the level of synergy and barriers to effective working within The State Hospital.

c) A Working Group will be established to take forward the cultures, behaviours and values work stream. This is a separate and distinct issues and will be disaggregated from the leadership aspects of this process.

d) A review of leadership developments needs will occur contemporaneously to assist the organisational management team in changing the dynamic and experience of staff working within The State Hospital.

e) A set of measures will be developed based on the 30 sub-themes and overlaid with the nine headings from the WWL approach noted above, and other models explored.

f) The implementation of the Clinical Model from April 2020 will have embedded principles that enable:

- staff satisfaction to be measured,
- escalation mechanisms for staff to highlight concerns or areas of good practice
- create space and time to allow team formation to be central to the workplace environment

3) Who? *(Who will be involved and what will be their responsibilities within the project? How will they be organised?)*

The project work stream will be chaired by the Chief Executive. The work stream will report into the Clinical Model Oversight Board. The project work stream support will be provided by Head of Corporate Planning and Business Support.

a) The key stakeholders that will be involved in the cultures, values and behaviours aspect will be representatives from (e.g.):

- Medical
- Nursing
- Security
- Estates and Facilities
- Partnership
- Administration
- Psychology
- AHPs
- Patient Focus and Public Involvement
- Human Resources
- Organisational Development
- Other

b) The key stakeholders that will be involved in the leadership aspect will be representatives from:

- The Senior Management Team
- The Senior Charge Nurse Cohort
- Heads of Department
- Organisational Development
- Human Resources
- Partnership

4) When? *(What is the project timeline and when will particularly meaningful points, referred to as milestones, be complete?)*

Following agreement in partnership for the placing of staff in any new staff groupings to support the re defined ward functions, team development to support and reinforce NHS cultures and values will be carried out. Themes emerging from staff engagement will also be used to inform future work towards creation of a supportive change culture within Hubs and wards

Resources

Wherever practical internal resources will be used to provide all leadership and management of this project. There may be a need to re prioritise some current work streams to enable a focus on the transition to the new model.

A Clinical Model Review Process will also be developed to monitor implementation. Terms of Reference for the Clinical Model Oversight Board and the Work Stream Groups will be developed to support project implementation, reporting and accountability.

It is likely that implementation will take place in a phased process to minimise disruption to patients and enable learning from each phase to inform the next. Contingency plans and risk assessment will take place prior to moves.

Project Plan

This will be developed a separate document to detail the key milestones and timelines associated with the project implementation.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2019
Agenda Reference:	Item No: 9
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:	For Decision

1 SITUATION

Following the successful recruitment of a Forensic Psychiatry Specialty Doctor, it is necessary for the Board to consider the approval of their Approved Medical Practitioner status.

2 BACKGROUND

In order for the newly appointed Forensic Psychiatry Specialty Doctor to perform her full role within the Hospital she requires to be approved as an Approved Medical Practitioner (AMP).

3 ASSESSMENT

The Forensic Psychiatry Specialty Doctor has 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 Vicki Gordon as Approved Medical Practitioner in line with the Mental Health (Care and Treatment) (Scotland) Act 2003 and that she is 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	As per report
Workforce Implications	Detailed in report
Financial Implications	No financial implications if approved
Route To Board Which groups were involved in contributing to the paper and recommendations.	Medical Director
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None Identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One There are no privacy implications. X There are privacy implications, but full DPIA not needed There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2019
Agenda Reference:	Item: 10
Sponsoring Director:	Director of Nursing and AHPs
Author(s):	Risk Mangement Team Leader/ Senior Nurse for Infection Control/ Health Records Manager
Title of Report:	Patient Safety, Infection Control and Patient Flow Report
Purpose of Report:	For Noting

1 BACKGROUND

This report is presented to the Board to provide an update in relation to patient safety, healthcare associated infection and patient flow.

2 PATIENT SAFETY UPDATE

The main focus since the last report has been around the development of the Observation Policy which is based on the Improving Observation in Practice guidance. This has required significant nursing input and will be launched for The State Hospital consultation in the very near future.

Other work continues around the '8' rights of Psychotropic PRN medication, leadership walkrounds (8 delivered during 2019), patient safety training as part of safeguarding day (28 November 2019) and links with the Physical Health Steering Group. A Patient Safety Group meeting was held on 3 December 2019 with the main focus being Draft 2 of the Observation Policy. The next meeting is proposed for February 2020.

3 HEALTHCARE ASSOCIATED INFECTION (HAI)

This is a summary of the Infection Control activity from 1st October 2019 – 30th November 2019 (unless otherwise stated).

Key Points:

- The submission of the hand hygiene audits continues to be a key priority which is monitored and reported both to the Board, Infection Control Committee and Senior Ward staff routinely. The Senior Nurse for Infection Control (SNIC) will contact individual Senior Charge Nurses to advise a non compliance.

- DATIX incidents continue to be monitored by the SNIC and Clinical Teams, with no trends or areas identified for concern with the exception of the Safe Management of Linen. Following

audits by the Risk Management Team Leader, SNIC and Housekeeping & Linen Services Manager during September improvements have been noted.

- The antimicrobial prescribing is minimal in comparison to other NHS Boards; however the prescribing that occurs within The State Hospital is being monitored by the antimicrobial pharmacist for compliance with NHS Lanarkshire Antimicrobial Prescribing Formulary. The Infection Control Committee review antimicrobial prescribing quarterly with no trends or areas identified for concern. The biennial audit will take place over the next few months to allow for adequate data to be examined.

- Seasonal Flu vaccinations clinics have been offered with promising uptake. A table top exercise to test the Pandemic Influenza Contingency Plan was conducted 5th December, learning from this exercise will be incorporated into the review of the plan and presented to the Infection Control Committee, Resilience Committee and Senior Management Team in the New Year.

Audit Activity:

Hand Hygiene
During this review period, there was a drop in the number of audits submitted. Investigation shows that those responsible for undertaking the audits were either on annual leave or night shift. This reinforces that the audit submissions remain person dependent. The Senior Charge Nurses have been made aware of this by the SNIC. Reminders from the Senior Nurse for Infection Control will continue.

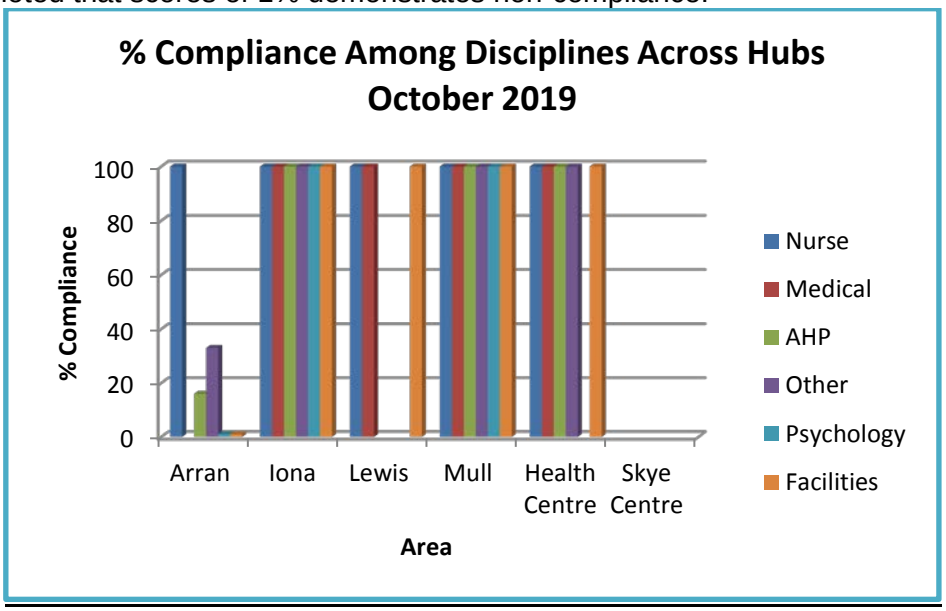
<u>October</u>
10 out of a possible 11 were submitted (Skye Centre omitted due to TSH30:30).

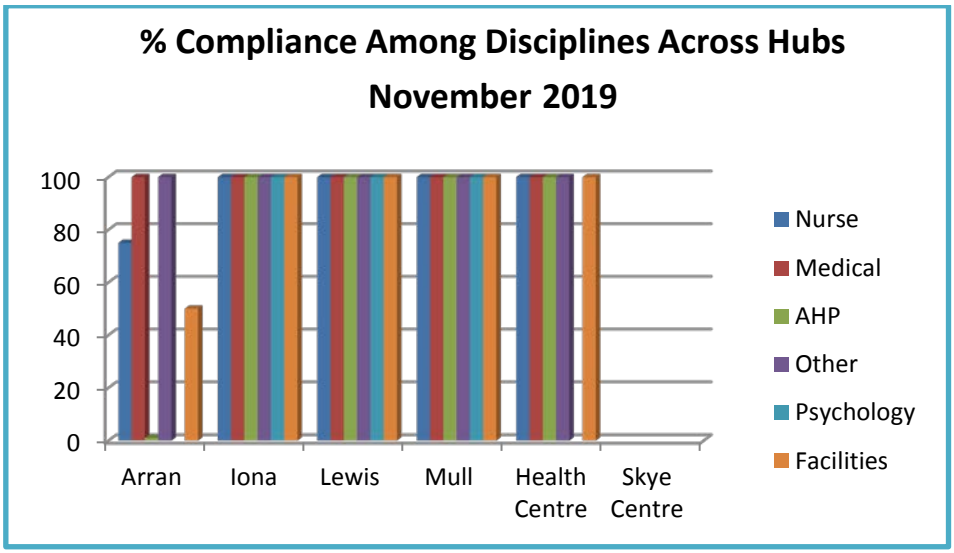
<u>September</u>
9 out of a possible 11 were submitted (Skye Centre omitted due to TSH30:30).

The overall hand hygiene compliance within the hubs varies between 65-100%. This is a decrease in one area and the Senior Nurse for Infection Control will liaise directly with the Senior Charge Nurses for this area.

The compliance within the Skye Centre continues to be of concern. Following agreement with the Senior Nurse for Infection Control no audits were submitted during this period. The rationale being, Palm to Palm (TSH30:30) initiative was underway during this period. Any improvements or suggestions for improvement will be reviewed by the Senior Nurse for Infection Control.

It should be noted that scores of 1% demonstrates non-compliance.





DATIX Incidents for Infection Control

There were a total of 7 incidents for the period under the Category of Infection Control;

- 5 of which relate to clinical waste (safe management of linen) which were investigated at ward level and process and policy reinforced to be monitored by SCN.
    - 4 incorrect segregation
    - 1 no label
- 1 Diarrhoea & Vomiting (all actions appropriate and in line with policy)
- 1 needlestick injury (all actions appropriate and in line with policy)

DATIX will continue to be completed until an improvement is noted. All Infection Control related DATIX incidents are investigated by the Senior Nursing Staff, Clinical Teams (as required) and reviewed by the SNIC to ascertain if there are learning outcomes identified. In addition, the Infection Control Committee is presented with this data quarterly.

Scotland's Infection Prevention and Control Education Pathway (SIPCEP) (previously Cleanliness Champions):

A breakdown by department of the 87 staff who had not completed the SIPCEP core modules at 30 September 2019 is provided below.

Department	No. of staff
AHP	3
Estates	8
Hub Admin	5
IT	3
Nursing	34
Occupational Health	3
Procurement	3
Security	5
Skye Centre	7
Social Work	5
Other departments (combined)	11
TOTAL	**87**

A breakdown by module of current completion numbers for the individual SIPCEP core module is provided for information below.

Core modules

1. Why Infection Prevention and Control Matters - 591 (88.6%) completions.
2. Breaking the Chain of Infection – 607 (91.5%) completions.
3. Hand Hygiene – 602 (90.1%) completions.
4. Respiratory and Cough Hygiene – 596 (89.4%) completions.

Other Modules (target groups are not all staff)

5. Safe disposal of waste (inc Sharps) – 383 (78.9%) completions.
6. PPE – 383 (81.1%) completions.
7. Prevention and Management of Occupational Exposure (inc Sharps) – 384 (79.2%) completions.
8. Blood and body fluid spillages – 393 (84.8%) completions.
9. Safe Management of Care Environment – 301 (75.6%) completions.
10. Safe Management of Care Equipment – 256 (72.9%) completion.
11. Safe Management of Linen – 308 (77.2%) completions.
12. Patient Placement/ Infection Risk – 259 (76.6%) completions.

The Learning & Development Team continue to report monthly to Line Managers staff who have yet to complete online modules.

Hepatitis C Treatment

Processes have been put in place to ensure that a delay in treatment does not occur in the future.

Policies and Guidance

All infection control policies and procedures are being reviewed as per policy schedule and there are no outstanding policies.

Flu vaccination Clinics

All staff received a letter advising them of the flu vaccination clinics and how they can make arrangements to receive their vaccine if they were unable to attend these clinics. The flu vaccinations for staff commenced on 28th October 2019. There were five clinics located in the Family Centre, facilitated by the Senior Nurse for Infection Control and Occupational Health Department. Three further clinics were held in Iona at 6.30am, one of which was held on a Sunday to enable night shift and weekend staff to received the vaccinations. The SNIC attended individual wards to provide staff the opportunity to receive the vaccine. In addition, the Occupational Health Nurse attended the Management Centre and Harris in order to increase uptake.

By way of promoting of the clinics the Healthy Working Lives Group donated a 'misfit' fitness tracker as a raffle prize for those who have received their vaccine, staff were offered tea/coffee, some home baking and small gift packs containing tissues, pens and post-its were made available. Early indications would suggest that there is an increase on last year's uptake. Further information will be provided in the next report.

Water Safety Group

Water safety continues to be an area of concern within NHS Scotland. Water Safety has been incorporated into the Infection Control Committee agenda and will be discussed at each meeting. On 5th December 2019 an extraordinary meeting was called to seek assurance that the hospital was responding appropriately to external recommendations. The Infection Control Committee are satisfied with all action taken.

Water Risk Assessments Update

The buildings of The State Hospital are used by a cross section of society with persons of varying ages, with the accompanying variance in health etc.

It must therefore be assumed that there is a potential for 'at risk' persons to use or be affected by the water services on site and therefore L8, HSG274 and SHTM04 compliance is required.

Within The State Hospital the two procedures used to control the water systems is temperature control and flushing. The hot water storage is monitored and kept above 55^{O}C and the cold water storage is monitored and kept below 20^{O}C. Both the hot and cold water systems prevent stagnation of the water via day to day usage, and where this not practical, a flushing regime is introduced.

Legionella Risk Assessments were carried out within all buildings in April 2018. These Risk Assessments raised a total of 338 recommendations across all buildings. The recommendations were further divided into categories, and the explanation of each category is provided below.

Category 1 **Urgent Significant Investigation & Urgent Remedial Action Required.** Carry out review of Control Procedures. Recommendations within this category should be carried out immediately / as soon as is reasonably practicable. Where appropriate remedial actions to rectify the faults cannot be taken immediately / as soon as is reasonably practicable alternative actions to reduce the risk should be carried out.

Within The State Hospital there were **no** Category 1 Recommendations

Category 2 **Significant Investigation & Remedial Action Required.** Carry out review of Control Procedures. Recommendations within this category should be carried out as soon as is reasonably practicable. Where appropriate remedial actions to rectify the faults cannot be carried out quickly practicable alternative actions to reduce the risk should be carried out.

Within The State Hospital there were **138** Category 2 Recommendations

Category 3 **Investigate / Reduce.** Remedial actions required. Recommendations within this category should be carried out in a timely manner. Additional monitoring / inspection to ensure the risk does not increase should be carried out until actions completed.

Within The State Hospital there were **111** Category 3 Recommendations

Category 4 **Maintain Level.** Managed by routine Planned Preventative Maintenance Procedures.

Within The State Hospital there were **89** Category 4 Recommendations

Below in table 1 is a breakdown of all recommendations by building and the number completed.

Table 1

Building	**Category 1**		**Category 2**		**Category 3**		**Category 4**	
	Comp	**To Do**	**Comp**	**To Do**	**Comp**	**To Do**	**Comp**	**To Do**
Arran Hub	N/A	N/A	10	0	3	0	0	6
Iona Hub	N/A	N/A	11	2	6	1	0	8
Lewis Hub	N/A	N/A	9	0	6	1	0	10
Mull Hub	N/A	N/A	4	0	11	0	1	1

Skye Centre	N/A	N/A	16	3	23	5	3	34
Family Centre	N/A	N/A	17	0	5	0	0	2
Harris	N/A	N/A	10	3	4	0	0	2
Management Centre	N/A	N/A	4	2	3	1	0	4
Islay	N/A	N/A	7	3	1	9	0	4
Essential Services	N/A	N/A	17	4	13	1	0	10
Reception	N/A	N/A	4	0	4	0	N/A	N/A
Occupational Health	N/A	N/A	7	5	6	8	0	4

In summary: Category 1 No Recommendations
Category 2 138 Recommendations – 116 Completed, 22 To be addressed
Category 3 111 Recommendations – 85 Completed, 26 To be addressed
Category 4 89 Recommendations – 4 Completed, 85 To be addressed

For all Category 2, 3 and 4 recommendations that have still to be addressed, the guidance within the Category explanations above are in place to keep the risks to a minimum.

The majority of Category 2 recommendations is in relation to the expansion vessels installed throughout the site.

The recommendation is to change these for a 'flow through' type of expansion vessel. The vessels we have installed have the potential to hold stagnant water. However, the replacement cost for one vessel to change to the 'flow through' type is approximately £2000 and we have over 20 on site. The cost for a like for like replacement is approximately £500. There are currently no problems with the vessels, so there is no requirement to change them. The Estates Department have a monthly PPM in place to flush the expansion vessels that alleviates the issue of stagnant water.

The Estates Department continue work through all recommendations and further updates will be issued to the Control of Infection Committee.

4 PATIENT ADMISSION / DISCHARGES

A detailed report on admissions and discharges is provided to the Clinical Governance Committee on a 6 monthly basis.

The following table outlines the high level position from 1 August 2019 to 30 September 2019.

	MMI	**LD**	**Total**
Bed Complement (as at 30/09/19)	126	14	140
Staffed Beds (ie those actually available) (as at 30/09/19)	108	12	120
Admissions (from 01/08/19 – 30/09/19)	3	0	3
Discharges / Transfers (from 01/08/19 – 30/09/19)	4	0	4
Average Bed Occupancy August - September 2019	-	-	101 84.2% of available beds 72.1% of all beds

The following table outlines the high level position from 1 October 2019 to 30 November 2019.

	MMI	**LD**	**Total**
Bed Complement (as at 30/11/19)	126	14	140
Staffed Beds (ie those actually available) (as at 30/11/19)	108	12	120
Admissions (from 01/10/19 – 30/11/19)	10	0	10
Discharges / Transfers (from 01/10/19 – 30/11/19)	3	0	3
Average Bed Occupancy October - November 2019	-	-	105 87.5% of available beds 75.0% of all beds

5 RECOMMENDATION

The Board is invited to note the content of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To provide the Board with specific updates on patient safety, infection control and patient admission and discharges as well as any other areas specified to be of interest to the Board.
Workforce Implications	As detailed within sections 2 and 3 of report.
Financial Implications	No financial implications identified.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Nursing and AHP Directorate/ Health Records – Board requested information.
Risk Assessment (Outline any significant risks and associated mitigation)	Not identified for this report.
Assessment of Impact on Stakeholder Experience	Not identified.
Equality Impact Assessment	Not formally assessed.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not identified as relevant.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ✓ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND **CF(M)19/03**

CLINICAL FORUM

Minutes of the meeting of the Clinical Forum held on Thursday 15 August 2019 which commenced at 10am in Harris Seminar Room, The State Hospital, Carstairs.

Chair: Dr Aileen Burnett	Consultant Clinical Psychologist
Present:	
Sandie Dickson	Person Centred Improvement Lead
David Hamilton	Social Work
Sarah Innes	Occupational Therapy
Carolin Walker	Professional Nurse Advisory
In attendance:	
Margaret Smith	Board Secretary
Apologies:	
Sheila Howitt	Consultant Psychiatrist
Lesley Murphy	ID Service
Sheila Smith	Clinical Effectiveness
Fiona Warrington	Pharmacist

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

The Forum Chair, Aileen Burnett, welcomed everyone to the meeting and apologies were noted.

NOTED

2. CONFLICT(S) OF INTEREST

There were no conflicts of interest declared.

NOTED

3 MINUTES OF PREVIOUS MEETING HELD ON 7 FEBRUARY 2019

The minutes of the meeting that took place on 9 May 2019 were approved.

NOTED

4 ACTION POINTS AND MATTERS ARISISING

The present positon was noted, and that a rolling action list would be put in place going forward.

NOTED

5 REVIEW OF THE CLINICAL MODEL

Members discussed the engagement of the Clinical Forum in this process, and the challenges this had presented. However, Members were of the view that this was a positive engagement and were keen to continue to contribute to the review process.

It was agreed around the table that work had progressed well and Members had met informally this month to continue to progress. The Forum Chair encouraged Members to continue to provide their input so that the Forum could be in a position to report to the workshop arranged for 21 August, which would centre on the benefits criteria. To do so, Aileen Burnett would share the most up to date version of the report with Members following this meeting and asking for their further input.

Members discussed the importance of ensuring wide engagement around the organisation at all level across the workforce. There was also concern raised on how realistic the review would be in terms of the possibility of change within the organisation, depending on the Board's overall financial position. It was noted that there was a general concern noted among staff that this process may not actually lead to change. The Forum noted the need for any proposed change to be pragmatic and realistic in terms of what would be possible. There was also some discussion around how any change to the clinical model within The State Hospital (TSH) would be viewed in the context of the national review of the forensic mental health estate.

The Forum also noted the invite for them to visit another high secure hospital e.g. Broadmoor, and it was agreed around the table that this was a helpful offer but that it may be more effective to take up this offer during the implementation stage of the process.

All Members were asked to provide any further feedback to Aileen Burnett by 20 August 2019.

Action – All Members

NOTED

6 TRIANGLE OF CARE UPDATE

Sandie Dickson provided an update to members, confirming that this would be reported to the Person Centred Improvement Group at their next meeting. She advised that good progress had been made over the past six months, but this was a very wide ranging piece of work and that it was important to take sufficient time to progress it effectively.

Carolin Walker noted the success of the visit from colleagues from Ashworth Hospital.

A full update would be brought to the next meeting of the Clinical Forum.

Action – Sandie Dickson

NOTED

7 TSH3030 2019

The Forum noted that the launch date for TSH3030 in 2019 would be 5 September.

Sandie Dickson noted that she would engage with patients to encourage their involvement, as they would not be attending the launch. Patients would be able to attend the awards ceremony at the conclusion of the initiative.

It was also noted that Quality Improvement training would be available to all staff during October, to help support the expansion of the available skill set among staff. Work was progressing well in coordination with Training and Development to promote a QI zone as part of eLearning at TSH

NOTED

8 PROMOTING THE CLINICAL FORUM

Margaret Smith provided a verbal update to members on the development of Clinical Forums within NHSScotland, and confirmed that governance advice and administrative support to the Forum would be provided by the Board Secretary and her team. She noted that given the particular nature of the care offered at TSH, the Clinical Forum at TSH may differ in function when compared to territorial NHS Boards. At the same time there were also similarities and she was arranging for links to be made for the Chair and Vice Chair of this Forum through the national Chairs Group for the national Area Clinical Forum Chairs Group.

The Forum discussed the way forward, and agreed that bi-monthly meetings mat be conducive to the effective review of business and agreed to the meetings taking place on the first Tuesday of the month (bi-monthly).

There was also discussion in relation to continuing to engage with the Chief Executive and the Chair, and it was agreed that they should be invited to attend meetings for a specific slot to provide an update from the Board. More widely, the Forum also discussed the benefit of inviting key Executive Leads to their meeting to discuss relevant items of business and provide updates directly to the Forum. It was agreed that this would be considered for the Forum going forward.

The Forum also discussed representation from the health centre and it was agreed to ask for a nomination from nursing colleagues in this regard.

The Forum also agreed that it would be helpful to benchmark their terms of reference to other NHS Boards, especially special boards. This should be added to the workplan.

It was agreed that Margaret Smith would take forward these actions on behalf of the Forum.

Actions – Margaret Smith

AGREED

9 UPDATES FROM EACH ADVISORY COMMITTEE ON SALIENTS POINTS/ APPROVED MINUTES TO NOTE.

The Forum noted the most recent minutes from the Nursing and Allied Health professional Advisory Committee (NAHPAC) held on 2 April and 18 June 2019, and Carolin Walker provided a summary of the main points of discussion.

Further updates from the advisory groups would be circulated.

NOTED

10 CLINICAL FORUM – FORWARD PLANNER

The forum discussed possible items to be added to the workplan including Board updates; TSH3030; Clinical Model; Triangle of Care; Sturrock Report; review of the Terms of Reference for the Forum. Margaret Smith would review and update the workplan based on this discussion.

Action – Margaret Smith

11 DATES OF MEETINGS

The revised schedule of meeting dates for 2020 was agreed. A further meeting of the Forum would be arranged for 2019.

AGREED

12 ANY OTHER BUSINESS

The Forum noted that the date of the next Annual Review for TSH had not yet been confirmed.

NOTED

13 DATE AND TIME OF NEXT MEETING

To be confirmed.

Board Paper 19/95

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2019
Agenda Reference:	Item No: 14
Sponsoring Director:	Interim Director of Human Resources
Author(s):	Interim Director of Human Resources
Title of Report:	The State Hospital Workforce Plan
Purpose of Report:	For noting

1 SITUATION

As part of the Clinical Model Implementation Plan, a Workforce Planning, Training and Development workstream will lead on the development of a workforce strategy to deliver the revised clinical model. This partnership group will develop the Board Workforce Plan, oversee any organisational change required to align staff to the revised model and ensure the hospital has the right staff, in the right place, at the right time, with the right skills. The group will endeavour to minimise risk and maximise safety of staff and patients during the transition.

Provisional timelines (Appendix I) have been set and these now indicate completion of a Workforce Plan in March 2020.

2 BACKGROUND

TSHs workforce plan 2017/2022 was produced in June 2017 in accordance with Scottish Government "Revised Workforce Planning Guidance", CEL 32 (Scottish Government, 2011).

The plan identified the anticipated internal and external drivers influencing the shape of TSH workforce over a 5 year time period and projected a reduction of 8 WTE staff by 2018; equating to 587.9 WTE.

The First Minister announced the Scottish Government's intention to enshrine safe staffing in law in 2016. In its Programme for Government 2017/18 it indicated its intent to deliver on the commitment starting with the nursing and midwifery workforce. These commitments led to the Health and Care (Staffing) (Scotland) Bill being produced to enable safe and high quality care by making the provision of appropriate staffing in health and care statutory, resulting in better outcomes for service users.

As a direct result of this action, TSH are obligated to run the Nursing and Midwifery Workload and Workforce Planning Tools as part of a 'Common Staffing Method' on an annual basis taking cognisance of the outcome and determining the best means to risk manage any identified shortfalls.

In October 2019, the Board endorsed a new Clinical Model and the Implementation Plan for this provides the framework for the Workforce Plan going forward.

3 ASSESSMENT

The Board Workforce Plan will be overseen by the Workforce Planning, Training and Development workstream as part of the Clinical Model Implementation process. The workstream group is being set up and has a proposed timeline to work to (Appendix I). The proposal is that the Workforce Plan will fully consider the revised Clinical Model and be developed in partnership.

In the meantime, work is ongoing on the application of the Common Staffing Method in nursing to ensure models are based on a safe staffing levels and all services have completed their initial workforce planning proposals for consideration by the workstream.

4 RECOMMENDATION

The Board is invited to note the content of this report.

Appendix I : Timeline for Workforce Planning, Training and Development Workstream

Action	**Date**
Workforce Strategy	Dec 2019
New development (e.g. 9-5 role)	March 2020
Training and Development Plan (including Training Needs Analysis)	Jan - March 2020
Staff Alignment	March 2020
Staff development through PDP	Ongoing through 2020
Common Staffing Method application	Ongoing
Workforce Plan – based on 2020/21 budget	March 2020

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Ensures projection of appropriate staff for future needs are aligned to Clinical Model
Workforce Implications	Ensures projection of appropriate staff for future needs
Financial Implications	Accurate workforce projections reduce demand on more costly staffing solutions e.g. overtime. Locums, etc
Route To Board Which groups were involved in contributing to the paper and recommendations.	N/A
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	None identified
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Board Paper 19/96

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2019
Agenda Reference:	Item No: 15
Sponsoring Director:	Interim HR Director
Author(s):	Interim HR Director
Title of Report:	Attendance Management Report
Purpose of Report:	For Noting

1 SITUATION

The State Hospital (TSH) sickness absence level in-month figure for September 2019 was 6.24%; with an average rolling 12 month figure of 6.53% for October 2018 to September 2019. The rolling 12 month figure is 2.41% lower than the October 17 to September 2018 figure (8.94%).

The Board should note the local target level is 5%.

2 BACKGROUND

Over the last 3 years, TSH monthly absence levels have frequently been between 8% and 10%. Consequently absence management and monitoring have been areas of particular focus.

Absence data reported is extracted from both the SWISS, the national source and SSTS local information system to provide this report.

3 ANALYSIS

The September 2019 sickness level of 6.24% is the lowest September figure recorded by TSH in the last 4 years. However, this does exceed the 5.0% target and the NHS Scotland level of 5.29% for the same period (Appendix IV).

Long/short term absence split is 4.28% and 1.96% respectively. These figures were recently recalibrated and therefore make comparison with historic data irrelevant. (Appendix II).

The in-month absence level equates to a loss of 5424.69 hrs /33.33 WTE.

The current average rolling 12 month sickness figure is 6.53% for the period 1 October 2018 to 30 September 2019. This represents a 2.41% lower figure than 2017/18 (8.94%). The current national target is to achieve a 0.5% reduction in sickness absence per annum over 3 years.

The main reasons for absence continue to be Anxiety/Stress/ Depression/Other Psychiatric Disorders (36%), Musculoskeletal (11%) and Fractures (9%) (Appendix I).

4 RECOMMENDATION

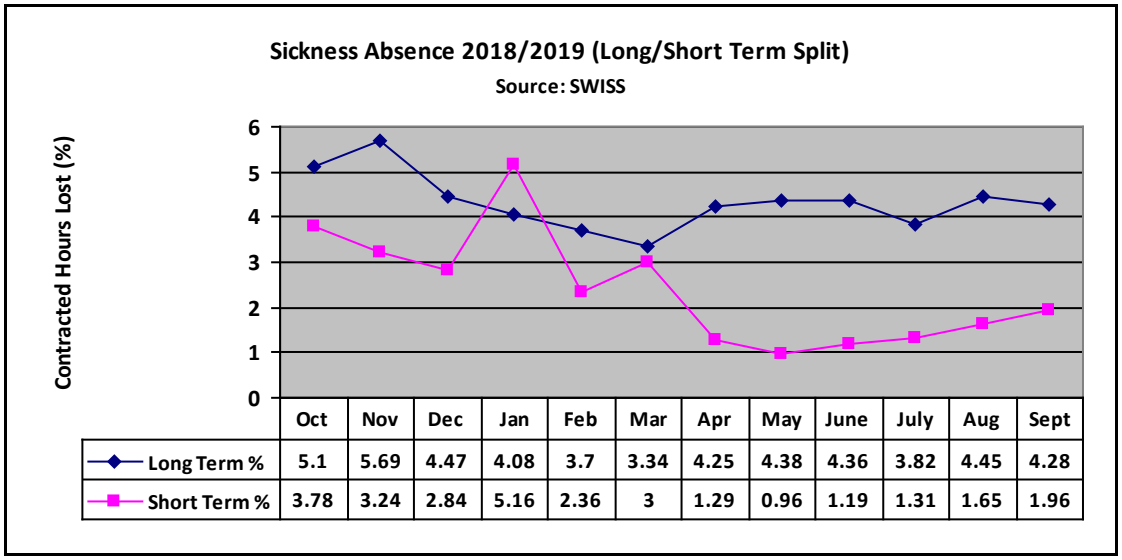
The Board is asked to **note** the content of the report.

Appendix I : Absence Reasons

Absence Reason Description	Short Term Sick %	Long Term Sick %	Total (SL+Il) Working Hours Lost	Total Sick Leave inc. Industrial Injury %
Anxiety/stress/depression/other psychiatric illnesses	8.48 %	46.74 %	33038.79	36.31 %
Other musculoskeletal problems	7.19 %	7.15 %	9795.21	10.76 %
Injury, fracture	4.55 %	8.10 %	7752.77	8.52 %
Gastro-intestinal problems	21.69 %	5.64 %	7687.01	8.45 %
Heart, cardiac & circulatory problems	1.98 %	6.74 %	4821.43	5.30 %
Cold, cough, flu - influenza	18.32 %	1.72 %	4477.62	4.92 %
Other known causes - not otherwise classified	4.30 %	4.66 %	4077.29	4.48 %
Back problems	7.84 %	3.22 %	3983.63	4.38 %
Genitourinary & gynecological disorders - exclude pregnancy related disorders	1.78 %	3.33 %	2529.24	2.78 %

Details all absences amounting to greater than 2%. Source: SSTS

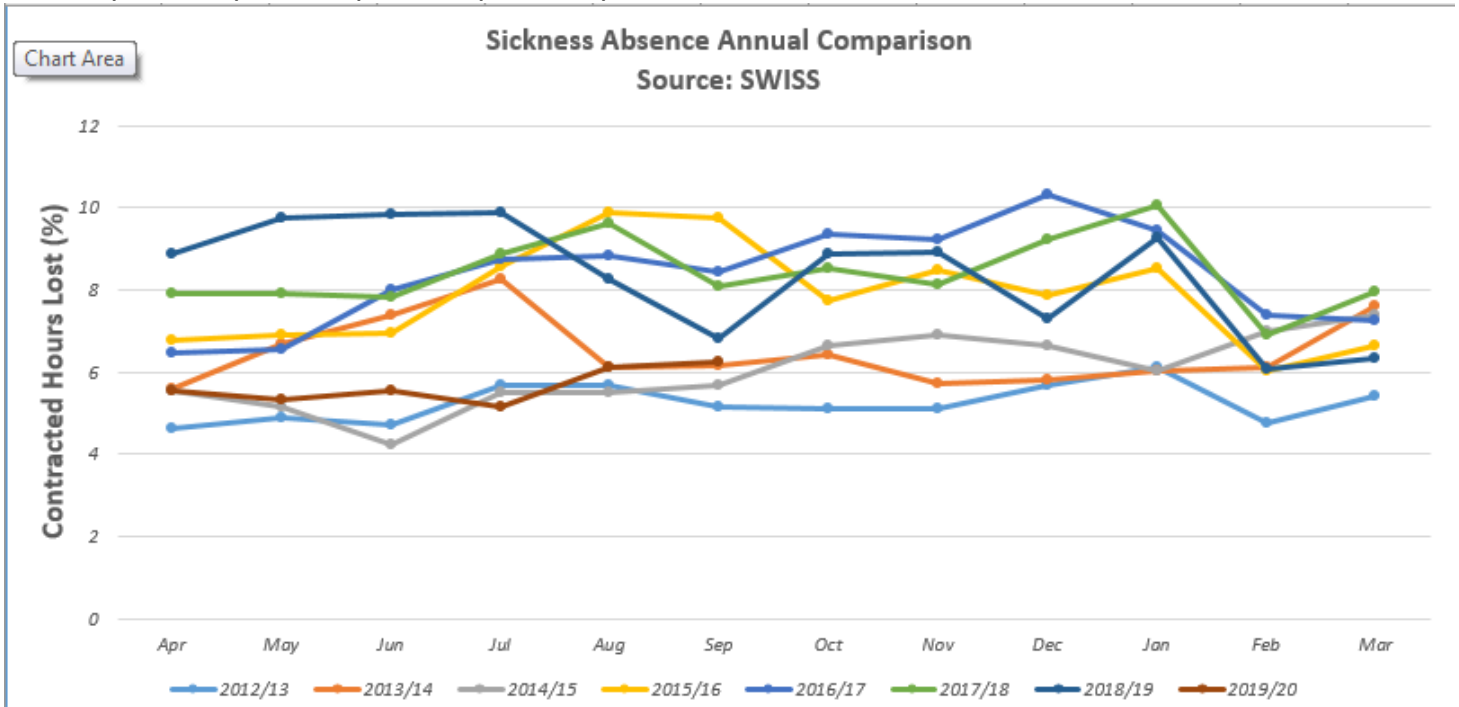
Appendix II : LONG / SHORT TERM ABSENCE BREAKDOWN – NATIONAL DATA (SWISS)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
Long Term %	5.1	5.69	4.47	4.08	3.7	3.34	4.25	4.38	4.36	3.82	4.45	4.28
Short Term %	3.78	3.24	2.84	5.16	2.36	3	1.29	0.96	1.19	1.31	1.65	1.96

Chart 1 provides a rolling monthly comparison of long and short-term absence from SWISS for the State Hospital only.

Appendix III : YEARLY AND MONTHLY COMPARISON - details the breakdown in percentage of sickness absence for the financial years 2012/13, 2013/14, 2014/15, 2015/16, 2016/17, 2017/18, 2018/19. This data is derived from SWISS.



Year/Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	4.64	4.88	4.72	5.69	5.69	5.17	5.11	5.09	5.67	6.1	4.74	5.42
2013/14	5.6	6.67	7.4	8.26	6.1	6.17	6.42	5.74	5.81	6.01	6.13	7.59
2014/15	5.54	5.13	4.21	5.49	5.52	5.68	6.66	6.91	6.65	6.02	6.98	7.38
2015/16	6.78	6.91	6.94	8.58	9.9	9.75	7.73	8.47	7.87	8.51	6.04	6.66
2016/17	6.46	6.56	8	8.75	8.83	8.42	9.34	9.23	10.32	9.46	7.38	7.26
2017/18	7.89	7.93	7.81	8.89	9.64	8.07	8.53	8.13	9.23	10.06	6.92	7.94
2018/19	8.87	9.73	9.84	9.9	8.27	6.83	8.88	8.93	7.3	9.25	6.06	6.34
2019/20	5.55	5.34	5.56	5.13	6.1	6.24						

Appendix IV : National Comparison with NHS Scotland and The State Hospital - September 2019

	Absence Rate			Instances			Absence Reason	
	Total	Long Term [1]	Short Term [2]	Total	Long Term [1]	Short Term [2]	Yes	No [3]
Scotland	**5.29**	**3.44**	**1.85**	**27,145**	**8,139**	**19,006**	**23,776**	**3,369**
NHS Ayrshire & Arran	4.64	3.14	1.51	1,450	457	993	1,324	126
NHS Borders	4.84	3.10	1.74	548	149	399	483	65
NHS National Services Scotland	4.67	3.21	1.46	541	156	385	512	29
NHS 24	8.93	5.59	3.34	524	155	369	443	81
NHS Education For Scotland	1.86	1.21	0.65	89	22	67	59	30
NHS Healthcare Improvement Scotland	2.96	1.82	1.14	62	10	52	60	2
NHS Health Scotland	3.50	1.07	2.43	54	4	50	43	11
Scottish Ambulance Service	8.43	6.18	2.25	893	385	508	840	53
The State Hospital	6.24	4.28	1.96	103	50	53	94	9
National Waiting Times Centre	4.23	2.37	1.86	280	69	211	246	34
NHS Fife	5.52	3.74	1.78	1,386	488	898	1,283	103
NHS Greater Glasgow & Clyde	5.59	3.83	1.76	6,387	2,290	4,097	5,854	533
NHS Highland	5.30	3.20	2.11	1,790	432	1,358	1,237	553
NHS Lanarkshire	5.72	4.03	1.69	1,878	714	1,164	1,645	233
NHS Grampian	4.61	2.70	1.91	2,614	595	2,019	2,035	579
NHS Orkney	4.96	2.39	2.58	132	16	116	128	4
NHS Lothian	4.87	2.72	2.15	4,436	969	3,467	3,907	529
NHS Tayside	5.21	3.47	1.74	2,060	595	1,465	1,828	232
NHS Forth Valley	5.56	3.79	1.77	985	334	651	927	58
NHS Western Isles	5.13	2.99	2.14	190	44	146	164	26
NHS Dumfries & Galloway	5.00	3.21	1.79	642	190	452	569	73
NHS Shetland	2.97	1.76	1.21	101	15	86	95	6

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Links to the Attendance Management Policy and aids monitoring of 5% attendance target set by the Scottish Government
Workforce Implications	Failure to achieve 5% target will impact ability to efficiently resource organisation.
Financial Implications	Failure to achieve 5% target results in additional spend to ensure continued safe staffing levels
Route To Board Which groups were involved in contributing to the paper and recommendations.	SMT, Partnership Forum
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	Failure to achieve the 5% target will impact on stakeholder experience
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	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 HOSPITAL BOARD FOR SCOTLAND

Date of Meeting:	19 December 2019
Agenda Reference:	Item No: 17
Sponsoring Director:	Director of Finance and Performance Management
Author(s):	Head of Management Accounts
Title of Report:	Financial Position as at 30 November 2019
Purpose of Report:	For Noting

1 SITUATION

The Board is asked to consider the Revenue and Capital Resources spending plans, and monitor financial outturn. This report provides information on the financial performance to 30 November 2019, which is also reported to the Senior Management Team and Partnership Forum, and is issued monthly to Scottish Government (SG) along with the statutory financial reporting template.

2 BACKGROUND

Scottish Government are provided with an annual Operational Plan and 3-year financial forecast template, which was confirmed at the 20 June 2019 Board meeting, setting out a balanced budget for 2019/20 based on achieving £2.103m efficiency savings, as referred to in the tables in section 4.

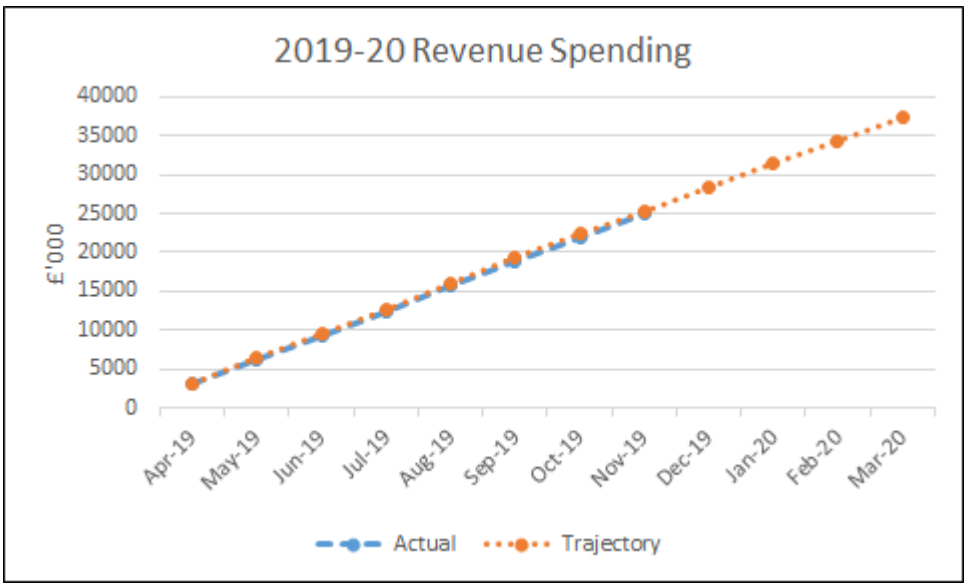
The annual budget of £37.654m is primarily the Scottish Government Revenue Resource Limit allocation, now augmented with the addition of part funding of the costs of the recent Pay As If At Work ("PAIAW") agreement).

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The Board is reporting an under spend of £0.217m to 30 November 2019 – which is a year-to-date variance of 0.8%.

Per the chart below, the current spending position is therefore closely aligned with the forecast trajectory / budget. It is currently anticipated that the forecast break-even position will be achieved for the 31 March 2020 year-end, although certain pressures are highlighted in paragraph 3.2, and outstanding savings pressures remain to be addressed per para. 4.



At this stage in 2018/19, there was an overspend of £0.289m. Much of the improvement is due to the reduction in Nursing ward overtime costs of £0.648m.

Specific nursing controls were introduced in 2019 with the aim of reducing overtime – e.g. limiting individual overtime hours in each month; restricting overtime for staff returning from sick leave. These controls are being monitored by nursing with the aim of evaluating their impact on 2019/20, and to provide meaningful comparisons for the future evaluation of the impact of the new clinical model in 2020/21.

However, while overtime levels are reduced, they continue to be affected by nursing staffing continuing to be under establishment.

3.2 **Key financial pressures / potential benefits.**

	PRESSURES	Risk	Best estimate £'k
(i)	Holiday Pay - Lock v British Gas - PAIAW - Full Year 19/20 (have also anticipated RRL of £141k for Aug 17 to Mar 18 retrospection)	High	210
(ii)	Rebandings arrears	High	tbc
(iii)	Clinical Model Review	High	tbc
(iv)	Legal Fees	High	103
(v)	Office 365	High	250
(vi)	3 yr up for opt out sup'an Nov 19 (approx 100 staff not sup'an)	Med	tbc
(vii)	EU Exit (may get guidance from sub group)	Low	tbc
(viii)	Perimeter Fence - FBC - Additional Staff (Capital funding pending)	Low	193
	BENEFITS	**Risk**	
(ix)	Exceptional Circumstance Patients (new - recharging host Board)	Med	290
(x)	VAT element on Utilities in our favour (v HMRC)	Low	120

i - PAIAW
Payments in 2019/20 to date comprise (SG funded) Aug 2017- Mar 2018 £141k, and TSH funded Apr 2018 - Mar 2019 £210k. In addition, the value for 2019/20 is estimated as £212k (first tranche of which is to be paid December 19, and is to be funded by TSH).
There has been a thorough review of central reserves and finance for this has been identified.

ii - Rebandings
There remain a number of rebanding appeals for certain posts within the hospital, the most recent of which was backdated to 2015; costs of these require to be recognised in the year of settlement.
This year to date (Nov 19) we have paid £25k of arrears.

iii – Clinical Model review
The review of the clinical model has identified potential recurring savings in ward nursing, - values to be confirmed – which would be beneficial from early 2020/21 and will be monitored as part of the overall evaluation of the model.
There are, however, potential unidentified 2019/20 costs yet to be determined subject to the steps required to prepare for the implementation of the model e.g. Estates costs – these are being established within the implementation plan now underway.

iv – Legal fees
These are currently higher than budgeted due principally to individual one-off cases requiring significant CLO input. All use of CLO is scrutinised to ensure it is essential and their advice is taken at all times regarding potential settlement of cases in order to minimise their input where possible.

v – Office 365
NHS Scotland are directing all Boards to the implementation of Office365 in 2020. This will require input from all directorates and much staff commitment. While the plan is likely to be underway in early 2020, the potential costs are being evaluated and should additional funding be required to meet the demands of this, a specific business case will be developed.

vi – Superannuation opt-out
Staff who are not superannuated will be automatically enrolled at the end of November 2019 (this happens every three years), for those who do not choose to opt out, the Board will incur sup'ers on costs.

vii – EU Exit
While there are no specific costs currently identified, this aspect will continue to be monitored regularly up to the 31 January proposed date.

viii – Perimeter Fence project
While we have had authorisation by email that certain additional staff costs (facilitation / support staff) directly related to the project will be able to be included in the final capital settlement, this remains noted as a potential risk in case there is any change in the application of the allocation by SG.

ix – Exceptional Circumstance patients
There are six boards who are due to pay TSH for patients who are at the Hospital under "exceptional circumstances" from other territorial boards – generally due to lack of bed availability. The six boards have all been written to formally regarding o/s payments and while one board has responded positively to date (£50k approx.), responses from the others remain (£290k approx.) This matter will be escalated between Finance Directors to Chief Executives should this be required.

x – HMRC
HMRC has settled in our favour to reduce VAT on utilities to 5% from 20%, providing a windfall payment, which has benefitted TSH in 2019/20 (£64k). This has concluded the process re Electricity costs, with details now awaited re Oil and Gas.

3.3 **Year-to-date position – allocated by Board Function / Directorate**

Directorates	Annual Budget 19/20 £'k	YTD Budget Nov 19 £'k	YTD Actuals Nov 19 £'k	YTD Variance (budget - actual) (adverse) / favourable Nov 19 £'k	Budget wte	Actual WTE
Nursing And Ahp's	19,762	13,286	13,077	209	378.53	375.01
Security And Facilities	5,915	3,994	3,883	111	123.63	120.21
Medical	3,732	2,461	2,316	145	36.58	33.84
Chief Exec	1,844	1,229	1,195	34	22.45	21.77
Human Resources Directorate	836	558	562	(4)	13.38	13.38
Finance	2,977	2,048	2,076	(28)	37.53	34.04
Cap Charges	2,857	1,905	1,902	3	0.00	0.00
Misc Income	(224)	(149)	(89)	(60)	0.00	0.00
Central Reserves	(45)	(180)	13	(193)	0.00	0.00
Under / (over) spend	**37,654**	**25,151**	**24,934**	**217**	**612.10**	**598.25**

Nursing & AHPs - see further detail below

Security & Facilities – see further detail below

Medical – There is in–year pressure due to cross-board costs for Senior Trainee Doctors, although this has been more than offset by continuing vacancies in Psychology (due to continued closure of two wards).

Chief Executive – There is a small underspend resulting from the current interim HR director being with TSH on a 0.5 WTE basis against a full-time budget.

HR – While there is no overall significant variance, there are in-year pressures from Occupational Health due to backdated invoicing for 2018/19, and for additional physiotherapy sessions (for which funding was in fact then released in September). These pressures have been offset by an underspend in course fees through the Learning Centre.

Finance – The main overspend is the result of the higher legal fees for the year to date (as noted in para 3.2.iv.

Capital Charges – These relate to depreciation for the period and have no significant variance.

Miscellaneous Income – The benefit is noted of the forecast saving for VAT benefits on utilities, now partly realised per para. 3.2. x.

Central Reserves – Balance of unidentified savings are higher than reserves, giving a small credit balance, remaining reserves are mainly for apprenticeship levy and provisions that hit the ledger at the year-end. Other reserves are for additional funding from SG for specific projects (many are Nursing), however there are timing delays and some of this helps fund some of the pressures noted in 3.2 above.

3.3.1 **Nursing & AHPs** – further breakdown as below –

Nursing & AHP's	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 8	Budget WTE	Actual WTE
Advocacy	147	98	97	2	0	0
AHP's & Dietetics & SLA'S	647	432	394	37	13	12
Hub & Cluster Admin & Clinical Operations	830	550	521	29	23	21
PCI & Pastoral	220	146	112	34	3	2
NPD & Infection Control & Clin Gov	416	277	263	14	6	1
Skye Centre	1,735	1,161	1,034	127	38	36
Ward Nursing	15,768	10,621	10,655	(34)	295	303
Total Nursing and AHP's	**19,762**	**13,286**	**13,077**	**209**	**378.53**	**375.01**

Underspends (apart from Advocacy) are due to staff vacancies.

Ward Nursing – further breakdown as below -

2019/2020							
Ledger Ward Nursing	Annual Budget £'k	In month / Year to Date Budget £'k	In month / Year to date Actuals £'k	YTD Variance (budget less actuals) £'k	Budget WTE	Actual WTE	Contracted/ conditioned wte's
Total April 19		**1,286**	**1,350**	**(65)**	**295.00**	**318.77**	**289.30**
Total May 19		**1,286**	**1,343**	**(58)**	**295.00**	**315.33**	**289.30**
Total June 19		**1,286**	**1,282**	**3**	**295.00**	**309.54**	**286.30**
Total July 19		**1,286**	**1,286**	**(1)**	**295.00**	**303.18**	**288.28**
Total Aug 19		**1,577**	**1,583**	**(6)**	**295.00**	**309.99**	**281.72**
Total Sept 19		**1,293**	**1,301**	**(8)**	**295.00**	**312.86**	**291.55**
Total Oct 19		**1,287**	**1,264**	**23**	**295.00**	**296.78**	**285.70**
Total Nov 19		**1,322**	**1,244**	**78**	**295.00**	**302.54**	**287.00**
Cumulative	**15,768**	**10,621**	**10,655**	**(34)**			
Variance analysis:		PAIAW Aug 19					
Overtime for vacancies backfill				(280)			
Phased savings (not yet realised)				(100)			
'Nursing Resource' to analyse			*	346	New control measures in place		
				(34)			

The overspend above of £0.034m, in comparison to the previous year's £0.648m, is significantly improved, this is due to management control measures now introduced and in place. It is hoped that this stabilisation since June 2019 will continue for the remaining months of 2019/20, although this will continue to be carefully monitored in order to prepare for meaningful comparison to levels under the new clinical model in 2020/21.

3.3.2 **Security and Facilities** – further breakdown as below –

Security & Facilities	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 8	Budget WTE	Actual WTE
Facilities	4,196	2,818	2,683	135	84	76
Security	1,637	1,094	1,118	(23)	40	39
Perimeter Security	82	82	82	(0)	0	5
Total Security & Facilities	**5,915**	**3,994**	**3,883**	**111**	**123.63**	**120.21**

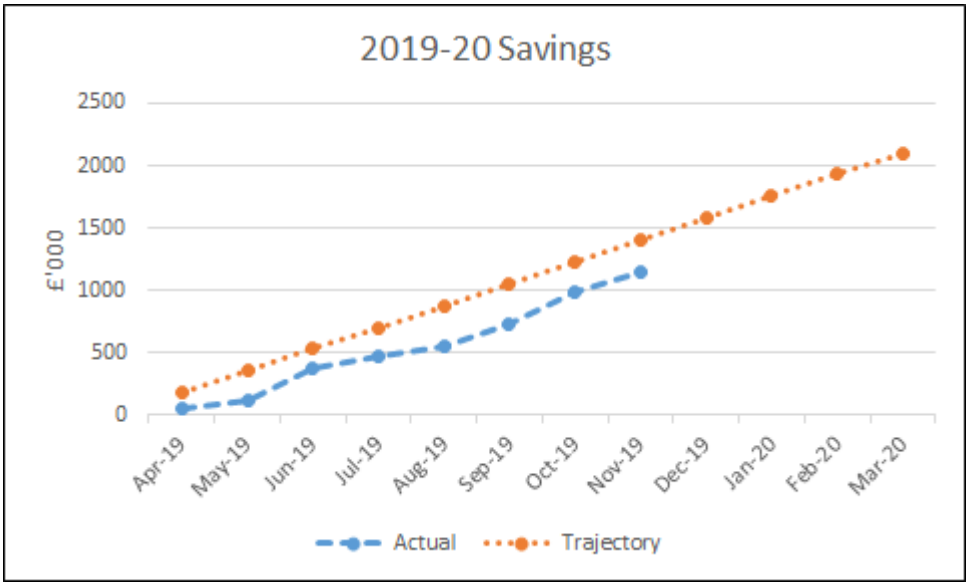
Facilities – The favourable variance for the period is due to vacancies in Estates & Housekeeping, and an underspend in the utilities costs for the year. Utilities costs remain difficult to forecast due to unpredictable weather through the year, and can vary significantly between months.

Security – The overspend is mainly due to Backfill for vacancies.

Perimeter Fence – The potential pressure of the costs of project staffing are currently recognised within unidentified savings pressures, pending final confirmation of their inclusion in capital funding (per para. 3.2. viii).

4 ASSESSMENT – SAVINGS

4.1 While there have been strong efforts across all directorates towards achieving a challenging savings target, the board at 30 November remains behind trajectory on the planned savings to date.



There remains a major focus through all directorate budget-holder reviews to identify the means of addressing this shortfall, and this will continue as the main financial priority.

The table shows the target savings from the Operational Plan, with savings achieved to date and the remaining balance still to be achieved by the year-end.

Savings Annual Target LDP	Savings Annual Target LDP 2019-20 Rec £'k	Non-Rec £'k	Total £'k	Savings (Achieved), as at Nov 19 2019-20 Rec £'k	Non-Rec £'k	Total £'k	Savings still to be achieved by year end 2019-20 Rec £'k	Non-Rec £'k	Total £'k
Efficiency & Productivity Workstreams:									
Service redesign (Clinical)	(22)	(95)	(116)	0	55	55	(22)	(40)	(61)
Drugs & Prescribing	0	(20)	(20)	0	36	36	0	16	16
Workforce	(57)	(481)	(538)	22	604	626	(34)	123	88
Procurement	0	0	0	0	0	0	0	0	0
Infrastructure *(e.g.facilities mgt, IT, other support services)*	(56)	(309)	(365)	5	199	204	(51)	(110)	(161)
Other	0	(100)	(100)	0	0	0	0	(100)	(100)
Financial Management / Corporate Initiatives	0	0	0	0	0	0	0	0	0
Unidentified Savings	0	(965)	(965)	0	223	223	0	(742)	(742)
Total In-Year Efficiency Savings	**(134)**	**(1,969)**	**(2,103)**	**27**	**1,116**	**1,143**	**(107)**	**(853)**	**(960)**
Trajectory (1/12ths of LDP)				**89**	**1,313**	**1,402**			
(under) / over achieved against trajectory				**(62)**	**(197)**	**(259)**			

It remains a key target to reduce the over-reliance on non-recurring savings. While the extensive work on the clinical model review was not undertaken with the aim of savings, it is anticipated that the planned model's implementation will however result in some being achieved – and this would provide a key contribution to improving the recurring / non-recurring balance.

While an improved level of the proportion of recurring savings is a national focus that has been highlighted by audit, it should be noted that of the Hospital's budget, nearly 85% of costs are pay/staff-related. The remaining non-pay cost element from which recurring savings are being pressured is therefore only 15%.
By comparison, many territorial boards have a non-pay cost element of around 65%, and other National boards have non-pay costs ranging from around 80% (NSS, NES) to 30/40%.

4.2 **National Boards Contribution**

The eight National Boards (formerly Special Boards) continue to work towards joint efficiencies and collaborative working. With a challenging £15m collective savings target to be achieved per annum, there is pressure on each board to contribute towards any shortfall. The State Hospital's share of this in 2017/18 was £440k, and when this was proposed again in 2018/19 it was resisted due to other costs and savings pressures, and a contribution was agreed of £220k as then approved by the Board. We have anticipated the return of the £0.127m.

While the level to which the Board have agreed for 2019/20 has remained at £220k, there continues to be pressure due to the £15m not yet being fully attained. However, the position presented by both the Finance & Performance Management Director and the Chief Executive at their respective National Board sessions is that £220k remains our maximum contribution, subject only to any significant underspend should it be the position after final year-end audit, and while also noting that there is currently no contribution for 2019/20 from another, larger board.

5 CAPITAL RESOURCE LIMIT

The capital allocation from Scottish Government for the year is £0.269m, from which as noted below a part-contribution is agreed each year towards the perimeter fence project.

The Capital Group meets regularly to monitor capital spend and demands across the site, and it is anticipated that the allocation will be fully utilised in the year, with projects identified for the remaining unspent balance.

	Annual Plan £'k	YTD Plan £'k	YTD Actual £'k	YTD Variance £'k
Estates	165	30	30	-
IM&T	104	104	104	-
Vehicles	-	-	-	-
Other equipment	-	-	-	-
Security Fence Dvpt	-	45	45	-
TOTAL	**269**	**179**	**179**	**-**

6 RECOMMENDATION

Revenue
Year-to-date: £0.217 under-spend; year-end projection: break-even
Capital
Year-to-date: break-even; year-end projection: break-even

Quarterly Financial Review meetings across all directorates, over and above the regular monthly Management Accounts meetings, help maintain accurate revenue budgeting in the accounts and support forecasting the year-end outturn. A strong emphasis on the management of savings remains the priority for the Board.

The Board is asked to note the content of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of Financial Position
Workforce Implications	No workforce implications – for information only
Financial Implications	No workforce implications – for information only
Route to SG/Board/SMT/Partnership Forum Which groups were involved in contributing to the paper and recommendations.	Head of Management Accounts
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ☑ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed. ☐ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2019
Agenda Reference:	Item No: 18
Sponsoring Director:	Finance and Performance Management Director
Author:	Head of Corporate Planning and Business Support
Title of Report:	Performance Report Q2 2019/2020
Purpose of Report:	For Noting

1 SITUATION

This report presents a high-level summary of organisational performance for Q1 July - September 2019. A summary table and run charts for the performance indicators may be found in Appendix 1. We have added Q4 red, amber, green data to this table to give some trend data.

The only national LDP standards directly relevant to the State Hospital are as follows: Psychological Therapies Waiting Times and Sickness Absence. Additional local KPIs are reported to the Board and included in this report. Going forward, the LDP process has been replaced by a requirement for each Board to submit an Annual Operational Plan for 2018-19. A review of the broader LDP standards is also being undertaken at a national level.

2 BACKGROUND

Members receive quarterly updates on Key Performance Indicator (KPI) performance as well as an Annual Overview of performance and a Year-on-Year comparison each June.

3 ASSESSMENT

We have maintained good levels of performance in many areas but performance in the following areas merit comment:

No 1 Patient have their care and treatment plans reviewed at 6 monthly intervals.

On 30 September 2019 there were 101 patients in the hospital. Five of these patients were in the admission phase. Eight CPA documents had not been reviewed within the 6 month period. All 8 were out of date (uncertain currently of reasons – being checked with relevant staff). This gives a compliance of 91.7% which is a slight drop from June's 92.6% compliance. This indicator remains amber.

Health Records staff continue to send reminder emails to RMOs and medical secretarial staff to advise that a patient's review or renewal of detention is due. The renewal of detention ties in with the annual CPA document being completed. These continue to be completed and uploaded to RiO by secretarial staff in shorter timescales than previously noted.

No 3 Patients will be engaged in off hub activity centres

For Q2, 84% of patients were involved in off-hub activities. This is a slight increase on last quarter (Q1 83%). This increase is due to new admissions being approved by Clinical Team to attend activity at the Skye Centre.

This percentage doesn't include patients planned to attend the hospital shop, patients scheduled to attend the Health Centre or those who regularly attending the Café Area. This means that patients engaging in off hub activities remains in the amber zone.

No 4 Patients will be offered an annual physical health review

This indicator improved from 71% to 100% in Q2. This moved the indicator from red to green.

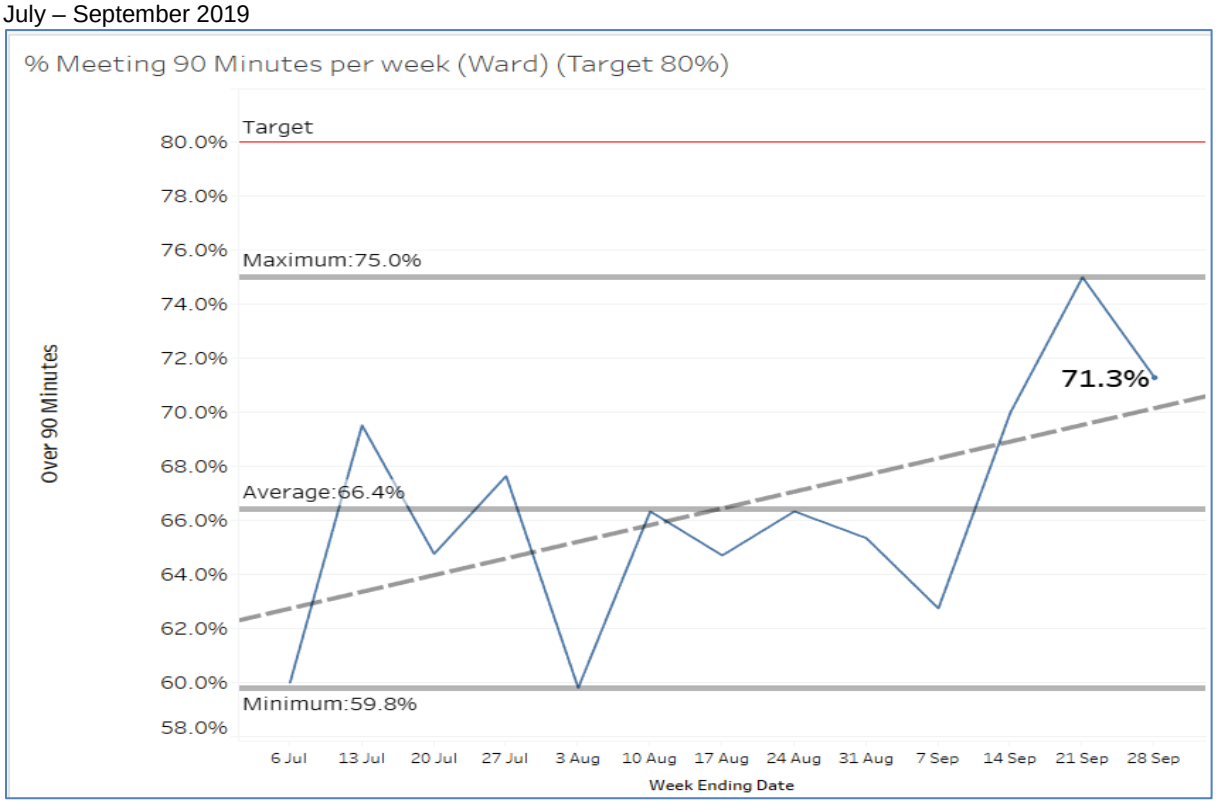
No 5 Patients will undertake 90 minutes of exercise each week

The Physical Activity levels over the second quarter have averaged 66.4%. This is an increase from 64.2% in the last quarter. The Physical Health Steering Group are currently reviewing data over the last year to look at trends and possible ways of improving the uptake of Physical Activity. Due to the 80% target this indicator remains in the red zone.

To ensure robustness of the data, spot checks were carried out to ensure a minimum of 2 physical activity entries were being completed in a 24 hour period. The spot check showed that there were 2 entries consistently being made per day and the data is therefore robust.

Data recorded is patient participation in Moderate physical activity intervention, this data includes patients participating at the Sports and Fitness, Gardens, ward and hub based activities, escorted walks, Walking Groups. This data also includes patients using Ground Access as a means of physical activity. Caution should be used to this however, as this is based on patient self-reporting.

July – September 2019



No 6 Healthier BMI.

The RiO report shows that 8% of patients have a healthy BMI in September 2019. This is a reduction from 10% in June 2019. This compares with 10% in March 2019, 11.6% in December 2018, 14.5% in September and 18.8% in June 2018. This is concerning as there has been a steady decline since June 2018. The data collection has moved to monthly in December 2018 for this indicator with nursing staff taking measurements as opposed to the Dietetic Technician measuring on a 6 monthly basis. This means we have more data being collected more regularly for all patients. This indicator remains in the red zone.

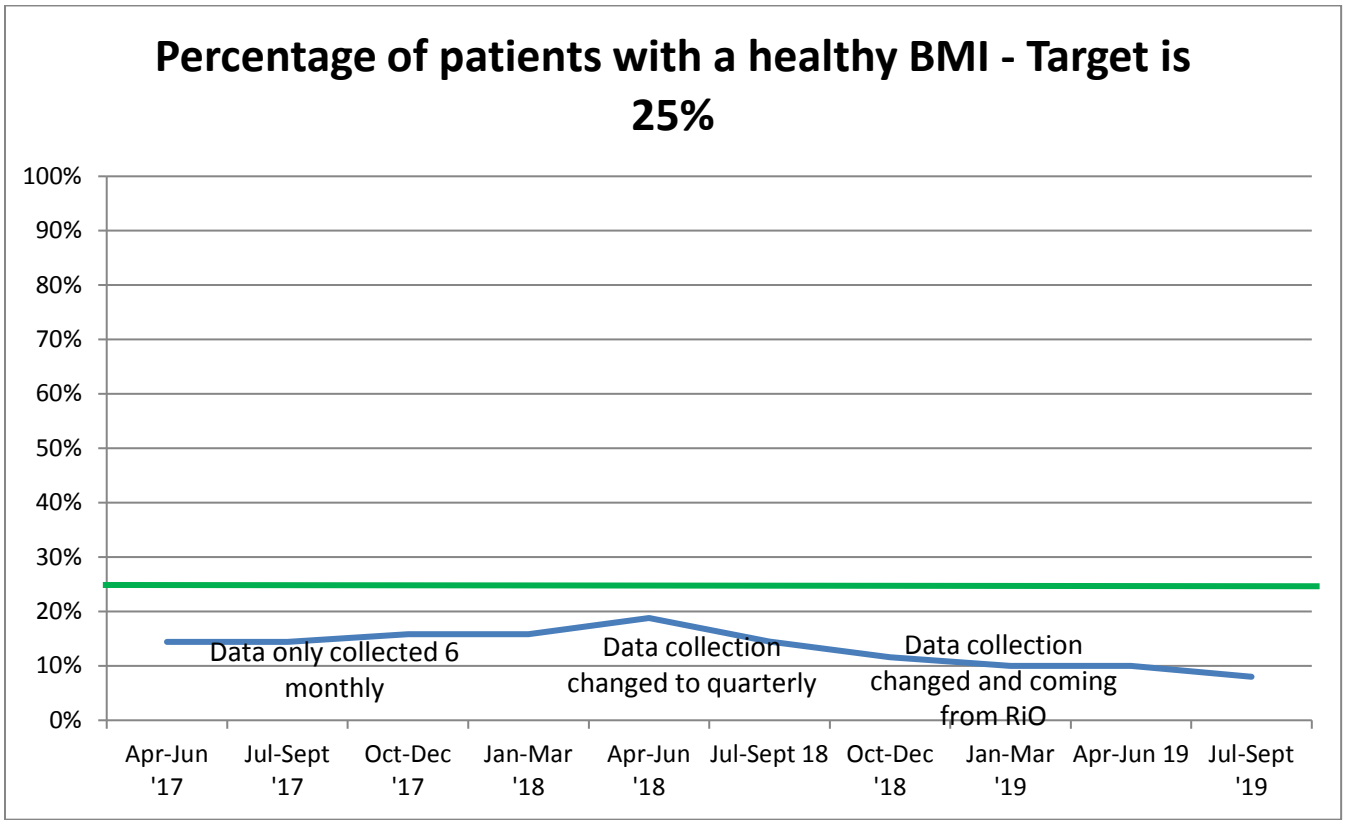


Table 1

Weight Range by BMI	Number of Patients (Q2 2019/20)	% (Q2)	Number of Patients (Q1 2019/20)	% (Q1)	Number of Patients (Q4 2018/19)	% (Q4)	Number of patients (Q3 2018/19)	% (Q3)
<18.5 underweight	0	0	0	0	0	0	1	0.9
18.5-24.9 healthy	8	8	11	10	10	10	15	14.5
25-29.9 overweight	38	92	38	89	39	90	30	85.5
30-39.9 obese	46		48		46		49	
>40 obese	8		6		8		8	

Over the last Quarter

- There were 3 new admission who all had an admission BMI over 25-29.9 overweight.
- There were 8 discharges; 4 had a BMI 30-39.9 obese, 3 had a BMI 25-29.9 overweight and 1 had a Healthy BMI
- 1 patient moved from the underweight category into the Healthy Category
- From the 8 patients within the >40 obese category; 2 patients have a BMI over 43

No 7 Sickness absence.

The sickness absence rate for the quarter was 5.82%. This is a slight increase from Q1 5.48%. July's figure was 5.13%, August 6.10% and September 6.24%. Within the quarter there was a month on month increase.

This moves this indicator from green to amber as the hospital is between 0.5% and 1% away from their target.

No 8 Staff have an approved PDP.

The PDR compliance level over July to September averaged out at 86.9% This is an increase of 0.6%% from the last reporting period (i.e. 30 June 2019).

Although this indicator remains in the red zone, monthly monitoring continues to show a positive upwards trajectory and there is clear evidence of month-on-month improvements in organisational compliance.

No 15 Attendance by clinical staff at case reviews.

Key Worker attendance has increased slightly to 81% from 72% in Q1. This is still a significant improvement from last years Q3 figure of 49%. The target is 80%.

Occupational Therapy attendance has decreased from 83% in Q1 to 79% in Q2 against a target of 80%. This indicator remains in the green zone at the moment.

Pharmacy has increased from 57% in Q1 to 63% in Q2 against a target of 60%. They remain in the green zone at present.

Clinical Psychologist attendance fell further from the 80% target to 61%, compared to 77% in Q1. This has moved them to the red zone. The Psychology attendance decreased from 91% in Q1 to 86% in Q2. This moves this indicator from amber to red.

Security attendance has increased further from 42% in Q1 to 56% in Q2 against a target of 60%. This moves this indicator from the red zone to the green zone.

Social Work attendance decreased from 74% in Q1 to 72% in Q2. This indicator remains at amber as the target is 80%.

4 RECOMMENDATION

The Board is asked to **note the contents of this report.**

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of Key Performance Indicator Performance in the TSH Local Delivery Plan (2017-2020) and the Operational Plan.
Workforce Implications	No workforce implications-for information only.
Financial Implications	No financial implications-for information only.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Risk, Finance and Performance Management Group
Risk Assessment (Outline any significant risks and associated mitigation)	There is a dependency on the Business Intelligence project. While we can identify other ways of obtaining and analysing data there will be continue to be limitations on the timeliness and granularity of the information reported.
Assessment of Impact on Stakeholder Experience	The gaps in KPI data which make it difficult to assess.
Equality Impact Assessment	No implications identified.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	n/a
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Appendix 1

Item	Principles	Performance Indicator	Target	RAG Q2	RAG Q1	Actual	Comment	LEAD
1.	8	Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	A	91.7%	The figure for June 2019 was 92.6%	LT
2.	8	Patients will be engaged in psychological treatment	85%	G	G	90.7%	*Figures for September 2019* – 91% (average) engaged in therapy.	JM
3.	8	Patients will be engaged in off-hub activity centres	90%	A	A	84%	Excludes shop / health centre information (brief visits). This also doesn't include patients who are regularly attending the Café Area	MR
4.	8	Patients will be offered an annual physical health review	90%	G	G	100%	All patients eligible for an annual physical health review were offered for Q2.	LT
5.	8	Patients will undertake 90 minutes of exercise each week	80%	R	R	66.4%	For this quarter the indicator remains in the red zone but has increased from 64.2% in the previous quarter. There has been up upward trend since January 2019.	MR
6.	8	Patients will have a healthier BMI	25%	R	R	8%	There has been a steady decline since June 2018.	LT
7.	5	Sickness absence rate(National HEAT standard is 4%)	** 5%	A	G	5.82%	5.13% in July, 6.10% in August and 6.24% in September gives a quarterly average of 5.82% This is a slight decline from last quarter of 5.48%	KS
8.	5	Staff have an approved PDR	*100%	R	R	86.9%	This indicator has been showing a steady improvement since October 2018.	KS
9.	1, 3	Patients transferred/discharged using CPA	100%	G	G	100%	This indicator maintained at 100% in Q2. All patients had a CPA meeting prior to transfer/discharge.	KB
10.	1, 3	Patients requiring primary care services will have access within 48 hours	*100%	G	G	100%	This indicator maintained at 100% in Q2.	LT
11.	1, 3	Patients will commence psychological therapies <18 weeks from referral date	**100%	G	G	100%	All patients referred and not already in treatment met the standard	JM
~~12.~~	~~1, 3~~	~~Patients will engage in meaningful activity on a daily basis~~	~~100%~~	~~-~~			~~*New indicators and business processes in development as reported to the June Board.*~~	~~MR~~
13.	2, 6, 7, 9	Patients have their clinical risk assessment reviewed annually.	100%	G	G	97.9%	101 patients. 5 new admissions, 94 patients with current risk assessments and 2 risk assessments out of date (one due to section change, the other is running late due to staff leave).	LT
~~14.~~	~~2, 6, 7, 9~~	~~Hubs have a monthly community meeting.~~	~~-~~	~~-~~		~~-~~	~~*New indicators and business processes in development as reported to the June Board.*~~	~~MR~~
15.		Refer to next table.						All Clinical Leads

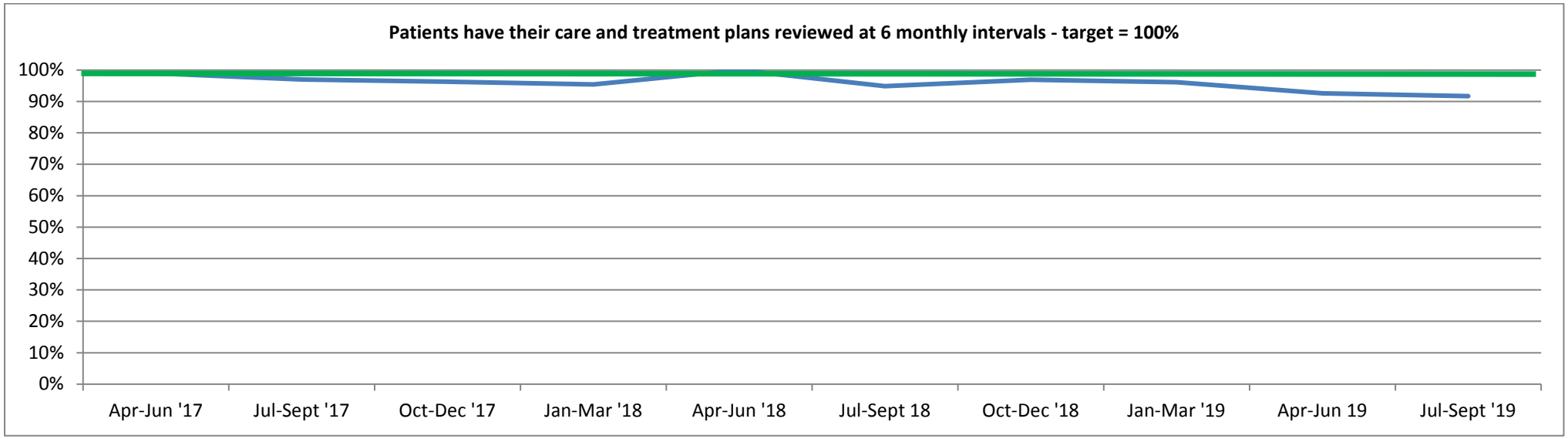
Item	Code	Principles	Performance Indicator	Profession (Lead)	Target	RAG Q2	RAG Q1	Overall attendance July-Sept 2019 (n=43)	Overall attendance April – June 2019(n=50)	Overall attendance Jan-Mar 2019 (n=53)	Overall attendance Oct-Dec (n=51)
15	T	2, 6, 7, 9	Attendance by all clinical staff at case reviews	RMO **(LT)**	90%	G	G	91%	93%	93%	90%
				Medical **(LT)**	100%	G	G	95%	96%	98%	96%
				Key Worker/Assoc Worker **(MR)**	80%	G	A	81%	72%	74%	49%
				Nursing **(MR)**	100%	G	G	98%	100%	98%	96%
				OT**(MR)**	80%	G	R	79%	83%	52%	61%
				Pharmacy **(LT)**	60%	G	G	63%	57%	71%	41%
				Clinical Psychologist **(JM)**	80%	R	G	61%	77%	79%	92%
				Psychology **(JM)**	100%	R	A	86%	91%	98%	98%
				Security**(DW)**	60%	G	R	56%	42%	41%	39%
				Social Work**(KB)**	80%	A	A	72%	74%	86%	71%
				Skye Activity Centre **(MR)** (only attend annual reviews)	tbc	-	-	5%	0%	0%	4%
				Dietetics **(MR)** (only attend annual reviews)	tbc	-	-	45%	67%	59%	30%

Definitions for red, amber and green zone

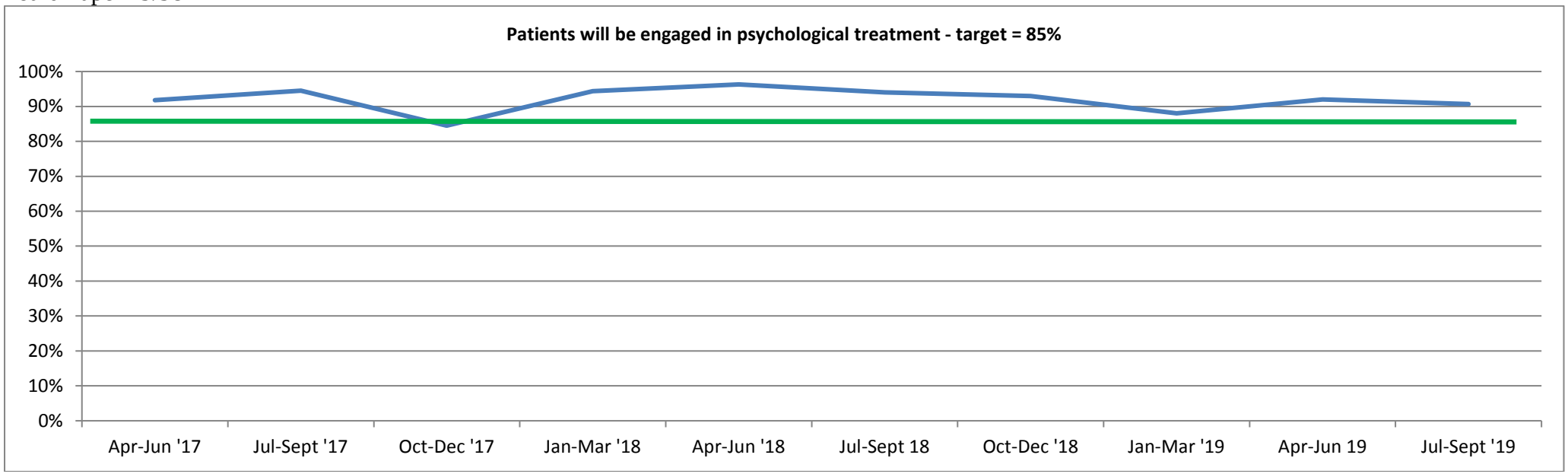
- For all but item 6 and 7 green is 5% or less away from target, amber is between 5.1% and 10% away from target and Red will mean we are over 10% away from target
- For item 6 'Patients have a healthier BMI' green will be 3% or less away from target, amber will be between 3.1% and 5% away from target and red will be over 5% away from target
- For 7 'Sickness absence' green is less than 0.5% from target, amber will be between 0.51% and 1% away from target and red will be over 1% and away from target

Trend Graphs for Performance Management Data

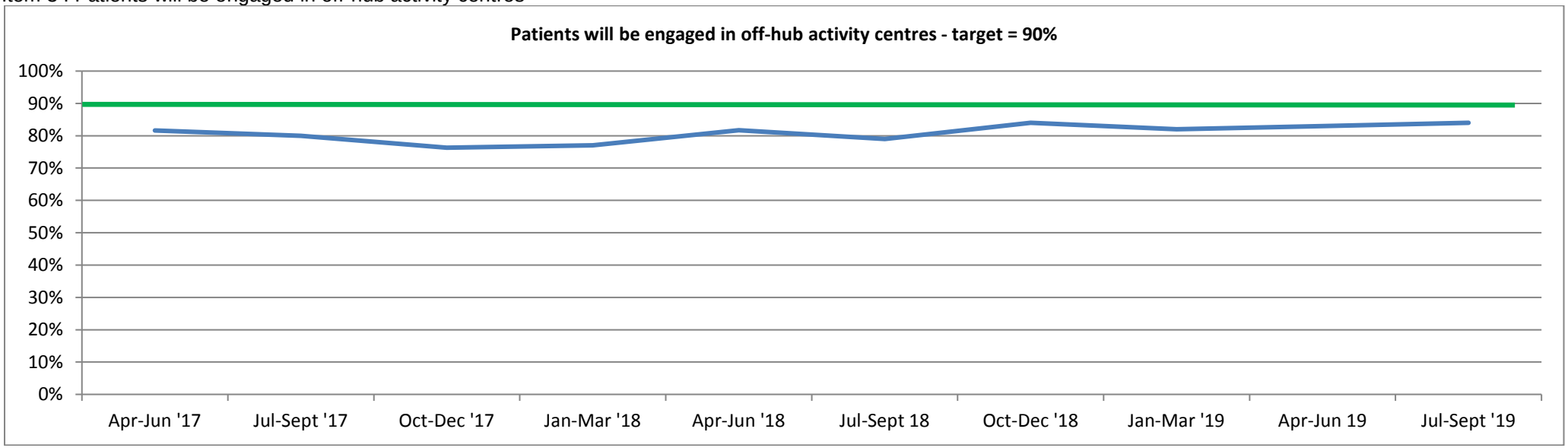
Item 1 : Patients have their care and treatment plans reviewed at 6 monthly intervals



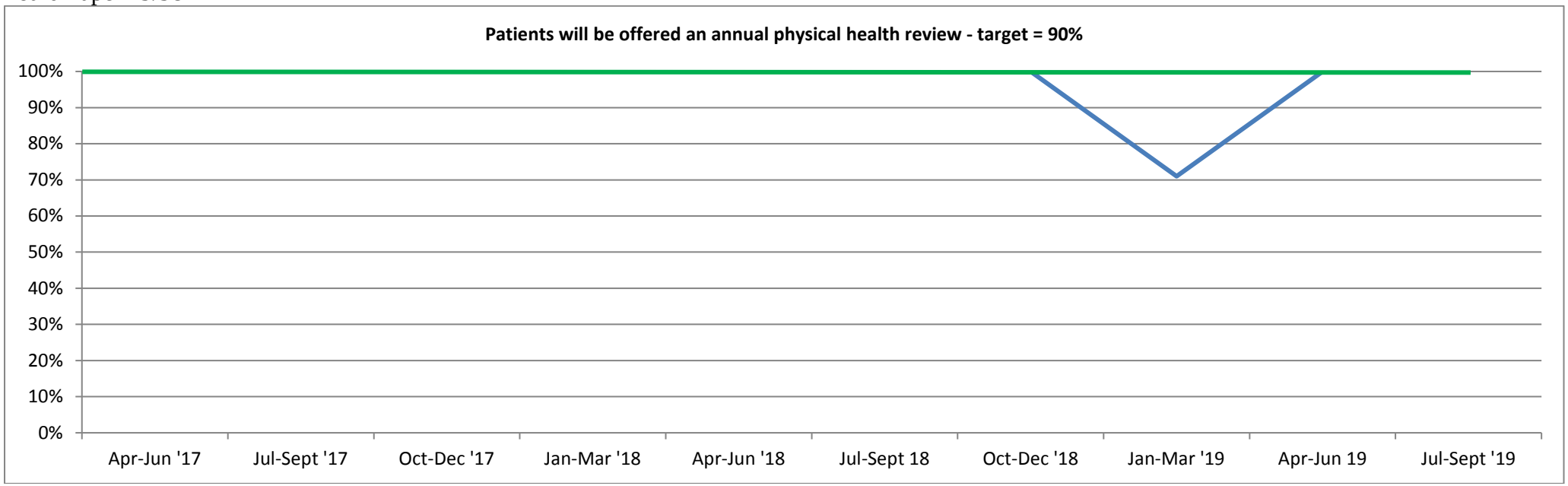
Item 2 : Patients will be engaged in psychological treatment



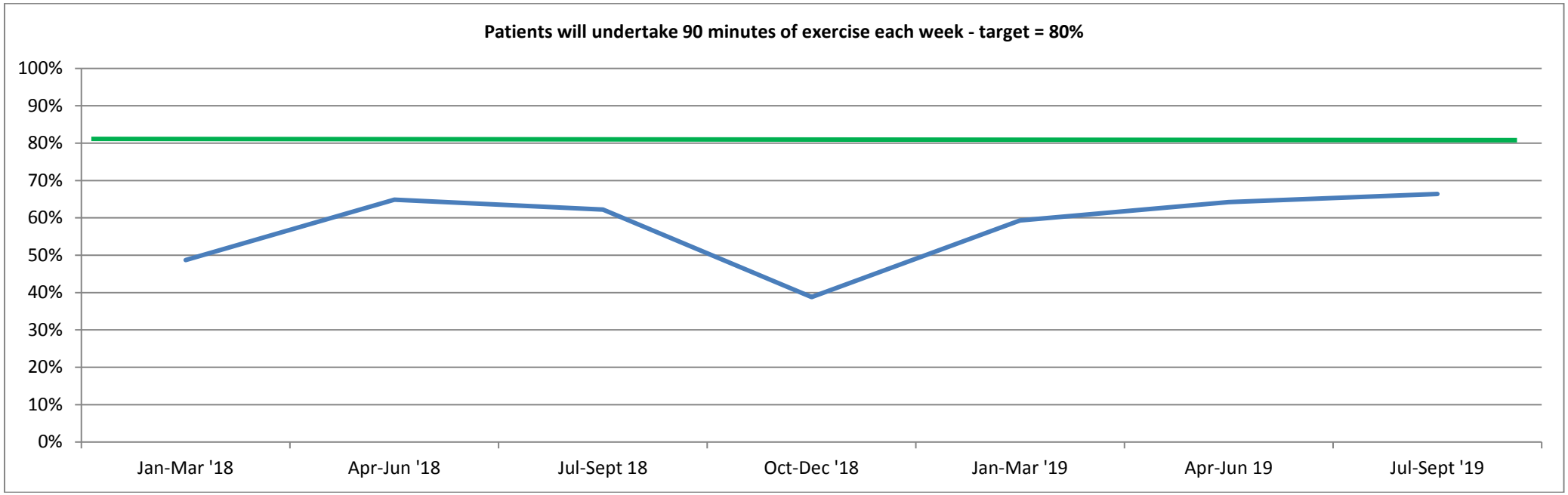
Item 3 : Patients will be engaged in off-hub activity centres



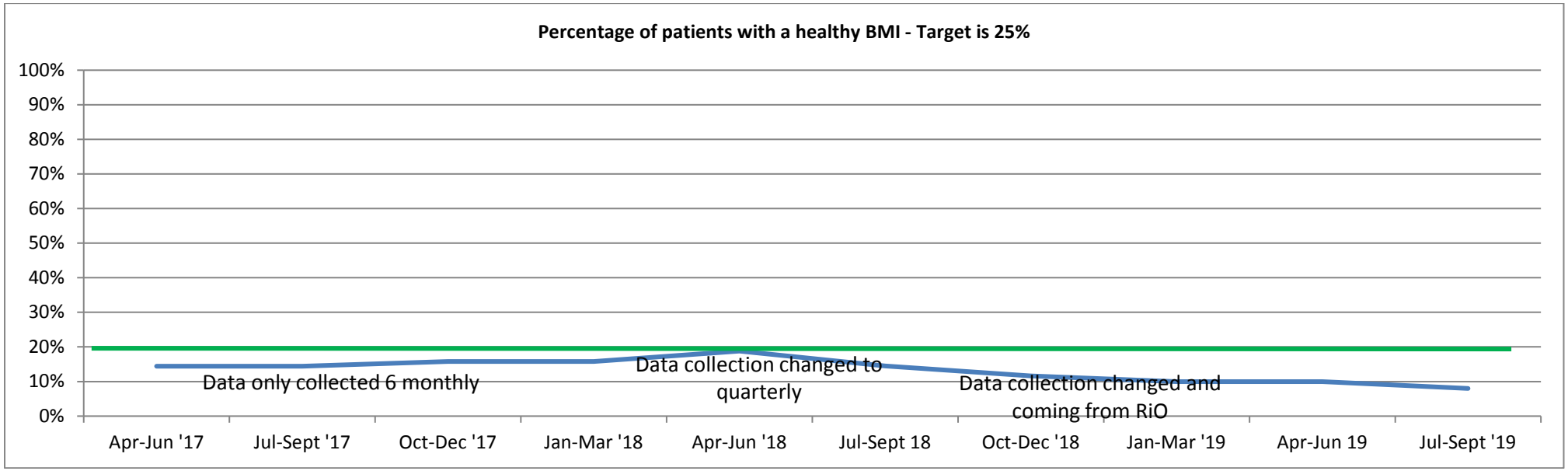
Item 4 : Patients will be offered an annual physical health review



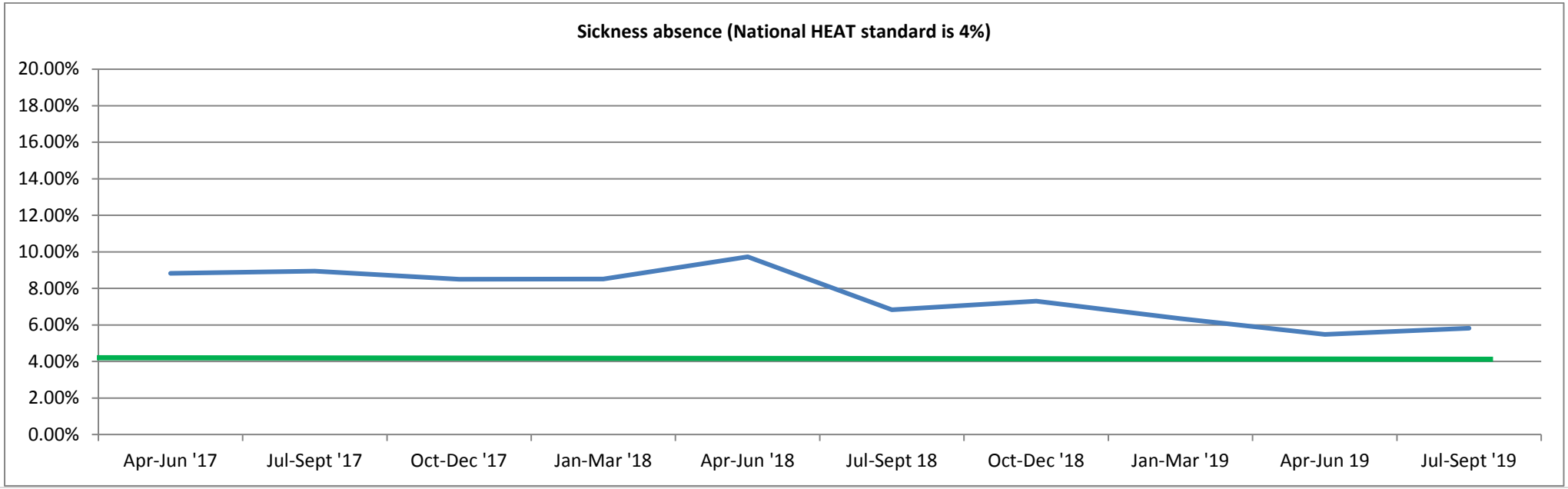
Item 5: Patients will undertake 90 minutes of exercise each week



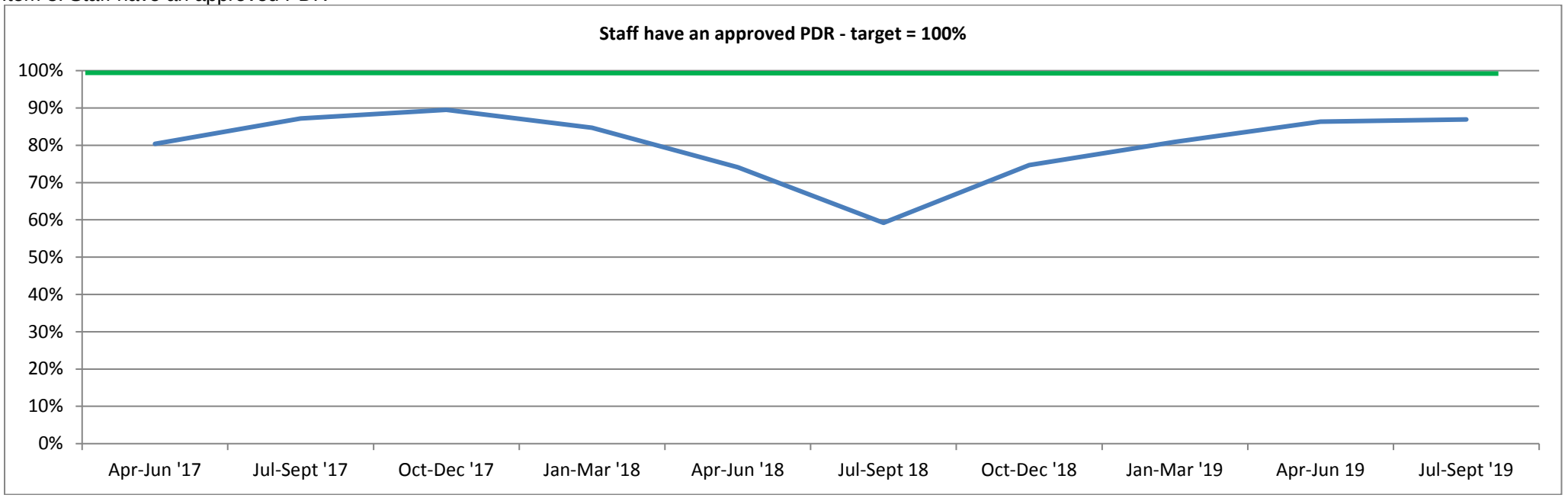
Item 6: Patients will have a healthier BMI



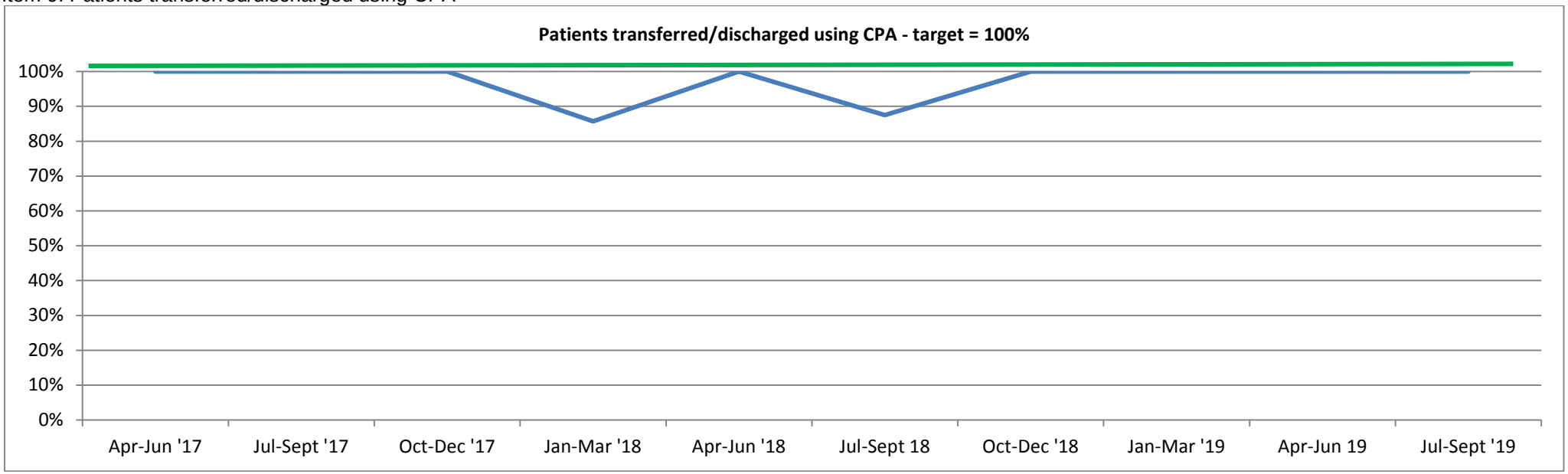
Item 7: Sickness Absence



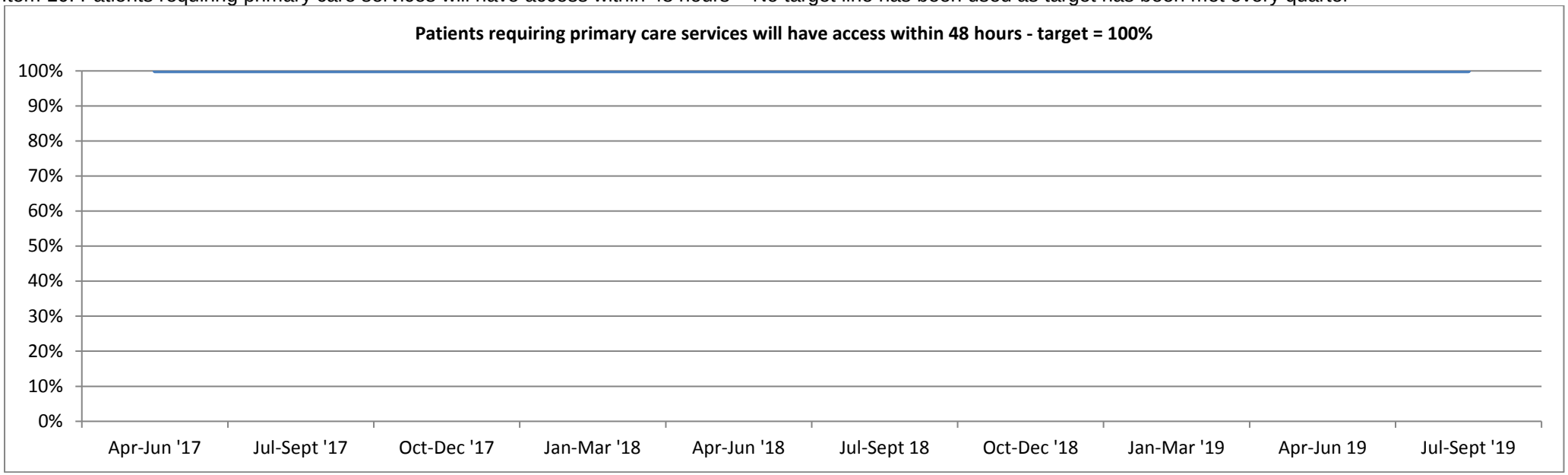
Item 8: Staff have an approved PDR



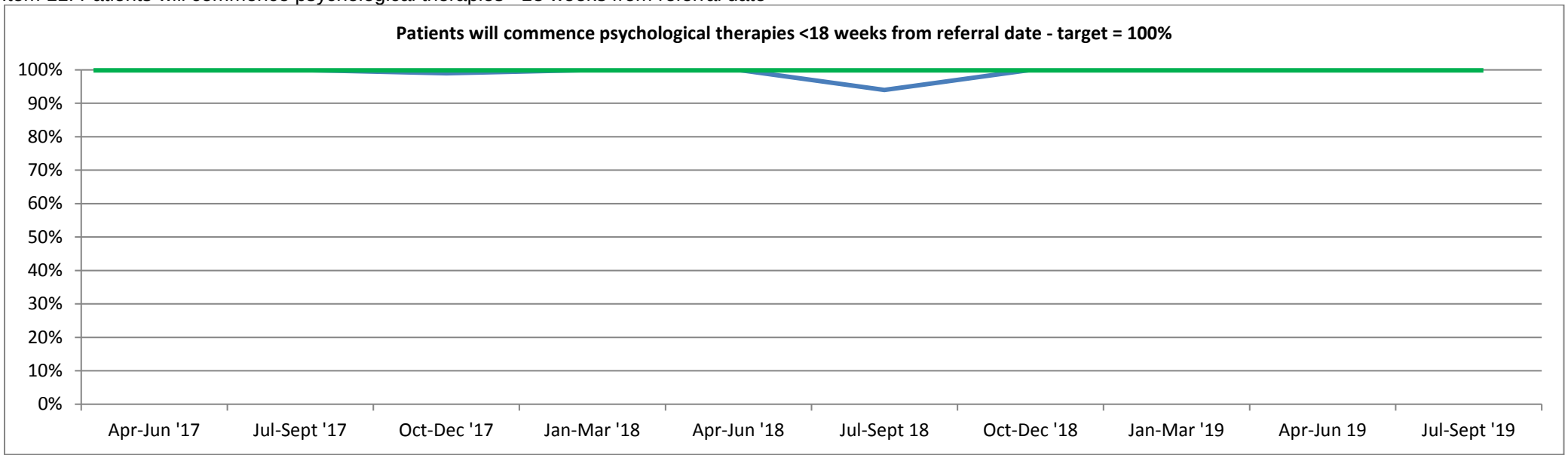
Item 9: Patients transferred/discharged using CPA



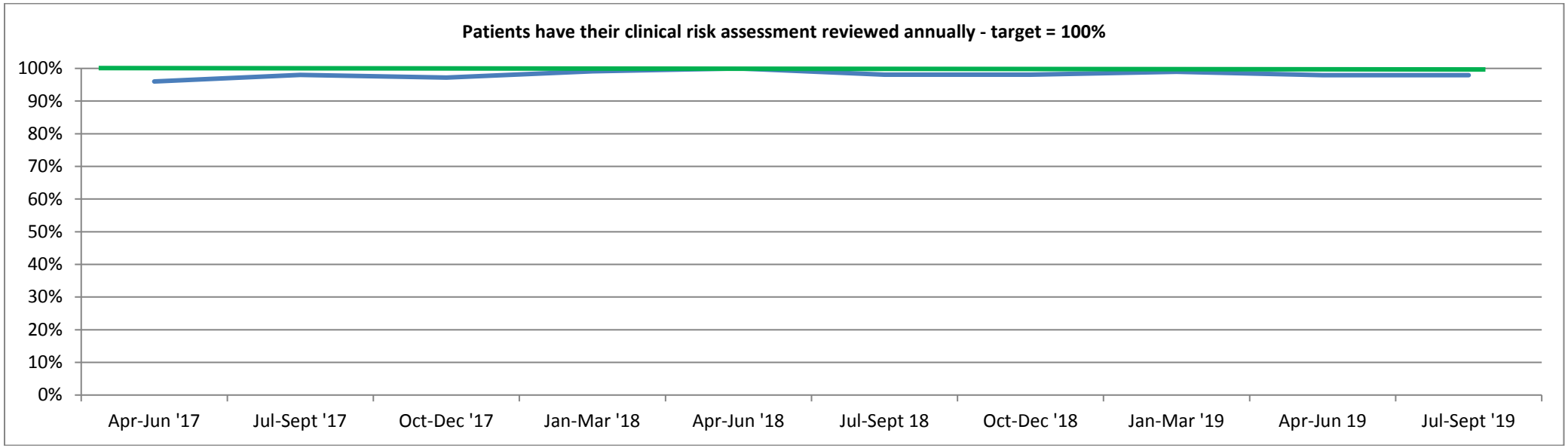
Item 10: Patients requiring primary care services will have access within 48 hours – No target line has been used as target has been met every quarter



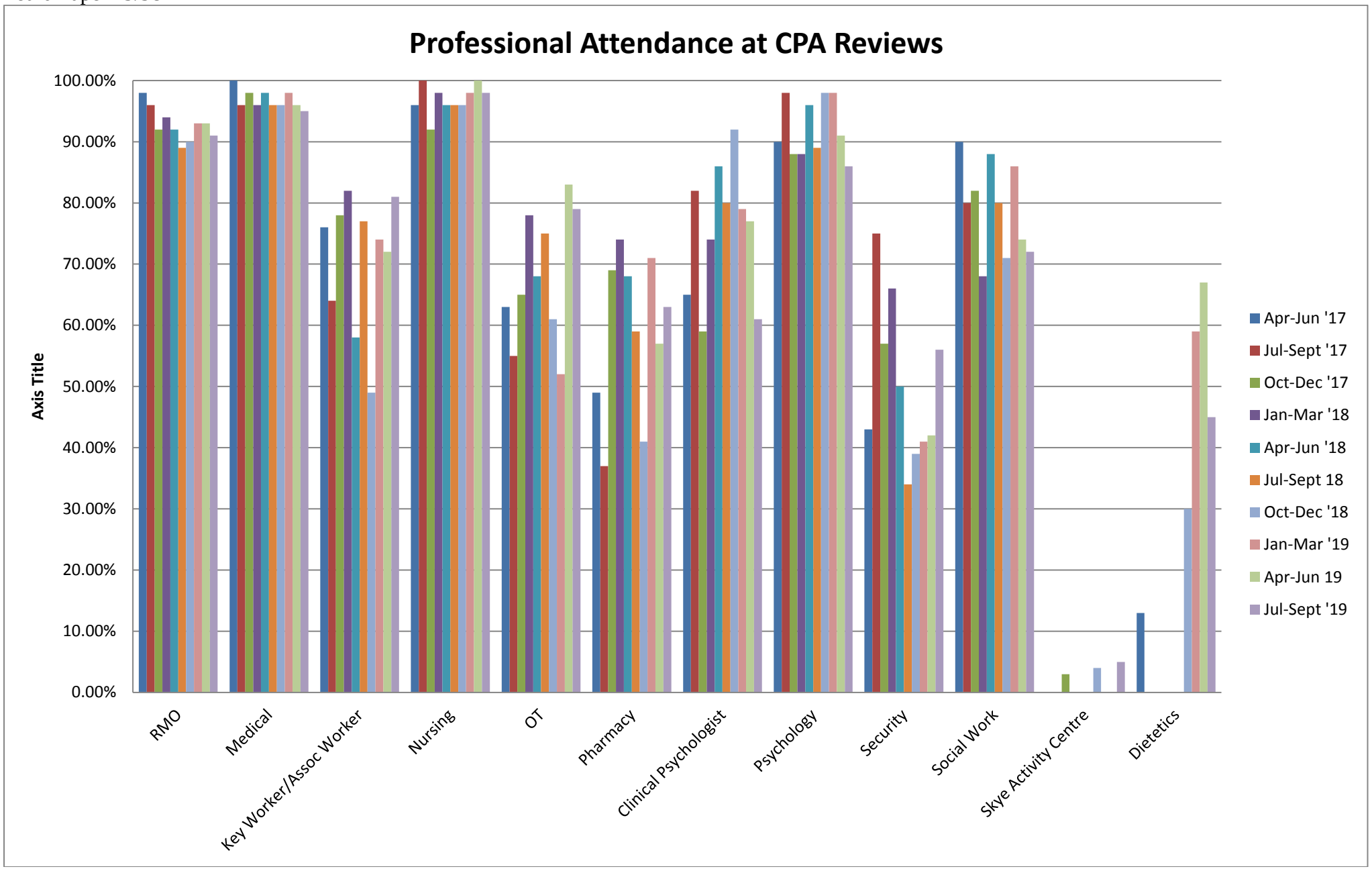
Item 11: Patients will commence psychological therapies <18 weeks from referral date



Item 13: Patients have their clinical risk assessment reviewed annually



Item 15: MDT Attendance at Case Review


Professional Attendance at CPA Reviews
Axis Title
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
RMO
Medical
Key Worker/Assoc Worker
Nursing
OT
Pharmacy
Clinical Psychologist
Psychology
Security
Social Work
Skye Activity Centre
Dietetics
Apr-Jun '17
Jul-Sept '17
Oct-Dec '17
Jan-Mar '18
Apr-Jun '18
Jul-Sept 18
Oct-Dec '18
Jan-Mar '19
Apr-Jun 19
Jul-Sept '19

Board Paper 19/99

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2019
Agenda Reference:	Item No: 19
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Corporate Governance Improvement Action Plan
Purpose of Report:	For Noting

1 SITUATION

Following Board self-assessment, an improvement plan was developed to support key corporate governance priorities as part of the Corporate Governance Blueprint.

The Board submitted its improvement plan to Scottish Government in April 2019, and submitted a six-month progress report in November 2019. It is understood that a further Board Self-assessment is being planned at a national level to take place in 2020, and further details will be provided as soon as these become available.

2 BACKGROUND

The five key areas of the improvement plan are outlined as follows:

- Setting the Direction
- Holding to Account
- Assessing Risk
- Engaging Stakeholders
- Influencing Culture

3 ASSESSMENT

The improvement plan has been updated to indicate progress against each item (Appendix A) and the Board is asked to note the content of the updated plan.

In particular, the Board is asked to note the work progressed within nursing on an effective rostering system (Action 2). This has included testing of an eRostering model. Additionally, flexible shift patterns have been introduced for all new appointments to ward nursing posts. The Board has received assurance reporting during 2019 on preparedness for the enactment of safe staffing legislation which will take place in 2020, and should now note that internal audit work will be carried out in this respect in January 2020.

The Board is also asked to note the work progressed in respect of recruitment (Action 11) particularly of new nursing graduates, and the intention to continue to develop this in the coming year.

4 RECOMMENDATION

The Board is asked to note progress in implementation of the improvement plan.

A further update will be brought to the next meeting of the Board in February 2020.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Corporate Governance Blueprint
Workforce Implications	None identified to date
Financial Implications	None identified to date
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board Standing Committees/ SMT
Risk Assessment (Outline any significant risks and associated mitigation)	None identified to date
Assessment of Impact on Stakeholder Experience	Implementation will benefit stakeholder engagement through the workstreams indicated in the improvement plan
Equality Impact Assessment	Not formally assessed
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No impact identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND - IMPROVEMENT PLAN **Appendix A**

BLUEPRINT FUNCTION		ACTION	LEAD	ASSURANCE SYSTEM	TIMESCALE	PROGRESS
SETTING THE DIRECTION	1	Reconfirm the Board's strategic direction, and communicate this through the Strategy Map and development of strapline statement for corporate documents.	CEO	CEBM	June 2019	**Completed:** Strapline finalised following hospital wide competition. Strategy Map reviewed as part of review of Corporate Objectives.
	2	Review of effective rostering system within nursing as component of focus on effective workforce utilization and safe staffing legislation.	Director of Nursing and AHPs	SMT	March 2020	**On Track**. Work is ongoing to ensure effective rostering is in place with the support of electronic systems. Currently testing SSTS eRostering module in one ward with a view to rolling this out wider. Restrictions on effective rostering remain due to fixed shift pattern; alternative, flexible shift pattern introduced for all new appointments to ward nursing posts. This has increased capacity and much more flexibility to support effective rostering. Internal Audit are undertaking work in January to review preparedness for safe staffing legislation.
	3	Development of more robust processes to compare planned and actual spend and to account for any variance.	Director of Finance & PM	SMT /Board	September 2019	**Completed:** Process in place- Planned and actual £ spend per budget line reviewed with each individual budget holder on a line-by-line basis from the 2019/20 mid-year 6-month

						reviews (30/9/19) – a summary of any significant or material variances is collated to be reported as appropriate.
HOLDING TO ACCOUNT	4	Ensure compliance with new national guidelines in management of Executive pay and performance through remuneration Committee approval for annual ESM pay and performance cycle.	Chair /Interim HR Director	Remuneration Committee	Ongoing	**On Track**
	5	Ensure implementation of attendance management policy through support from HR to line managers help identify and act upon patterns of absence. Continued implementation of the action plan developed through the Attendance Management Improvement Task Group (AMITG).	Interim HR Director	AMITG/ SMT	October 2019	**On Track.** Training for Line Managers and HR Managers implemented. Update presented on attendance management to each Board Meeting. AMITG paused to reflect action plan implemented and wider work plan through Sturrock response.
	6	Implementation and compliance with Once for Scotland HR policies within TSH. Focus on policy awareness through completion of metacompliance / staff bulletins/ staff training in Single Investigatory process.	Interim HR Director	Partnership Forum/SMT	December 2019	**On Track** – to align with roll out of the national guidance.
	7	Review performance framework and assurance information systems to support review of performance.	CEO	CEBM	July 2019	**On Track -** Strategic Review of Performance underway with draft performance framework in development based on balanced scorecard approach of better

						health better care, better value and better workforce. Operational definitions for suggested KPI's being developed with associated data sources identified.
	8	Blueprint Improvement Plan to be placed on Board Workplan for review at each Board Meeting.	Chair	Board	June 2019	**Completed**
ASSESSING RISK	9	Further development of risk management with focus on risk register to ensure this is clearly defined with set of mitigating measures against each risk which also have a focus on improvement actions.	Director of Finance	Audit Committee / Board	December 2019	**Update:** Underway through closer Risk Register monitoring and review process (managed by Risk Team Leader) and reporting to Risk Finance and Performance Group – All risk register items either now with action plan in place or underway. Board Workplan 2020 to include regular updates on Corporate Risk Register.
ENGAGING STAKEHOLDERS	10	Review and develop the Communications Strategy to include proactive engagement with aim of addressing dissonance between strategic aims of the hospital and public perception of these aims.	CEO	Board	March 2020	**Review of media strategy in progress:** with regular updates to the Board.
	11	Promotion of The State Hospital as an employer in the local area. Increase number of modern apprenticeships.	Interim HR Director	SMT	March 2020	**Ongoing** – engagement work commenced at university level to recruit new graduates to nursing

		Participate in local school careers events, local and university recruitment fairs				posts. This was trialed in one University and plan is to roll out further for 2020 graduates. Further recruitment to take place early 2020 for registered nurses.
	12	Encourage carers / volunteers /staff / local population to attend public Board Meetings through additional promotion and links with local community.	Board Secretary	Board	September 2019	**On track** – through promoting Board Meetings and in due course Annual Review session in 2020.
	13	Hold two Board Meeting each year at external locations to promote role as national Board.	Board Secretary	Board	April 2020	Planning in place for external Board Meetings.
	14	Annual Review - Public Meeting to be held outside of the hospital to help engage public engagement and attendance.	Board Secretary	Board	April 2020	Plan to be progressed as part of Annual Review planned expected summer 2020.
INFLUENCING CULTURE	15	Define culture in The State Hospital in terms of key strengths and weaknesses - take forward through development sessions	CEO	Board	December 2019	**Review in progress** – progressed in conjunction with response to Sturrock and update to December Board.
	16	Implement a Staff Recognition Scheme for long service as well as individual contribution to the organisation.	Interim HR Director	SMT	September 2019	**Completed**- first ceremony 24 October 2019.
	17	Embed a culture of quality across the organisation through initiatives such as TSH3030, Quality Forum and sharing our work more widely.	CEO	SMT	March 2020	**On Track** - QI Forum initiatives underway. TSH 3030 took place successfully in November 2019, with update to Board in December.

	18	Senior Management visibility through regular front line staff engagement meetings with CEO / Directors' Group - plan a calendar of events to ensure regular engagement.	CEO	SMT	July 2019	**On Track** - CEO Business Meetings venue held weekly across site, for visibility. CEO attending staff groups across site. OD Lead supporting wider engagement plan across TSH – progressed in conjunction with response to Sturrock.
	19	Senior Team / RMO presence at key events in hospital calendar e.g. patient learning awards/ sportsman dinner. Promote this through management structures.	CEO / Medical Director	SMT	September 2019	**On Track** -Coordination of central diary of events to help facilitate attendance.
	20	Link in with Scottish Government once appointment of the Independent National Whistleblowing Champion has been appointed.	CEO	Board	April 2020	**On Track** National Recruitment process underway.
	21	Plan a schedule of Non-Executive Director informal visits across TSH to help promote the values and behaviours of the organisation.	Chair	Board	August 2019	**On Track** -Approval at August Board, for planned schedule including walkrounds, staff induction and patient engagement, and taken forward in 2020.

Board Paper 19/100

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2019
Agenda Reference:	Item No. 20
Sponsoring Director:	Chief Executive Officer
Author(s):	Board Secretary
Title of Report:	Corporate Leadership
Purpose of Report:	For Noting

1 SITUATION

The corporate management structure should be reviewed and refreshed regularly to ensure to ensure effective development and oversight of strategy, policy and performance against the NHS Board's agreed corporate objectives; and to provide effective reporting to the NHS Board in these areas.

2 BACKGROUND

Review of the existing structure to support corporate management within The State Hospital (TSH) is required to ensure continuation of effective governance.

The corporate leadership of the organisation should manage the business of the NHS Board through the development and endorsement of Board strategy and policies. This should ensure that a corporate positon is achieved prior to submission to the Board and its Standing Committees for consideration and decision-making.

3 ASSESSMENT

A benchmarking exercise has been carried out with other NHS Boards to consider the structures in place across NHS Scotland and to help consideration of whether a change to the present structure within TSH should be taken forward.

From this exercise, it can be seen that the structure within TSH is somewhat flatter in comparison to other NHS Boards; with evidence of a more layered and structured approach in place across NHS Scotland to facilitate and support strategic leadership and oversight of policy and performance.

A new Corporate Management Team (CMT) will now be formalised, with clear terms of reference in place, and will meet fortnightly. In conjunction to this, the Senior Management Team (SMT) will continue to function with oversight of the operational functions of the organisation. To ensure effectiveness, SMT will report to the CMT, acting as an additional mechanism on key operational areas to highlight any potential areas of concern.

There should also be a link from the Partnership Forum to the CMT, to facilitate partnership working and the Employee Director should continue to sit as a member of SMT. In addition, the Employee Director should be in attendance at CMT by invitation on key sessions arranged to discuss strategy and policy on workforce issues. This structure will continue to underpin strong partnership working within TSH.

This revised structure should be a platform from which to generate a review of reporting within TSH, within each discipline taking into account the remit of the group receiving reporting, and the purpose of the report being submitted. This will support the CMT with an effective flow of information to underpin informed decision-making and to support the achievement of the Board's aims and objectives.

The CMT will report directly to the Board, through a number of avenues including the Chief Executive's update submitted to each meeting, as well as reporting through each Executive Lead for their remit. This new structure will strengthen the corporate leadership of TSH to provide the Board with expert advice on how to take forward the corporate objectives of the organisation as well as the ability to monitor performance across all metrics, from a fully informed position.

The CMT key functions should encompass the following:

- Provision of clinical service delivery for high quality service and consideration of patient and staff feedback;
- Planning in the development of proposed strategic direction;
- Security of the hospital;
- Leadership in the Board's financial plan and delivery of financial performance;
- Oversight of a robust performance management framework and implementation of the Annual Operational Plan;
- Oversight and delivery of the Workforce Plan.
- Risk, including oversight of the Corporate Risk Register and Health and Safety;
- Property and Asset Management.

The revised structure should include reporting to the CMT from the following groups:

- Clinical Governance Group
- Security Governance Group
- Health, Safety and Welfare Committee
- IT Sub-Group
- Information Governance Group/ FOI Committee
- Capital Group
- Risk, Finance and Performance Group
- Person Centred Improvement Group

4 RECOMMENDATION

The Board is invited to note the following developments:

- A revised corporate structure, led by the Corporate Management Team.
- The terms of reference of SMT and other reporting groups will undergo refresh to reflect this structure.
- Note the refresh of reporting arrangements to the Board, linked through the Board workplan and led by the Corporate Management Team.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support the Board's Corporate Objectives and strengthen reporting to the NHS Board
Workforce Implications	Not applicable
Financial Implications	Not applicable
Route To Board Which groups were involved in contributing to the paper and recommendations.	Executive Team
Risk Assessment (Outline any significant risks and associated mitigation)	As outlined within report
Assessment of Impact on Stakeholder Experience	As outlined in report
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not relevant
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2019
Agenda Reference:	Item No: 21
Sponsoring Director:	Chief Executive Officer
Author(s):	Board Secretary
Title of Report:	Board Workplan – 2020
Purpose of Report:	For Decision

1 SITUATION

The Board requires to review its workplan for the coming year to to identify the key considerations and actions required during 2020.

2 BACKGROUND

The Board considers and approves a workplan annually, and the Board Secretary will support the Board by ensuring that each component part of the workplan is allocated to meeting(s) throughout the year.

3 ASSESSMENT

The updated Board Workplan for 2020 is attached.

In particular, the Board is asked to note the reporting arrangements for the implementation of the Clinical Model to April 2020, followed by quarterly review reporting on the impact and effectiveness of the new model.

The Board will receive updates in relation to preparation for the enactment of Health and Care Staffing legislation, followed by compliance reporting to the Board.

A Quality Assurance and Improvement report will be brought to each meeting of the Board as a piece of additional assurance reporting, dedicated to and summarising all the work in this remit (e.g. complaints/ clinical effectiveness indicators) as well as a key focus on Quality Improvement. This will be a consolidated report to bring together reporting made separately to the Clinical Governance Committee throughout the year.

The Board will undertake a refresh of security arrangements during the coming year, with a Project Board being established. Given the sensitivity around security arrangements for The State Hospital, elements of reporting will be made in private session. However, at the same time there will be transparency through progress reporting to the public session of the Board.

The Corporate Risk Register has been added as a standing item to the Workplan meaning that the Board will review this at each meeting; and will also have an opportunity to decide whether any item discussed at each meeting would necessitate it being added to the register. This will be supported by an annual Risk Management Report, as well as resilience reporting to each meeting on a standing basis.

4 RECOMMENDATION

The Board is asked to:

- Review the revised workplan and advise whether this provides a robust structure for the consideration and scrutiny of the Board's business in 2020.

- To consider any addition required and/or to approve the plan.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support the Board's Corporate Objectives and strengthen reporting to the NHS Board
Workforce Implications	Not applicable
Financial Implications	Not applicable
Route To Board Which groups were involved in contributing to the paper and recommendations.	Executive Team
Risk Assessment (Outline any significant risks and associated mitigation)	As outlined within report
Assessment of Impact on Stakeholder Experience	As outlined in report
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not relevant
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: BOARD BUSINESS 2020

27 February 2020	23 April 2020	18 June 2020	27 August 2020	22 October 2020	17 December 2020
• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report • Annual Schedule of Board/Committee meetings	• Board Minute and Actions • Chair's Report • CEO Report
• Governance Committee Minutes • Clinical Forum Minutes • Corporate Governance Blueprint Update	• Governance Committee Minutes • Clinical Forum Minutes • Board Effectiveness Self-Assessment *(date tbc)* • Corporate Governance Blueprint Update • Annual Review Planning Update – 2019/20	• Governance Committee Minutes • Clinical Forum Minutes • Governance Committee Annual Reports • Clinical Forum Annual Report • Corporate Governance Blueprint Update	• Governance Committee Minutes • Clinical Forum Minutes • Corporate Governance Blueprint Update	• Governance Committee Minutes • Clinical Forum Minutes • Corporate Governance Blueprint Update • Annual Review 2019/20 Feedback	• Governance Committee Minutes • Clinical Forum Minutes • Corporate Governance Blueprint Update

27 February 2020	23 April 2020	18 June 2020	27 August 2020	22 October 2020	17 December 2020
• Clinical Model Implementation Plan • Patient Learning Annual Report • Consultant – Annual Report • Patient Advocacy Annual Report *(deferred from Dec 2019*) • Patient Safety, Infection Control and Patient Flow Report	• Patient, Carer & Volunteer Stories • Clinical Model Implementation Update • Nurse and AHP Revalidation – Update • Quality Assurance and Improvement • Patient Safety, Infection Control and Patient Flow Report	• Clinical Model Implementation Update • Skye Centre 12 Monthly Report • Forensic Network Annual Report • Quality Assurance and Improvement • Patient Safety, Infection Control and Patient Flow Report	• Patient, Carer and Volunteer Stories • Clinical Model Review Quarter 1 • Implementation of Specified Persons Annual Report • Medical Education Annual Report • Duty of Candour Annual Report • Quality Assurance and Improvement • Patient Safety, Infection Control and Patient Flow Report	• Clinical Model Review – Quarter 2 • Medical Appraisal and Revalidation Annual Report • Quality Assurance and Improvement • Patient Safety, Infection Control and Patient Flow Report	• Patient, Carer and Volunteer Stories • Person Centred Involvement Annual Report • Patient Advocacy Annual Report • Quality Assurance and Improvement • Patient Safety, Infection Control and Patient Flow Report
• Attendance Management – Update • Safe Staffing – Update • Sturrock Action Plan Update	• Attendance Management Update • Workforce Plan • Safe Staffing – Update • Sturrock Action Plan Update	• Attendance Management Update • Safe Staffing Report • Sturrock Action Plan Update	• Attendance Management Update • Safe Staffing Report • Sturrock Action Plan Update	• Attendance Management Update • Safe Staffing Report • Sturrock Action Plan Update	• Attendance Management Update • Safe Staffing Report • Sturrock Action Plan Update
• Finance Report • Draft Corporate Objectives • Draft Annual Operational Plan • Performance Report Quarter 3 – 2020/21 • Corporate Risk Register • Resilience Reporting	• Finance Report • Annual Review of Standing Documentation • Corporate Risk Register • Project Board Update • Resilience Reporting	• Finance Report • Annual Accounts • Performance Annual Report 2019/20 • PAMS Submission • Corporate Risk Register • Project Board Update • Resilience Reporting	• Finance Report • Performance Report Quarter 1 – 2020/21 • Communications Annual Report • eHealth Annual Report • Corporate Risk Register • Project Board Update • Resilience Reporting	• Finance Report • Corporate Risk Register • Risk Management Annual Report • Project Board Update • Resilience Reporting	• Finance Report • Performance Report Quarter 2 -2020/21 • Information Governance Annual Report • Corporate Risk Register • Project Board Update • Resilience Reporting

THE STATE HOSPITALS BOARD FOR SCOTLAND

Draft Minutes of the meeting of the Audit Committee held on Thursday 10 October 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

PRESENT:

Non-Executive Director	Bill Brackenridge
Employee Director	Tom Hair
Non-Executive Director	David McConnell **(Chair)**

IN ATTENDANCE:

Internal

PA to Finance and Performance Management Director	Fiona Higgins **(Minutes)**
Procurement Manager	Mary Frame *(Item 11)*
Chief Executive	Gary Jenkins
Finance and Performance Management Director	Robin McNaught
Interim Human Resources Director	Kay Sandilands *(Items 6 and 7)*
Risk Management Team Leader	Nicola Watt *(Item 12)*

External

Auditor, Scott Moncrieff	Mhairi MacMillan *(excluding item 16)*
Head of Internal Audit, RSMUK	Marc Mazzucco *(excluding item 16)*
Senior Manager, RSMUK	Asam Hussain *(excluding item 16)*
Auditor, RSMUK	Sue Brookes *(excluding item 16)*

1 APOLOGIES

David McConnell chaired the meeting and welcomed those present, introducing Mhairi MacMillan of Scott Moncrieff to her first meeting.

Apologies for absence were noted from Terry Currie; Maire Whitehead and Monica Merson.

In order to accommodate diary commitments for two of the presenters it was agreed that Items 11 – Procurement Strategy and Annual Report and 12 – Risk Management Annual Report would be heard at the start of the meeting, the running order of the minute has not been amended to reflect this rather it has been kept in line with the published agenda.

2 CONFLICTS OF INTEREST

Marc Mazzucco advised of a conflict of interest at agenda item 16 – Internal Audit Review and members agreed that this item would be heard following the main meeting and would be held in private with Audit Committee members only in attendance, again the running order of the minute has not been amended to reflect this rather it has been kept in line with the published agenda.

3 MINUTES OF THE PREVIOUS MEETING OF 20 JUNE 2019

The Minutes of the previous meeting held on 20 June 2019 were **approved** as an accurate record.

4 MATTERS ARISING - ACTION NOTES UPDATE

Members **noted** that all actions were either complete or were on the agenda for further discussion.

INTERNAL AUDIT

5 PROGRESS REPORT 2019/20, INCLUDING TRACKING REPORT

Members received and noted a Progress Report on 2019/20 Internal Audit work for the period to date, which was presented by Marc Mazzucco, Head of Internal Audit, RSMUK. The report provided an update on progress against the internal audit plan, approved at the Audit Committee in March 2018. To date a Sickness and Absence Management Audit has been undertaken with an outcome of Reasonable Assurance and a Payroll Audit with an outcome of Partial Assurance, both of these are on the agenda.

Work continues on progressing actions from previously agreed audit management actions and a status update on these actions is provided within the Tracking Report which accompanies the Progress Report. Members agreed with the approach being taken by RSMUK in ensuring that the timelines for actions accurately reflect the scope, scale and implementation work required to realistically complete the action.

In relation to the Audit Plan as approved in March 2018 it was agreed that changes may be required in relation to the timings of the Clinical Model Audit and the Security Post Project Evaluation.

Members **noted** the Progress Report and Tracking Report and the possible change to the Audit Plan which will be discussed further at the next meeting,

6 PAYROLL – FINAL INTERNAL AUDIT REPORT

Members received and noted the finalised report following the internal audit of Payroll which was presented by Asam Hussain, Senior Manager, RSMUK. The report's conclusion was noted as Partial Assurance, with the undernoted areas of weakness identified within the current operating controls:

- Authorised Signatory List not being utilised by Human Resources
- Timing of input of new starts and leavers
- No monitoring of changes applied to eESS payroll system
- Errors noted within SSTS entries, including pre-authorisation of overtime

David McConnell noted the Partial Assurance outcome of the audit and the importance of early action. Kay Sandilands responded to the report by advising that in relation to the eESS system, a new National Operating System was implemented at the State Hospital in April 2019, but still requires the manager self service functionality to go live; this would have resolved the errors noted. It is expected that this function will be fully compliant with the Hospital Standing Financial Instructions by the end of this year. In relation to monitoring of changes, as this is a new system staff are only now aware of how the system can be interrogated and reports created to ensure checks are in place. However the early indications of the issues arising from the audit have been helpful in order to promptly address the issues arising from the implementation of a new system.

ACTION: KAY SANDILANDS

In relation to the authorisation of timesheets in advance of the overtime being worked Gary Jenkins agreed that he would discuss the implementation of a more robust process through the Senior Management Team.

ACTION: GARY JENKINS

Members **noted** the conclusions of the audit, the recommendations made and the planned management actions.

7 SICKNESS AND ABSENCE MANAGEMENT – FINAL INTERNAL AUDIT REPORT

Members received and noted the finalised report following the internal audit of Sickness and Absence Management which was presented by Kay Sandilands, Interim Human Resources Director. The report provided the Audit Committee with an outcome of Reasonable Assurance in what is traditionally a challenging area for the Hospital. Members noted the significant reduction in the absence rate from 9.9% in June 2018 to 5.34% in May 2019 against a target of 5% absence as set by the Scottish Government.

Kay Sandilands informed members that the decrease was as a result of continued effort by both Human Resource staff and hospital line managers. This had been despite the challenges associated with changes to trigger points following issuing of interim PIN Guidance in advance of the finalised Attendance Management Policy from the Scottish Government as part of the Once for Scotland Policy Suite due to be received in March 2020, which may result in further changes to the trigger matrix.

Members **acknowledged** the progress made and the continued improvements with policy compliance and absence management and **noted** the recommendations within the audit which Sue Brooke confirmed that the Hospital had implemented.

8 UPDATED INTERNAL AUDIT PLAN AND STRATEGY 2019/20

Members received and noted an updated Internal Audit Plan and Strategy for the period 2019/20 which was presented by Marc Mazzucco, Head of Internal Audit, RSMUK, who highlighted the proposed change, as detailed on page 10 of the report, where the Risk Management Audit has been moved to 2021/22 in light of both the Critical Planning and Business Continuity Audits and the Incident Management Audit taking place in quarters 1 and 3 of 2020/21.

Members also noted that, as discussed at item 5, it may be necessary to move the audits of both the Clinical Model and the Security Post Project Evaluation. Confirmation of this will be provided to the January Audit Committee. Mark Mazzucco advised that if this was necessary there were options for moving Rostering and Scheduling of Workforce Audit and Clinical Observation Audit.

David McConnell asked that future reports have a covering paper which highlights any proposed changes or key issues.

ACTION: RSMUK

Members **agreed** to the proposed change to the Internal Audit Plan to move the Risk Management Audit to 2021/22.

ACTION: RSMUK

OTHER ISSUES

9 FRAUD UPDATE

Members received and noted an update on fraud allegations and notifications received from Counter Fraud Services, which was presented by Robin McNaught, Finance and Performance Management Director. Robin advised that since the previous Audit Committee, two alerts had been received, both now closed with no further actions required. One further alert, reported by the State Hospital, has been highlighted to Counter Fraud and will be included in the next update to the January Committee. This is in relation to a current contract where an accusation of third party involvement was raised. The January report will also include the conclusion of the investigation into the allegation that a staff member received payment for hours not worked.

ACTION: ROBIN McNAUGHT

Members noted the content of the alerts circulated by Counter Fraud Services in the last quarter and the update on fraud allegations.

10 FRAUD ACTION PLAN

Members received and noted an update on the Board's approach to countering fraud and the level of engagement with Counter Fraud Services based on the discussions from the annual customer engagement visit. The update was presented by Robin McNaught, Finance and Performance Management Director, who advised that, as detailed within the report, the last annual prevention meeting to discuss the services available in the Counter Fraud Services Work Plan was held in October 2015. Despite several attempts to arrange this, staffing issues at Counter Fraud Services has prevented this from moving forward.

Marc Mazzucco advised that RSMUK have a Fraud Action Team and suggested that perhaps they could attend the Hospital to undertake a review / provide an awareness / focus on fraud session, over a 5 to 10 day period.

Members agreed that this would be a helpful approach and would be proactive in raising awareness of fraud across the site and agreed that Gary Jenkins and Robin McNaught would discuss this further outwith the meeting.

ACTION: ROBIN McNAUGHT/GARY JENKINS

Members **noted** the progress on engagement activities; **noted** the update on Communication; **reviewed** the Fraud Action Plan (appendix 1) and **noted** the review of the top ten risks identified from the FRAM (appendix 2).

11 PROCUREMENT STRATEGY AND ANNUAL REPORT

Members received and noted the Procurement Strategy for the period 2018/2021 and Annual Report for the period April 2018 to March 2019 which was presented by Mary Frame, Procurement Manager, who advised that the report is required by the Scottish Government in order to ensure there is a continuous drive across all Boards to achieve excellence in procurement activities and focusses on the Regulated Procurement of purchases and contracts in excess of £50k. Members noted that in light of the small size of the organisation and its minimal requirement for procurement purchases over £50k that in the main the return is not highly reflective of the work undertaken by the department.

The Annual Report provided a summary of the regulated procurement expected to be undertaken in the next two years, including:

- Security Upgrade to Perimeter Fence
- Refurbishment of Harris Building
- Replacement of eHealth Wireless Network Infrastructure
- Staff Rostering System
- Security Vehicle refresh
- Patients Advocacy Service
- Fire and Security
- Biomass Fuel Supply

The report also detailed the collaborative work undertaken by the department with the National Health Boards Procurement Group which focusses on collective targeted savings through joint working across the National Procurement community. Being part of this has allowed the Hospital to benefit from the ability to purchase unique products at competitive prices.

Not contained within the report but key to the work and overall business of the Procurement Department members noted that National Procurement are well prepared for any EU Exit issues with no concerns to highlight in relation to the State Hospital.

Members also noted that the implementation of a new Provaleado software will allow the department to accurately record savings that it makes across the financial year and will be an interesting addition to next year's annual update to the Audit Committee.

ACTION: ROBIN McNAUGHT/MARY FRAME

Robin McNaught commented on the significant amount of work undertaken by a small Procurement Department across various areas of work and noted his thanks to the department for their commitment and efforts throughout the year.

Members agreed it was a detailed and useful report and thanked Mary Frame for her presentation to the Committee.

The Procurement Strategy for the period 2018 to 2021 had been presented to the Audit Committee for approval last year and is presented this year for information with no changes to its content.

Members **noted** both the Procurement Strategy for the period 2018/21 and the Annual Report for the period 2018/19.

12 RISK MANAGEMENT ANNUAL REPORT

Members received and noted the Risk Management Annual Report for the period April 2018 to March 2019 which was presented by Nicola Watt, Risk Management Team Leader. The report provided a summary of the work undertaken by the Risk Management team over the reporting period and provides information relating to proposed pieces of work for the 2019/20 period, including:

- Supporting various Committees and Groups, including Health and Safety, Resilience, Risk, Finance and Performance and Patient Safety
- Management of Corporate and Local Risk Registers
- Resilience Planning
- Health and Safety
- Category 1 and 2 Reviews
- Complaints and Claims
- Datix Incident Management
- Participation in National Forums

Members agreed this was a detailed and useful report and thanked Nicola Watt for her presentation to the Committee.

Bill Brackenridge noted the significant rise in patient complaints for the period 2017/2018 in comparison the previous and post reporting period and Nicola Watt advised that this was in relation to two separate issues, a focus on the adherence of the Patient Telephone Policy and removal of bedroom chairs, both of which were undertaken without prior consultation with patients thus resulting in a significant increase in complaints. Lessons from this were learnt. Members were pleased to note that in relation to the new Complaints Procedure a more meaningful engagement process resulting in a positive responsive to ownership of issues and quicker resolution has been a positive benefit for both staff and patients.

Members were assured that a robust process is now in place in relation to auditing of the Hospital's Health and Safety Control Books, this has resulted in increased compliance levels and is monitored through the Hospital's Health and Safety Committee.

In relation to the Corporate Risk Register and as detailed in the September Risk, Finance and Performance minutes, which are presented to the Committee at agenda item 14 for information. Members noted that the Risk, Finance and Performance Group focus on all high risks and corresponding action plans. This will provide assurance to the Audit Committee that the risk and mitigations are being monitored and that control measures are sufficient to address the risk. The Risk, Finance and Performance Group further agreed that the governing Board Sub Committees should also be sighted on any high risks which fall within their remit to allow the sub committees the opportunity for further scrutiny.

Robin McNaught commented on the significant amount of work undertaken by a small Department, experiencing staffing shortages, and providing support across various areas of work and noted his thanks to the department for their commitment and efforts throughout the year.

Members **noted** the content of the report and the significant amount of work undertaken by the department during the reporting period and noted that this had been presented to the Risk, Finance and Performance Group in September 2019.

13 POLICY UPDATE REPORT

Members received and noted the six monthly report on policy implementation across the Hospital, which was presented by Sheila Smith, Clinical Effectiveness Team Leader. The report detailed that, since the previous report, of the 132 policies currently in place across the Hospital:

- 44 policies are outwith the agreed review date, which excludes the Human Resource Policies which form part of the Once for Scotland Policy Suite
- 12 policies are at consultation stage
- 12 policies have been updated and approved
- 8 policies have been uploaded to the State Hospital website
- 3 policies are scheduled for metacompliance

Members noted that focus is now being placed on the 44 policies which are outwith the agreed review date.

Members noted their concern that the number of out of date policies had doubled in comparison to the previous year and Gary Jenkins agreed that a framework to ensure directors take accountability for policies within their areas would be developed, with overall responsibility sitting with the Finance and Performance Management Director and linked to the Chief Executive.

ACTION: SHEILA SMITH / ROBIN McNAUGHT

Members agreed that training and education for Policy Owners would assist with ensuring appropriate review dates and compliance with process. Sheila Smith advised that training will be rolled out on conclusion of new / updated guidance.

It was agreed that a target of reducing the out of date policies to 18 be set and that this be actioned in consideration of the policy risk rather than those that are easy to update.

ACTION: SHEILA SMITH

Members **noted** the content of the report and provided the advice noted above in order to speed up the policy review timeline.

14 RISK, FINANCE AND PERFORMANCE GROUP – MINUTES: 21/2/19; 24/7/19 AND 21/9/19

Members received and **noted** the minutes from the Risk, Finance and Performance Group for its meetings held on 21 February; 24 July and 21 September 2019 which were presented for information.

15 DRAFT AUDIT COMMITTEE WORKPLAN 2020

Members **approved** the Audit Committee Workplan for the period January to December 2020.

ACTION: FIONA HIGGINS

16 INTERNAL AUDIT REVIEW

Item held in private.

17 ANY OTHER BUSINESS

There was no other competent business.

18 DATE AND TIME OF NEXT MEETING

The next meeting is proposed to take place on Thursday 23 January 2020 at 9.45am in the Boardroom.

THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 27 FEBRUARY 2020
9.45am

Jerviswood Hall, Lanark Memorial Hall,
13 St Leonard St. Lanark
ML11 7AB

A G E N D A

1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 19 December 2019	For Approval	TSH(M)19/13
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 20/01
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
	CLINICAL GOVERNANCE		
7.	**Clinical Service Delivery Model Implementation Planning and Governance Arrangements** Report by the Chief Executive	For Decision	Paper No. 20/02
8.	**International Travel Request** Report by the Medical Director	For Decision	Paper No. 20/03
9.	**Patient Safety, Infection Control and Patient Flow Report** Report by the Director of Nursing and AHPs	For Noting	Paper No. 20/04
10.	**Patient Advocacy Service – Annual Report** Sponsored by the Director of Nursing and AHPs	For Noting	Paper No. 20/05
11.	**Clinical Governance Committee** Approved Minutes of meeting held 14 November 2019 Chairs Report of meeting on 13 February 2020	For Noting	CGC(M)19/04
12.	**Clinical Forum** Approved minutes of meeting held 5 December 2019	For Noting	CF(M)19/04
	STAFF GOVERNANCE		

13.	**Attendance Management – Board Update** Report by the Interim Director of HR	For Noting	Paper No. 20/06
14.	**Staff Governance Committee** Approved Minutes of meeting held 29 November 2019	For Noting	SG(M)19/04

CORPORATE GOVERNANCE

15.	**Draft Corporate Objectives** Report by the Chief Executive	For Decision	Paper No. 20/07
16.	**Draft Annual Operational Plan** Report by the Chief Executive	For Noting	Paper No. 20/08
17.	**Project Oversight Board – Update and Governance Arrangements** Report by the Director of Security, Estates and Facilities	For Noting	Paper No. 20/09
18.	**Finance Report to 31 January 2020** Report by the Finance & Performance Management Director	For Noting	Paper No. 20/10
19.	**Performance Report – Quarter 3 2019/20** Report by the Finance & Performance Management Director	For Noting	Paper No. 20/11
20.	**Resilience Reporting** Report by the Director of Security. Estates and Facilities	For Noting	Paper No. 20/12
21.	**Corporate Governance – Improvement Plan Update** Report by the Board Secretary	For Noting	Paper No. 20/13
22.	**Audit Committee** Chair's Report of meeting held 23 January 2020	For Noting	Verbal
23.	**Corporate Risk Register** Report by the Finance & Performance Management Director	For Discussion	Paper No. 20/14
24.	**Any Other Business**		
25.	**Date and Time of next meeting** 23 April 2020, 9.45am in the Boardroom at The State Hospital.		

26. EXCLUSION OF PUBLIC AND PRESS

To consider whether to approve a motion to exclude the Public and press during consideration of the items listed as Part II of the Agenda in view of the confidential nature of the business to be transacted.

THE STATE HOSPITALS BOARD FOR SCOTLAND TSH (M) 19/13

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 19 December 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

Chair:	Terry Currie
Present:	
Non-Executive Director	Bill Brackenridge
Employee Director	Tom Hair
Chief Executive	Gary Jenkins
Non-Executive Director	Nicholas Johnston
Non-Executive Director	David McConnell
Director of Finance and Performance Management	Robin McNaught
Director of Nursing and AHPs	Mark Richards
Medical Director	Lindsay Thomson
In attendance:	
Head of Communications	Caroline McCarron
Head of Corporate Planning and Business Support	Monica Merson
Interim HR Director	Kay Sandilands
Board Secretary	Margaret Smith
Person Centred Improvement Advisor	Leanne Tennant
Director of Security, Estates and Facilities	David Walker

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Currie welcomed everyone to the meeting, and apologies were noted from Mrs Maire Whitehead, as well as from Ms Aileen Burnett, Chair of the Clinical Forum.

2 CONFLICTS OF INTEREST

There were no declarations of conflicts of interests from Members in respect of the business to be discussed at this meeting.

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 24 October 2019 were noted to be an accurate record of the meeting, subject to a minor amendment to Item 12, Clinical Governance Committee, to note that Mr Johnston had not been present at the meeting, and that the Board had noted the content of the minute submitted.

The Board:

1. Approved the minute of the meeting held on 24 October 2019.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board noted progress on the action points from the last meeting with each item completed.

The Board:

1. Noted that the action list was up to date.

5 CHAIR'S REPORT

Mr Currie reported on two meetings of the NHS Chairs' group, which had taken place on 28 October 2018 and 9 December 2018.

Mr John Sturrock QC had attended at the meeting on the 28 October 2018, and his message had been for NHS Chairs both to encourage open dialogue within the Board setting, as well as to challenge Ministers when appropriate. At this meeting the Cabinet Secretary had highlighted the key importance of Health and Social Care integration with a huge shift in this expected this year. NHS Chairs had been advised that a national directory was being compiled in respect of NHS staff who had completed improvement training, with Chairs being asked to report on progress within individual NHS Boards. Mr Currie noted that the position in The State Hospital (TSH) was encouraging with five staff already involved in Quality Improvement Initiatives.

At the meeting on 9 December 2018, the NHS Chairs received a presentation on forensic examination of victims of sexual crimes, given that the NHS would shortly be taking responsibility for this.

The Cabinet Secretary had highlighted to NHS Chairs that Scottish Government were unable to set a budget within the normal timeframe for 2020/21, as the U.K Government had deferred its budget announcement following the General Election in December 2019, and that a date for publication of the U'K budget had not yet been announced.

The Cabinet Secretary had noted that a national campaign for nursing, and allied health professional staff would be launched shortly. She had highlighted the uptake of the flu vaccine by NHS Staff, and Mr Currie noted that the uptake in TSH was less than 50% and was therefore a key area for improvement.

NHS Chairs had also received a presentation on NHS infrastructure with the challenges faced being many fold. Key areas of the NHS Estate need either refurbishment or replacement in the medium term and a nationally coordinated investment programme would be developed. Chairs were asked to ensure that there was a strong focus on infrastructure within NHS Boards, to understand the status of the existing estate and equipment and plans for maintenance and upgrade to ensure actions were taken to mitigate identified risks.

Mr Currie confirmed that NHS Boards would shortly be informed of the Non-Executive appointment of a Whistleblowing Champion, and that the Frequently Asked Questions note produced by Scottish Government had been circulated to all Board Members.

Mr Currie advised that, along with Mr Jenkins, he had attended a mid-year review meeting with Mental Health Directorate colleagues on 8 November 2019 and noted the positive nature of this meeting.

Along with key members of the Executive Team, Mr Currie had attended the Health and Sport Committee on 3 December 2019 to give evidence to the Committee as part of their remit to scrutinize NHS Boards. The 90 minute session had been a helpful opportunity to answer Committee questions, and it was expected that the Convenor would write to the Chief Executive shortly to ask any follow up questions or seek further clarification on specific points.

TSH had received a visit form the Moderator of the Church of Scotland on 30 October which had been very successful.

On 24 November, the Chair had attended the Scottish Health Awards with members of the Executive Team, where Dr Khuram Khan, Consultant Psychiatrist, had been nominated as a finalist in the Global Citizenship category and this was noted as a fine achievement on his part.

The Volunteers Christmas Lunch had taken place in the hospital on 12 December and had gone very well. Mr Currie added that the annual ecumenical service took place on 16 December.

Finally, Mr Currie advised the Board that the TSH3030 ceremony events had taken place across the hospital on 18 December, and that a further report in this regard would be provided at Item 11 of the agenda for today's meeting.

The Board:

1. Noted the update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins provided the Board with an update of his activities since the date of the last Board meeting.

He had visited Barlinnie Prison with colleagues from Scottish Government on 31 October 2019. .An exchange visit with colleagues from SPS was scheduled to take place to learn about healthcare delivery as a primary function in a high secure environment.

Mr Jenkins confirmed that depending on political developments at a U.K level, The State Hospital EU Exit meetings would re-commence in January 2020.

He advised the Board that following a self-assessment exercise in relation to civil contingencies – assurance had been submitted to Scottish Government in relation to the organisation's planning process. Feedback had since been received from Scottish Government indicating satisfaction with the organisation's resilience planning. This correspondence would be circulated to Board Members.

Action – Ms Smith

Mr Jenkins confirmed that he had attended a mid-year review meeting with the Mental Health Directorate and that key topics included leadership and succession planning. A first draft of the Annual Operational Plan (AOP) for 2020/21 was submitted on 16 December 2019 and this would be reviewed with Scottish Governments colleagues over the next 8 weeks. He noted the requirement to share AOPs across National Boards (when approved).

He advised that he has commenced in his role as Chair of the Police Care Network Board.

Mr Jenkins noted that he has also been invited to chair the National Boards Estates Strategy for Scotland and the National Prisoner Healthcare Network.

Mr Jenkins highlighted the Staff Awards ceremony> He paid tribute to the staff who co-ordinated this very successful event and reflected on the positive feelings which the event had generated both for staff and patients.

He had taken part in staff engagement sessions which had been arranged following the decision made by the Board on the Clinical Model, and noted the positive aspect of these sessions overall across the organisation.

Mr Jenkins had attended a recent Triangle of Care event – advising that a really good presentation had been delivered by the Person Centred Improvement Team and that the model had been adopted and endorsed by The State Hospital

He also provided the Board with feedback following the 'Evidence and Scrutiny of NHS Boards Session' of the Health & Sport Committee on 3 December 2019 – issues had covered leadership, attendance, workforce planning, skill mix, media, communication, forensic estate overall, finances, adolescent services, physical health and obesity, clinical model and the change process.

Mr Jenkins advised that the Acting Chief Executive Officer for NES had attended TSH on 6 December, as part of the 'Sharing Intelligence for Health and Care Group'. This was a positive session with no issues of concern for The State Hospital. Feedback would be issued in writing to TSH in due course and this would be made available to Board Members.

Action – Ms Smith

He had also taken part in the TSH3030 Oscars event within TSH on 18 December, which had been extremely positive and successful, especially the involvement of the TSH Choir and the ceremonies that took place within the Hubs which had enabled patients to take part alongside staff.

A presentation had been received from internal auditors RSM on audit software which will be introduced within TSH as a quality improvement initiative.

Mr Jenkins noted the development of the 'Discovery Tool' for performance benchmarking within NHS Boards – although this tool may not be directly useful within TSH given the nature of services, this development provided an opportunity to explore other options for comparing metrics, possibly with NHS England Benchmarking services.

Mr Jenkins also noted that the establishment of a Centre of Excellence for Infection Control and Building Standards is being taken forward by National Services Scotland.

Finally, Mr Jenkins had attended national NHS Chief Executive Officer meetings in November and December 2019.

The Board:

1. Noted the update from the Chief Executive Officer.

7 VOLUNTEER STORY

Ms Leanne Tennant provided a presentation to the Board, from a volunteer at the hospital who had been working with patients in the Skye Centre on therapeutic gardening.

This volunteer story was from an individual who was working towards a masters degree qualification in psychology and who had become a volunteer within TSH to help build her professional skills. Her story was one in which her experience at TSH had exceeded her expectations and which she had found to be both personally rewarding as well as enhancing her skills with patients.

This story was received very warmly by the Board, who noted the mutually beneficial nature of this volunteer's experience. Board Members considered that this type of experience, personally related, may be helpful in promoting the excellence of care provided at TSH, as well as the positive nature of employment within the hospital.

Mr Currie thanked Ms Tennant for the presentation, and asked her to relay the Board's appreciation of the work carried out by the Person Centred Improvement Team.

8 CLINICAL SERVICE DELIVERY MODEL (INCORPORATING UPDATE ON STURROCK RESPONSE)

A paper was received from the Chief Executive Officer and Medical Director, which provided the Board with a detailed overview of the proposed implementation process for the new clinical service delivery model. The paper confirmed that the Board was being asked to endorse the detailed planning implementation process allowing TSH to transition into a ten ward model based on eight major mental illness wards and two intellectual disability wards, taking note of the deliverables in each workstream plan.

Mr Jenkins provided the Board with a summary of the series of engagement exercises undertaken across TSH since the Board Meeting on 24 October 2019, when the Board had approved the new Clinical Service Delivery Model. These sessions had been arranged to connect with as many staff as possible directly, and had proved to be positive and constructive events. This had been followed by an extended session with the Senior Management Team on 18 December 2019, to outline the proposed way forward including the structure developed of a Clinical Model Oversight Board and six workstreams. This session had also been used to invite members of SMT to consider their own roles and how they could engage in the process.

Mr Jenkins emphasised that a key feature in implementation planning would be ongoing communication and engagement, and that the approach of taking engagement sessions to staff across the hospital would be powerful. In addition, there would be the continuation of strong partnership engagement on each of the workstreams and sub-groups as well as the oversight board.

This represented a comprehensive approach, and as such also linked the TSH approach to the Sturrock report. This would be integrated into implementation planning to ensure that these process could be sequenced together rather than parallel processes. This would be the key focus of the workstream led by Mr Jenkins on Culture, Values and Behaviours and Leadership.

Mr Jenkins advised that it was proposed that the Clinical Model oversight Board would also include key external stakeholders such as the Mental Welfare Commission.

Should the Board endorse the approach outlined, the implementation process would necessarily require to be fast paced especially through the final quarter of 2019/20 and moving into the first quarter of the next financial year. This would be followed by a review period of up to two years as the new model was embedded within the organisation, and also to allow cognisance of the national landscape most notably the independent review of forensic mental health services which was due to report to Scottish Government in June 2020.

Professor Thomson added an update with reference to the Clinical Delivery workstream in which work would require to be progressed quickly to establish the clinical alignment of hubs within the hospital in a way that demonstrated fidelity to the new clinical model. This alignment would necessarily have implications for the review conducted under other workstreams, especially security.

Mr Richards underlined that although the time frame may be challenging, there was significant commitment to the model demonstrated by staff groups and that this would be a key driver in taking the program forward. Mr Currie added his agreement that ownership by staff groups across the hospital was of key importance.

Mr McNaught noted that although there were potential financial benefits, it would be important to get accurate figures during January to March 2020 on expected benefits so that this could be compared to the impact of the new model once implemented.

Mr Hair added his support to the partnership approach being taken, and confirmed that he would share with joint staff side colleagues.

Mr McConnell welcomed the paper, and asked for further assurance on whether a consolidated plan

would be presented to the Board at its next meeting in February. Mr Jenkins confirmed that this would be the case, and that this would be interdependent with the Board's strategic overview for the coming year.

Mr Johnston noted the comprehensive nature of the plan which was linked to a good sense of urgency for implementation. He asked for further consideration on the risk and resilience of the project especially focussed on the resilience of the team to deliver the overall project, especially in the context of the interdependencies of the workstreams. He also asked that in terms of governance arrangements, the CMOB should also provide reporting for the Board's Governance Committees, as well as to the Board itself. Professor Thomson added her agreement that the Clinical Governance Committee would have a key role in terms of guidance.

Action – Ms Merson/Ms Smith

Mr Jenkins acknowledged that given the size of the organisation, there was no dedicated project support team and advised that the Corporate Management Team were committed to ensuring that the project was supported.

Mr Brackenridge added his support to the planned way forward, particularly in the inclusive nature of staff engagement, which would help to facilitate change.

On behalf of the Board, Mr Currie summarised the views around the table in support the recommended program to for implementation of the new clinical model. He recognised the need to continue to deliver care in the hospital; as well as taking forward this project. This paper was helpful in outlining how the new clinical model would be implemented in practice. He summarised the Board's view that the short timescale was the right way forward. He also added that given Ms Haughey, the Minister for Mental Health, had shown strong interest in our work around the Clinical Model, it would be a sensible idea to invite her to the hospital and update her on the progress being made.

The Board:

1. Endorsed the detailed planning implementation process as outlined to allow TSH to transition into a ten ward model based on eight major mental illness wards and two intellectual disability wards
2. Noted the deliverables in each workstream plan.

9 APPROVED MEDICAL PRACTITIONER REQUEST

A paper was received from the Medical Director, which advised that TSH had successfully recruited a Forensic Psychiatry Specialty Doctor – Dr Vicki Gordon. There the Board was asked to approve their Approved Medical Practitioner status.

The Board:

1. Approved Dr Vicki Gordon as Approved Medical Practitioner in line with the Mental Health (Care and Treatment) Act 2003.

10 PATIENT SAFETY, INFECTION CONTROL AND PATIENT FLOW REPORT

A paper was received from the Director of Nursing and AHPs, which summarised activity within the hospital in relation to patient safety, healthcare associated infection (HAI) and patient flow. Mr Richards summarised the report for the Board highlighting the increased uptake of the flu vaccination in the hospital this year. He also noted the work of the Water Safety Group which was led through the Infection Control Committee. A special meeting had been convened on 5 December 2019 to

seek assurance that the hospital was responding appropriately to external recommendations, given that water safety continued to be an area of concern within NHS Scotland.

In answer to a question from Mr McConnell, on whether this should be recorded on the Corporate Risk Register, Mr Walker confirmed that he would seek further advice on this point in terms of whether this should be recorded at local or corporate level, and report back to the Board. He gave assurance on the action taken routinely by the Estates Department to guard against water stagnation in the hospital especially in unoccupied areas. The Board noted the content of this report and asked that Mr Richards being back an update in this regard for continued assurance.

Action – Mr Richards/ Mr Walker

The Board:

1. Noted the content of the report.
2. Requested clarification on how water safety risk was recorded at local or corporate risk register level;
3. Requested a further update on water safety.

11 TSH3030 – 2019

Ms Merson provided the Board with a verbal update on the quality improvement project, TSH3030, which concluded with an Oscar Award ceremony on 18 December 2019.

She highlighted the importance of quality improvement alongside quality assurance and quality planning. There had been improvements across the organisation in 2019, especially in demystifying quality improvement methodology and increasing awareness that quality improvement does not have a clinical focus alone, and can be used in all roles within the organisation. This approach had been supported through QI training online and in delivered sessions. This was a helpful place for staff groups to be, before stepping into a change process through implementation of the new clinical model.

A total of 38 projects had been submitted this year with 28 seen through to completion. There had been 18 Oscars warded in events which took place in the Skye Centre as well as the four hubs.

The projects had been creative and thought provoking and a final poster booklet had been produced, which would be made available to each Board Members.

Action – Ms Merson

On behalf of the Board, Mr Currie gave thanks and appreciation to Ms Merson and her team for their leadership in this project, adding that the Oscars ceremony had been a great experience for everyone involved.

The Board:

1. Noted the content of the update form Ms Merson and offered their thanks and appreciation to her team.

12 CLINICAL GOVERNANCE COMMITTEE

Mr Johnston provided a verbal report on the Clinical Governance Committee which had taken place on 14 November 2019.

The Board noted the key issues discussed included a 12 monthly report on rehabilitation therapies within TSH, and that the discussion item for the committee had been Supporting Healthy Choices.

The increasing BMI for patients continued to be a matter of concern, and a workshop was being arranged to take place in January 2020.

The Board:

2. Noted the content of the update from the Chair of the Clinical Governance Committee for the meeting which took place on 14 November 2019.

13 CLINICAL FORUM

The Board received and noted the minutes of the meeting of the Clinical Forum which took place on 15 August 2019.

In the absence of the Chair of the Clinical Forum, the Board Secretary provided an update on the meeting which took place on 5 December 2019. The Forum had received an update form the Chief Executive on his own activities as well as that of the Board. The Clinical Forum had also invited the Board Chair to attend meetings to provide updates. Ms Merson had also attended to provide an update on implementation planning for the new clinical model. The Forum had welcomed these update reports.

Ms Smith also asked the Board to note the continued establishment of the Clinical Forum within the hospital in its role as an independent advisory committee. Further work would now be taken forward by the Chair to link with the national Area Clinical Forum Chairs Group.

It was noted that Ms Smith would note Mr Johnston's willingness to attend a meeting of the Clinical Forum in his role as Chair of the Clinical Governance Committee.

Action – Ms Smith

The Board:

1. Noted the content of the minutes of the meeting of the Clinical Forum of 14 August 2019 as well as the further update provided by the Board Secretary.

14 WORKFORCE PLAN – UPDATE

A paper was received from the Interim Director of Human Resources, which provided the Board with an update on progress in development of the Workforce Plan, to update the existing plan in place taking into account the Clinical Model endorsed by the Board at its meeting in October 2019.

Ms Sandilands advised the Board that the Implementation Plan for the Clinical Model would inform the framework for the Workforce Plan going forward and would be developed in partnership. She also asked Members to note TSH commitment to the Health and Care (Staffing) (Scotland) Bill which was expected to be enacted in 2020.

The Board:

1. Noted the content of the report.

15 ATTENDANCE MANAGEMENT REPORT

A paper was received from the Interim Director of Human Resources, which outlined staff attendance data over the course of the latest reporting period of September 2019 and placed this within the context of the rolling 12 month figures.

Ms Sandilands advised the Board that although a slight increase had been experienced in the September figure, the rolling 12 month figure continued to demonstrate an overall reduction with the previous 12 month period.

The Board:

1. Noted the content of the report.

16 STAFF GOVERNANCE COMMITTEE

The Staff Governance Committee Chair, Mr Brackenridge, provided an overview of the key points discussed at the meeting held on 29 November 2019 which had included continued close focus on attendance management, staff development and statutory and mandatory training; as well as receipt and discussion of annual reporting from Occupational Health delivery.

The Board:

1. Noted the update from the Staff Governance Committee held on 29 November 2019.

17 FINANCE REPORT AS AT 30 NOVERMBER 2019

The Finance Report to 30 November 2019 was submitted to the Board by the Finance and Performance Management Director, and Members were asked to note the content of this report. Mr McNaught led Members through the report highlighting the key areas of focus notably that the Board was reporting an overall underspend position of £217k.

Mr McNaught asked Board Members to note that the report format has been restructured as requested from previous Board meetings, having the aim of improved clarity of both presentation and explanation, and any observations on the report format would be welcomed.

He advised that while the overtime and nursing staff costs remained the key issue, the improved levels in the last six months had been significant in the overall position. However, continued focus was required on this position to ensure a clear understanding of the specific underlying overtime pressures and causes was in place by March 2020. It would be important to enable meaningful measure of the transition to the new clinical model for comparison to the expected benefits as identified and quantified in advance by nursing through options evaluations – to support the aim of ensuring long-term sustainability.

Mr McNaught advised that the savings requirement in 2019/20 continued to be extremely challenging, and while a reasonable proportion of what was required had been identified though the budget reviews undertaken to date, the Board remained behind trajectory. There also continued to be a risk of savings pressure through the National Boards' Collaborative. Discussion and reviews would continue on individual budget savings plans with the focus remaining on reducing the unidentified savings that were still to be addressed this year, and to reduce the non-recurring proportion. He noted that any current underspend may be required to be utilised to address this. Mr McNaught noted that the capital resource budget was anticipated to be fully utilised in 2019/20.

The Board welcomed the report which demonstrated a much improved position, in comparison to prior years, and noted that this positive position was primarily due to controls implemented successfully in the management of nursing overtime, and to overall cost efficiencies in all directorates. Mr Richards provided a more detailed overview of how this has been progressed including the introduction of a pool of nursing staff, and a continued, close focus on attendance management. At the same time, he asked the Board to note that TSH had experienced a less challenging period clinically during the last quarter and this had also impacted on nursing requirements during this time. Mr Hair raised an issue of detail around the arrangements for staff at handover, and this was agreed to be within the remit of the Partnership Forum and would be remitted

there as appropriate.

Mr Currie asked for further assurance on the cost of staff re-banding appeals in terms of the length of time taken to resolve the appeals, and Mr Jenkins confirmed that this had been recognised and that the Head of Human Resources was taking forward a review of this with the aim of resolving this process going forward to include appropriate control measures. Mr McNaught confirmed that Finance were receiving monthly updates in this respect in terms of any potential financial implications.

The Board thanked Mr McNaught and his team for the refreshed presentation of this report, which was considered to be helpful.

The Board:

1. Noted the content of this report.

18 PERFORMANCE REPORT – QUARTER 2 2019/20

The Board received a paper from the Finance and Performance Management Director, which provided a high level summary of organisational performance for Quarter 2, July to September 2019. Mr McNaught led Members through the report, and asked them to note the re-fresh to the report to include trend analysis. Further, that work was continuing to be progressed on local Key Performance Indicators (KPIs) leading to a new structure for 2020/21.

The Board:

1. Noted the content of this report.

19 CORPORATE GOVERNANCE IMPROVEMENT PLAN

A paper was received from the Chief Executive, which outlined progress made in relation to the Corporate Governance Improvement Action Plan since the date of the last Board Meeting. Ms Smith asked the Board to note that a six month update report was submitted to the Cabinet Secretary in November 2019, and that a repose to this was currently awaited.

Mr Richards confirmed that work continued to be progressed on rostering and preparation for safe staffing legislation with an internal audit to be carried out in January 2020. He also assured the Board that there was continuing and proactive focus on nurse recruitment, particularly in developing links with universities.

Ms Smith acknowledged that there had been some logistical difficulty arranging to have the Board meeting outwith the hospital but that this was being taken forward for the meeting in February 2020. She noted that the Chair had made mention of this at the Health and Sport Committee as part of the Board's plan to engage more widely with the public and that this had been well received. The Board agreed that a strategy should be developed to promote this to the public as well as to local elected officials. There was discussion on the Board's position as a national Board and to consider holding Board Meeting at city and national level as well as locally. It may be helpful to showcase particular work progressed by the Board with relevant to local and national audiences and link the Board Meetings to Question and Answer opportunities for the wider public.

Action – Ms Smith

The Board:

1. Noted the content of this report

20 CORPORATE LEADERSHIP

A paper was received from the Chief Executive, which outlined recent review of the corporate management structure within TSH, to ensure effective development and oversight of strategy, policy and performance against the Board's agreed corporate objectives. Ms Smith provide an overview of the paper highlighting the timely nature of this review to link with the implementation of the new clinical model which encompassed the workstream being led by the Chief Executive on Values Culture Teamwork and Leadership.

The Board was asked to note the formation of a Corporate Management Team to lead on the Board's strategy as well as oversight and accountability for performance. This formalised governance around the Executive Team Leadership with a more structured approach. The Senior Management Team would continue in its role with senior leaders there able to focus effectively on its operational role. Ms Smith underlined the importance of continued strong partnership working with the Employee Director continuing to be a member of SMT and also being invited to CMT particularly for workforce discussions and formation of policy.

The aim is for the CMT to give a stronger platform of reporting into the Board with a clear link into to the work being progressed through the Head of Corporate Planning and Business Support on performance reporting, and this would be evidenced further in the following paper in regard to the Board's Workplan for 2020.

The Board welcomed this report, and found assurance in the revised corporate structure, led by the Corporate Management Team. Further that this structure would strengthen the corporate leadership of the organisation, and to provide the Board with expert advice to take forward the corporate objectives of the organisation as well as the ability to monitor performance across all metrics from a fully informed position.

The Board:

1. Noted the content of this report and endorsed the development of the Corporate Management Team.

21 BOARD WORKPLAN – 2020

The Board received a report which provided a review of the Board Workplan, to identify the key considerations and action required during 2020.

Ms Smith led Board Members through the details of the workplan noting in particular regular reporting arrangements for the Board in relation to implementation of the new clinical model, as well as ongoing quarterly review of the impact of the new model once implemented. She also noted that the Board would receive regular updates on preparation for the enactment of Health and Social Care Staffing legislation, and on compliance reporting thereafter.

A new reporting mechanism would be introduced through a Quality Assurance and Improvement report with the aim of providing an overarching report in these areas. Ms Merson added that the Quality and Assurance report would be a key piece of governance reporting for the Board going forward, and that it would be essential to test the reporting requirements on both austerity assurance and improvement activities.

The Board would receive further reporting in relation to the security re-fresh project to ensure transparent reporting into the public board session as far as possible.

The Corporate Risk Register would be reported to the Board as a standing item to give the Board that assurance and also allow the Board to consider at each meeting depending on the business of

each meeting whether any change or addition should be made. This would be supported further with an annual reporting to the Board on risk management.

Further, Resilience Reporting had been added to the Workplan as added as a standing item to give assurance and focus to the Board on any potential risk on the horizon.

The refreshed Workplan was welcomed by Board, and the additional reporting mechanisms se as being essential additions to give a robust structure for the consideration and scrutiny of Board business in 2020.

The Board:

2. Approved the Board Workplan for 2020.

22 AUDIT COMMITTEE

As Chair of the Audit Committee, Mr McConnell asked the Board to note the minutes of the meeting of the Audit committee on 10 October 2019. He had provided a verbal update on the key issues to the Board at its meeting on 24 October 2019.

The Board:

1. Noted the draft minutes of the meeting of the Audit committee heldon10 october2019.

23 ANY OTHER BUSINESS

Mr Currie congratulated Ms Sandilands on her new appointment as Director of Human Resources for NHS Lanarkshire which she would be commencing in early 2020.

He offered since thanks to Ms Sandilands for her work at TSH and the significant progress made during her time in post as Interim Human Resources Director.

24 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 27 February 2020.

25 EXCLUSION OF PUBLIC AND PRESS

Members approved a motion to exclude the public and press during consideration of the items listed at Part II of the agenda in view of the confidential nature of the business to be transacted.

ADOPTED BY THE BOARD

CHAIR _____
(Signed Mr Terry Currie)

DATE 19 December 2019

MINUTE ACTION POINTS
THE STATE HOSPITALS BOARD FOR SCOTLAND
(From December 2019)

ACTION NO	AGENDA ITEM NO	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	6	CEO Report	Circulate Scottish Government Feedback on resilience arrangements and Sharing Intelligence for Health and Care feedback	Margaret Smith	February 20	**Completed**
2	8	Clinical Model	Ensure reporting for Governance Committees as well as reporting to the NHS Board	Monica Merson/ Margaret Smith	Immediate	**Completed**
3	10	Patient Safety, Infection Control and Patient Flow Report	Further update on water safety and risk reporting in this respect	Mark Richards/ David Walker	February 2020	**On agenda (Item 8)**
4	11	TSH3030	Circulate final poster book	Monica Merson	December 19	**Completed**
5	13	Clinical Forum	Arrange for Chair of Clinical Governance Committee to attend a meeting of the Clinical Forum during 2020	Margaret Smith	February 20	**Completed**
6	19	Corporate Governance Improvement Plan	Development of strategy of public engagement further through the improvement plan, linking arrangement of Board meetings	Margaret Smith	February 20	**On agenda – added to improvement plan (Item 21)**

Board Paper 20/02

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2020
Agenda Reference:	Item No. 7
Sponsoring Director:	Chief Executive /Medical Director
Author:	Chief Executive / Head of Corporate Planning
Title of Report:	Transition plan for implementation to the new Clinical Service Delivery Model
Purpose of Report:	For information

1. SITUATION

The Board has received regular progress reports on the status of the Clinical Care Model process.

The Board endorsed the preferred option for the new Clinical Care Model at its meeting on 24 October 2019. This model outlined a 10 ward model with eight major mental illness wards and two intellectual disability wards. The Board agreed to a quarterly review process to review effectiveness and challenges of operating the new model review.

2. BACKGROUND

A detailed planning and implementation process was developed and presented at the Board meeting in December 2019. This process included the establishment of a Clinical Model Oversight Board, with associated work streams for

- Workforce
- Clinical Delivery
- Culture, values, behaviours and leadership
- Finance
- Security and Environment
- Communication and Engagement

This paper reports on progress towards planning for implementation.

3. ASSESSMENT

This paper provides an overview of the progress achieved towards the planned implementation process including:

- Update on the Clinical Model Oversight Board
- Progress of six work stream to plan for the transition
- Commitment to continue to engage with the Clinical Forum, Partnership Forum, staff, patients and stakeholder in development of the plan for transition
- Commitment to establish a quarterly review process

4. RECOMMENDATION

The Board is asked to:

- Note the progress made towards the planning and implementation process allowing The State Hospital to transition into a ten ward model based on eight MMI wards and two ID wards
- note the deliverables identified in the work stream plans

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support implementation of the clinical model
Workforce Implications	As considered and detailed within report
Financial Implications	As considered and detailed within report
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested
Risk Assessment (Outline any significant risks and associated mitigation)	As detailed within report
Assessment of Impact on Stakeholder Experience	As detailed within report
Equality Impact Assessment	To be reviewed as part of process
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None identified to date
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One 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

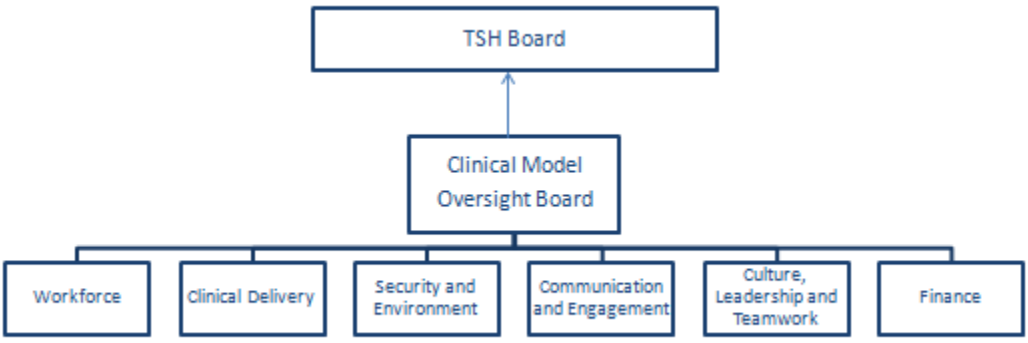
Leading Change -The State Hospital Clinical Model Implementation

Introduction

The transition to a new clinical model is complex involving multiple stakeholders and will result in changes in practice for clinical staff and placement of patients' in the hospital Hub environment. It has executive leadership and multiple interdependent work streams delivering a range of diverse 'products'. Implementation will require the use of a variety of approaches including the opportunity to use quality improvement methods in the development of some aspects of work. Co design and co production are important aspects of the developing programmes of work to ensure successful transition to the new model to support delivery of high quality care, organisational effectiveness and an open transparent culture

Leadership and governance

The Clinical Model Oversight Board was established and met on 27th January 2020 with a role to provide strategic leadership, guidance and receive reports on the delivery of the project. Terms of Reference are included as appendix 1. Project Work Streams have been established and report into the Clinical Model Oversight Board. Each work stream lead is responsible for managing and reporting on the individual work streams, managing the risks and issues, milestones and timelines. The Clinical Model Oversight Board will monitor the risks and issues associated with the delivery of the transition to the new model.



Reporting and accountability

The chart above provides an overview of the reporting and accountability structure. Reporting will be through the Clinical Model Oversight Board to the State Hospital Board. The Clinical Model Oversight Board includes representation from the Clinical Forum and Partnership Forum, external stakeholder are represented by the Mental Welfare Commission and The Scottish Government.. The Clinical Model Oversight Board will enable identification of any associations, themes or dependencies that sit across the work streams and will advise on any sequencing of activities to

support preparation for transition. The Clinical Model Oversight Board will meet every 4 weeks in the planning and implementation phase, this will be reviewed following implementation.

A logistics group will be established in late February to oversee patient and staff moves and ensure that moves are carried out safely, in accordance with agreed protocols and staff are supported. Any key learning from each move will be used to inform future work.

Consideration is also given to how to enable the voice of patients and carers in discussions, through linking into PPG regularly as well as other routes of engagement.

Project Management

A project plan has been developed to detail the key milestones and timelines associated with the project implementation. A project risk register has been developed to identify the main risks associated with the project and enable mitigating plans to be developed.

Update from work streams for implementation

a) Workforce

Lead: Mark Richards Director of Nursing and AHP, Elaine ADirectonderson Interim Director of Workforce

Aims:

- Delivery of a clear strategic approach to workforce planning and development that is aligned with the delivery of the revised clinical service delivery model.
- Develop and oversee the organisational change required to align staff to the revised model
- Ensure that risk is minimised and the safety of staff and patients is maintained during transition process
- Ensure the hospital has the right staff, in the right place, at the right time, with the right skills.

Objectives:

- Sustainable, affordable, workforce plans are developed across all clinical and non-clinical functions affected by clinical model redesign.
- Our workforce that has knowledge and skills to deliver safe and effective care across all clinical service areas.
- Staff are identified and aligned to revised ward and service functions through an agreed process which will focus on minimising disruption.
- That legislative requirements are met as they relate to safe staffing legislation, and specifically the use of the Common Staffing Method.
- Work is underpinned by a strong commitment to partnership working and engagement at all levels of the organisation.

Progress towards achieving agreed purpose:

1. Workforce workstream paper completed, based on six steps methodology.
2. Workforce planning template issues to Leads for completion by 14 February 2020.
3. Draft Terms of Reference set for group with meeting date of 23 January 2020.

Current activity:

1. Workforce planning templates being populated.
2. Engaged with Glasgow Caledonian University re delivery of a Training Needs Analysis for the intellectual disability service.

Issues, risks and concerns:

1. No specific risks identified related to the completion of this workstream at this point in time.
2. We need to agree the specifics of the 9-5 roles as any role which may require matching will result in a delay in being to get these posts to advert.
3. We need to agree a process for transition of staff to different wards and functions, which closely aligns with the shift in ward functions.

b) Clinical Delivery

Lead: Lindsay Thomson, Medical Director and Mark Richards, Director of Nursing and AHP

Aims:

- To develop clinical policies and guidance for admission and assessment wards
- To develop clinical policies and guidance for treatment and recovery wards
- To develop clinical policies and guidance for transition wards, including addressing the issues of graded security and joint working with Skye Centre
- To develop clinical policies and guidance for intellectual disability service
- To develop working methods across hubs in clinical teams to transitions
- To establish clear bed management processes
- To create governance arrangements to check clinical model fidelity

Objective:

To create a sustainably improved:

- Clinical service
- Tailored security
- Increased opportunity for activity

Progress towards achieving agreed purpose:

Clinical Delivery Guidance Development sub group met and agreed terms of reference with aim to develop overall clinical guidance with sub sections on Admissions and Assessment, Treatment and Recovery, Transitions and Skye Centre, and Intellectual Disabilities Service. Weekly meetings arranged to progress towards this with multidisciplinary involvement. The draft guidance was completed by 14/2/20 and has been shared with the chairs of the different

subgroups. The CDG will engage in a wider consultation process with staff on guidance once immediate feedback has been received. The guidance will be adapted in light of the feedback. Information will also be shared via the Bulletin.

c) Security and Environment

Lead: David Walker, Director of Security

Aims:

- Create a safe and secure working environment for staff, patients and visitors
- Identify and prioritise work streams to support the transition towards implementation of the new model within set timescales**.**

Objective:

- Ensure the environmental adaptations support the safety and security of TSH and comply with legal requirements.

Progress towards achieving agreed purpose;

- Seclusion Rooms**:** awaiting final costings then to Capital Group
- Ward Allocation**:** Clinical work streams to define ward allocation
- Health and safety**:** dependent on Leadership structure within each hub – need to clarify appointment of E-control book holder dependent on role.
- Hospital Risk assessment **–** work ongoing to develop an Intelligence system to support decision making on patient allocation and movement. Requires implementation of a system that allows submission of information, ability to extract relevant information from systems and thereafter assessment and dissemination.

Current activity:

- Lead in time for Seclusion room redesign is approx. 10 weeks therefore has been identified as current priority and being led by Head of Estates.

Issues, risks and concerns;

- Security Refurb Project – plan still to be defined therefore impact is unknown at present but may present a risk to delivery as ward enhancements take place.
- Define environmental layout including ward allocation for each hub and seclusion room prioritisation.

d) Communications and Engagement

Lead: Monica Merson, Head of Corporate Planning

Aims: To ensure effective communication and engagement regarding the transition to the clinical model with:

- Patients
- Staff
- Stakeholders

Objectives:

A communications and engagement plan will be developed to

- ensure all stakeholders including patients, carers, staff and external interested parties are kept informed of planning for change
- ensure that where appropriate, stakeholders are engaged in shaping changes.
- ensure that scope, timescale and milestones are communicated appropriately
- ensure consistency of message and transparency of development
- inform the development of an EQIA for the implementation process

Progress towards achieving agreed purpose;

- Draft Communication and Engagement plan developed
- Planning underway for EQIA in February
- Stakeholders invited to attend CMOB

Current activity;

- Update presentation delivered to Clinical Team Meetings, Harris, Skye Hubs and engagement hub team meetings with security and facilities. 80 staff attended sessions. Feedback collated.
- CMOB meetings established and TOR developed

Issues, risks and concerns;

- There is a risk that key messages are communicated in a way that s not clear
- There is a risk that informal communication and 'hear say' creates anxiety and mis information across the site in relation to the Clinical Model

e) Finance

Lead: Robin McNaught

Aims:

- Review the team structures of, and support provided by finance, procurement, risk/CE and eHealth **a**ligned to the model implementation.
- Review any organisational change required if there is any realignment of directorate services to the revised model.

Objective:

- Consideration of directorate operational requirements which are identified at all stages from the working groups engaged in the development of the new model

Progress towards achieving agreed purpose;

Initial discussion with leads of Finance, eHealth, Procurement, Clinical Effectiveness & Risk (Head of Corporate Planning and Business Support) – to consider potential implications for directorate teams / activity arising from the new Clinical Model.

Both eHealth (inc. Health Records) and Finance have indicated potential for considerable work required to address in particular patient and staff movement. Procurement also indicated possible implications.

Current activity;

Directorate leads meeting currently being arranged. This is to establish for all departments -
1 – what potential actions and issues there may be;
2 – which Clinical Model workstream would be the source; and
3 – what timeframes and dependencies there would be.

Issues, risks and concerns;

Key concern is that if there are matters impacting on, for example, eHealth or Health Records, which will require action and which are not identified at an early stage and the relevant workstream is not aware of the impact – then there will be insufficient time for the action to be undertaken by the required deadline.

Early involvement, subsequent identification of actions and setting of timescales is critical.

f) Values, Cultures, Behaviours and Leadership.

Lead: Gary Jenkins, Chief Executive / Monica Merson, Head of Corporate Planning

Aims:

- Refresh the hospital wide leadership model and management structure
- Create a consistency of values, behaviours and culture embedded with the model implementation
- Team fidelity to the Clinical Model and the values of The State Hospital

Objective:

Create a sustainably improved:

- Culture
- Level of staff engagement, morale and sense of value
- Team approach and fidelity to the values of the organisation
- Sense of worth and empowerment for all staff across The State Hospital
- Leadership model for The State Hospital

Progress towards achieving agreed purpose:

- Culture, Values, Behaviour and Leadership work stream paper drafted to outline the complexity of the work stream and the current thinking and evidence towards achieving sustainable change in organisational culture and values.
- Invitations issues for staff to join the group with attention to multi disciplinary team working.

Current activity:

- Planning further scoping work to be undertaken to assess how cultural, values and behaviours based improvement can be achieved, delivered and sustained across the entire organisation.
- Plan for group to meet mid February

Issues, risks and concerns:

No specific risks identified related to the development of this work stream at present
If work stream does not make progress then the impact and opportunity that the change to the clinical model may not be fully realised.

Appendix 1

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL MODEL OVERSIGHT BOARD

TERMS OF REFERENCE

PURPOSE

The State Hospital NHS Board (Board) has established a Clinical Model Oversight Board (CMOB) to provide strategic leadership, guidance and receive reports on the delivery of the project. It will advise on any sequencing of activities to support the preparation and implementation processes related to the change. This will provide assurance to the Board on the planning and transition into the new clinical model.

MEMBERSHIP

Co Chairs:
Mr Gary Jenkins {Chief Executive Officer} and Professor Lindsay Thomson {Medical Director}

Members:
Mr Mark Richards {Director of Nursing and AHPs}
Mr David Walker (Director of Security, Estates and Facilities}
Ms Elaine Anderson (Interim HR Director)
Ms Monica Merson {Head of Corporate Planning and Business Support)
Mr Robin McNaught (Finance and Performance Management director)
Mr Tom Hair (Employee Director)
Dr Aileen Burnett (Chair of Clinical Forum}/Dr Gordon Skilling {Vice Chair of Clinical Forum}

In Attendance:
Ms Caroline McCarron {Head of Communications}
Mr Paul Noyes {Mental Welfare Commission}
Ms Laura McCulloch {Senior Policy Advisor, Mental Health Directorate, Scottish Government}

REPORTING ARRANGEMENTS

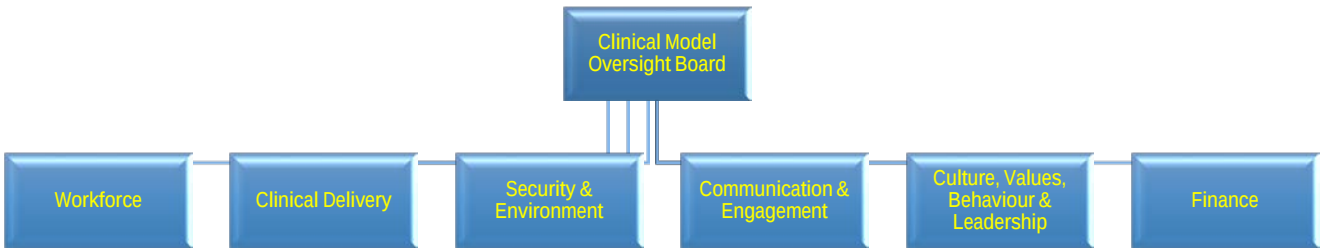
The CMOB will report to the Board at each Board meeting, through the submission of the minutes of each meeting of the CMOB as well as a summary of the key issues and recommendations.

KEY RESPONSIBILITIES

1. To enable the collaboration and overall leadership of the transition to the new clinical model, including to ensure that each workstream delivers its agreed remit within the transition timescale.

2. To ensure that the transition remains consistent with the agreed scope and principles of the new model.
3. To review and report any changes in terms of time, cost and quality to the Board.
4. To ensure that the resources required to deliver the new clinical model are available and committed.
5. To ensure appropriate governance of the transition through its strategic leadership, providing accountability and assurance to the Board.
6. To review the Risk Management Plan to ensure that all risks are identified, that appropriate mitigation strategies are applied, managed and escalated as necessary to provide assurance to the Board that all risks are being effectively managed. To produce a Risk Register.
7. To ensure that staff and patients are engaged in designing and operating the criteria that will inform the detailed design and overall procedures that will apply within the model.
8. To ensure that the communications plan ensures the appropriate involvement of, and communication with, all stakeholders (internal and external).
9. To develop the performance framework to monitor and report on the effectiveness and impact of the new model.
10. When the project has reached a stage where staff and patients are transitioning to the new model, a logistics group will be established oversee moves and ensure they are carried out safely. This will be done in accordance with agreed protocols, and ensure staff and teams are fully supported. Any key learning from each move will be used to inform future work.

Six distinct work streams have been established to encapsulate the diverse change framework required to implement the new model. The six work streams will report to the CMOB.



CONDUCT OF BUSINESS

CMOB will meet every four weeks in the planning and implementation phase.

Quorum will be met with five members present.

If the Co-Chairs are not present, the meeting will be chaired by Mr Mark Richards {Director of Nursing and AHPs}.

An agenda will be circulated three working days in advance of each meeting.

Minutes and an Action Log will be taken and available for each meeting. The minutes will be submitted to the Board.

Papers will be accepted for submission in the approved template, and should be submitted for consideration five working days prior to the meeting.

The Risk Register should be submitted for review at each meeting.

Administrative Support will be provided to the CMOB.

INFORMATION REQUIREMENTS

For each meeting of the CMOB, each of the six workstreams will provide a report in the agreed format covering:

- Progress towards achieving their agreed purpose;
- Current activity;
- Issues, risks and concerns;
- Next Steps

Each meeting will receive the Risk Register (of the CMOB).

ACCESS

CMOB Members will have free and confidential to the Co-Chairs of the CMOB.

Authors; Monica Merson {Head of Corporate Planning and Business Support}/ Margaret Smith {Board Secretary}

Review Date: June 2020

Submit for ratification to the Board – February 2020.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2020
Agenda Reference:	Item No: 8
Sponsoring Director:	Medical Director
Author(s):	Associate Medical Director
Title of Report:	Overseas Travel Request
Purpose of Report:	For Approval

1 SITUATION

Requests for overseas travel require to be submitted to the Board for their approval. This request relates to work currently being undertaken by Dr Khuram Khan in Pakistan to assist with the development of mental health services. This is in keeping with the NHS Global Citizenship initiative.

2 BACKGROUND

The following request has been received. Line management approval has been given and there are no financial costs to the State Hospital or Forensic Network.

Travel costs will be at Dr Khan's expense.

EVENT/LOCATION	*DATE*	*STAFF INVOLVED*	*COST*
Protecting Human and Legal Rights of Mentally Disordered People and Offenders in Pakistan.	29th and 31st Jan 2020. 1st, 2nd and 5th Feb 2020.	**Dr Khuram Khan**	£0

3 ASSESSMENT

Many of the Hospital's staff are asked to present at Conferences and this is an opportunity to share best practice with colleagues from other organisations and to raise the profile of the work carried out within The State Hospital and within the Forensic Network.

Dr Khan has been actively involved in assisting mental health professionals in Pakistan in improving mental health services. Through this work he has been invited to provide an educational presentation on the rights of patients and offenders with mental health problems in Pakistan. This work is in keeping with the NHS Scotland Global Citizenship initiative.

Attendance at this event is regarded as a positive opportunity to raise the profile of the Forensic Network and State Hospital initiatives.

Any leave taken will be in line with Dr Khan's standard leave allowances.

4 RECOMMENDATION

Members are asked to approve the request received for overseas travel for Dr Khan to attend this event.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of spend of staff requests for International Travel related to sharing of best practice, training and development.
Workforce Implications	Cover by Consultant Colleagues for study leave
Financial Implications	None – organisers are covering the costs
Route To Board Which groups were involved in contributing to the paper and recommendations.	Request received by Chief Executive. Board Members to consider at their next meeting thereafter.
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholders	Learning shared across the organisation for the benefit of patient care. Awareness of international developments in service provision and research.
Equality Impact Assessment	No issues

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2020
Agenda Reference:	Item: 9
Sponsoring Director:	Director of Nursing and AHPs
Author(s):	Risk Mangement Team Leader / Senior Nurse for Infection Control / Health Records Manager
Title of Report:	Patient Safety, Infection Control and Patient Flow Report
Purpose of Report:	For Noting

1 BACKGROUND

This report is presented to the Board to provide an update in relation to patient safety, healthcare associated infection and patient flow.

2 PATIENT SAFETY UPDATE

The last Patient Safety Group meeting was held on 4 February 2020.

Provided below is a brief summary of SPSP activity across the hospital in the last two months under the 4 four workstream headings:

Communication
Post incident debriefs remain ongoing, work is being taken forward through the Senior Charge Nurse development programme around training for those leading the debriefs.

Weekly pre-weekend safety briefing continue on a Friday afternoon to ensure multi-disciplinary awareness of any expected or potential issues that may arise, this includes the on-call Duty Director and Responsbile Medical Officer.

Least Restrictive Practice
The draft Improving Observation Practice (IOP) Workstream policy was out for consultation until end January 2020. Work was led by our local IOP lead who's funding is in place until end of March 2020. This will be taken forward by Nursing Practice Development thereafter.

Leadership and Culture
2020 programme has been developed with one walkround taking place in January for Skye Centre administration staff. Discussion took place at the last Patient Safety Group meeting and it was agreed to review the walkround documentation. Actions are prepared following the walkround and these are discussed monthly at the Corporate Management Team Meeting and quarterly by the Patient Safety Group.

Physical Health - Safer Medicines Management
The electronic PRN (as required medicine) form compliance continues to be monitored via weekly spot checks of data in all hubs. Arran and Lewis had 100% completion during January, closely followed by Iona with 96%.

Links continue with the Physical Health Steering Group to ensure compliance with this workstream.

The group also had a demonstration of the Tableau business intelligence software and can see how this could be utilised to help provide on ward current data.

The next meeting is scheduled for April 2020.

3 HEALTHCARE ASSOCIATED INFECTION (HAI)

This is a summary of the Infection Control activity from 1st October – 31st December 2019 (unless otherwise stated).

Audit Activity:

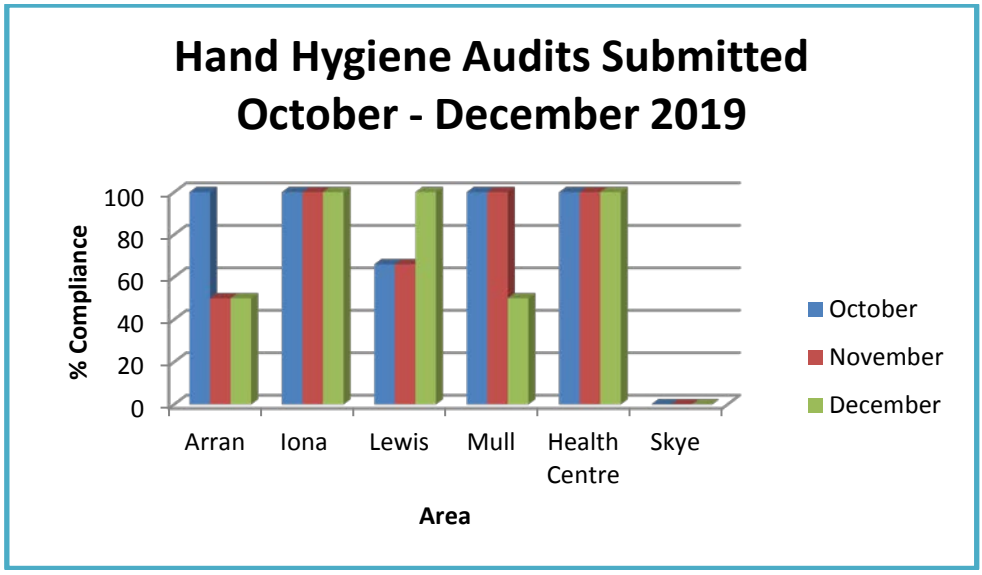
Hand Hygiene
Over the last two quarters there has been consistent numbers of audits submitted. This has been a decline since the first quarter.

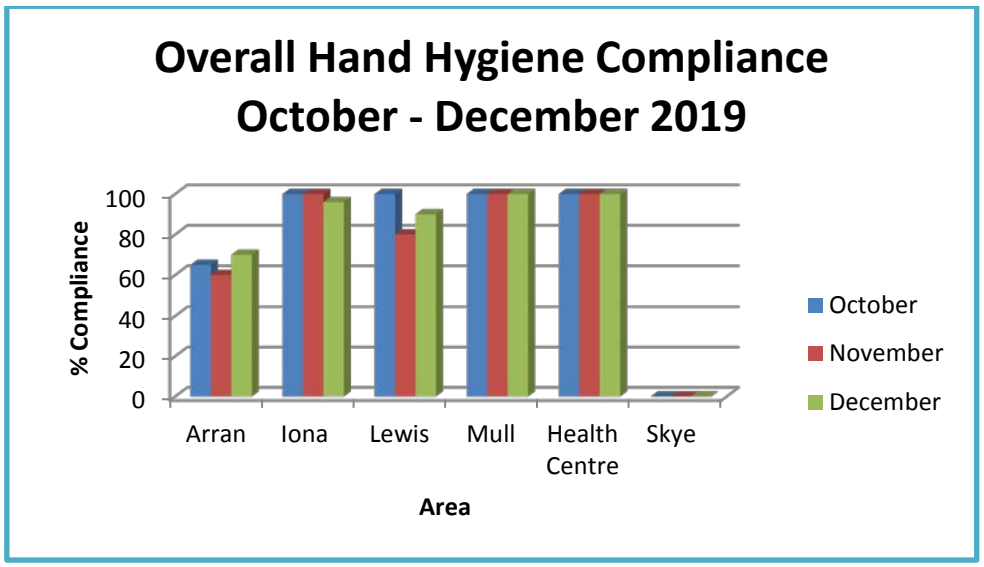
The Senior Charge nurses have been made aware of this by the SNIC. Reminders to submit and follow up of non compliance will continue to be carried out by the SNIC.

October 2019
10 out of a possible 12 were submitted (x1 not submitted due to TSH30:30 Skye Centre project).

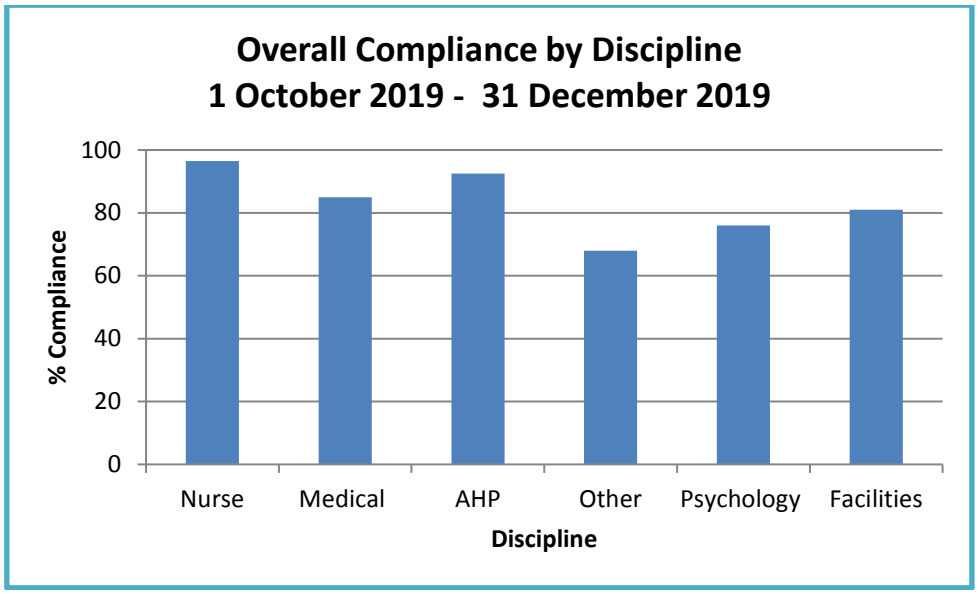
November 2019
9 out of a possible 12 were submitted (x1 not submitted due to TSH30:30 Skye Centre project).

December 2019
9 out of a possible 12 were submitted (x1 not submitted due to TSH30:30 Skye Centre project).





The overall hand hygiene compliance within the hubs varies between 68-96.5%. The category identified as 'Other' relate to the following groups; Admin staff, Senior Management, Pharmacy, Social Work and Advocacy.



As part of the TSH30:30 the Skye Centre Atrium staff undertook a quality improvement project on hand hygiene compliance within this area.

Healthcare Waste
Following discussions between Director of Nursing & AHPs and Head of Business Support it has been agreed that that support will be granted to supply the compliance of audits submitted. This information will be passed to the Senior Nurse for Infection Control who will review compliance with criteria.

Data not received for quarter 3.

Workplace Inspections
Following discussions between Director of Nursing & AHPs and Head of Business Support it has been agreed that that support will be granted to supply the compliance of audits submitted. This information will be passed to the Senior Nurse for Infection Control who will review compliance with criteria.

Data not received for quarter 3.

DATIX INCIDENTS FOR INFECTION CONTROL 1st OCTOBER 2019 – 31st DECEMBER 2019
15 infection control related incidents -

- 9 of these pertained to Safe Management of Linen e.g. bags not being tagged and bags not being managed via the correct route. The Senior Nurse for Infection Control has contacted the wards directly to offer advice, provided copies of the policy, laminated segregation chart and placed in each ward next to the laundry cart. In addition, this has been communicated via the Senior Charge Nurses and been discussed at staff business meetings. The Safe Management of linen is included in the Health & Safety Training day for staff and will be back on the nursing induction program from August 2019.

- 4 episodes of diarrhoea and vomiting.

- 1 episode of exposure to blood and body fluid – needlestick injury. Medical staff sustained a needlestick injury with appropriate follow up action taken. No further action required.

- 1 incident whereby Podiatry instruments were returned from ASDU unsterilized and in original packaging. Investigation by Senior Nurse for Infection Control determined that the fault arose at the ASDU. The Infection Control Committee have requested that a joint investigation takes place, this will be facilitated by the Risk Management Team.

There were 2 occasions were infection control was cited as a secondary incident - 2 episodes of exposure to blood and body fluids;

1. Patient spat on staff member during a restraint (no further follow up required by Senior Nurse for Infection Control).

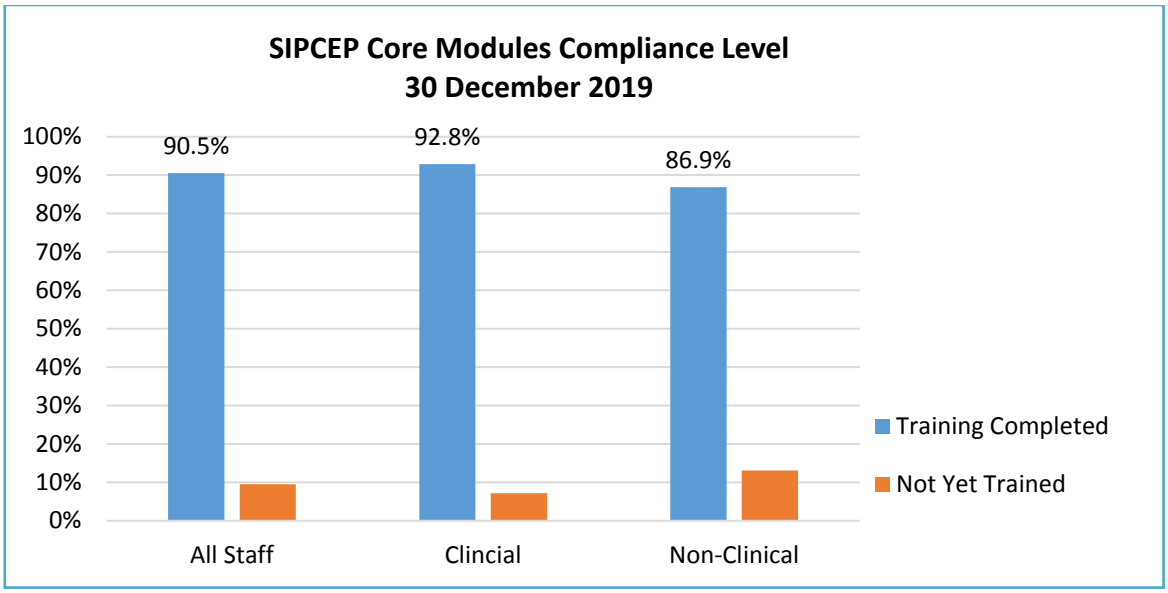
2. Patient self harmed by banging his head off the wall causing an old wound to re-open (no further follow up required by Senior Nurse for Infection Control).

Scotland's Infection Prevention and Control Education Pathway (SIPCEP):
The State Hospital identified 4 core modules for all staff to complete as part of their mandatory training. The table below shows the compliance rate per department;

Department	Target	Completed	Compliance %
Advocacy	6	5	83.3
AHP	17	16	94.1
Arran 1	29	25	86.2
Arran 2	29	23	79.3
CED & Risk	9	9	100
Estates	27	20	74.1
Finance	7	7	100
Forensic Network	7	7	100
Hotel services	17	17	100
Housekeeping	55	54	98.2
Hub admin	21	16	76.2
HR	6	5	83.3
I&E	2	2	100
Iona 1	28	27	96.4
Iona 2	28	28	100
Iona 3	28	25	89.3
eHealth	12	8	66.7
L&D	10	10	100
Lewis 1	31	30	96.8
Lewis 2	29	26	89.7
Lewis 3	26	23	88.5
Management Centre	13	12	92.3

Medical	13	11	84.6
Medical Records	3	3	100
Mull 1	28	28	100
Mull 2	32	31	96.9
Nurse Dir	5	5	100
Nursing Pool	9	9	100
NPD	4	4	100
Ops Mgt	6	6	100
OHS	4	1	25
Pharmacy	8	8	100
Procurment	7	4	57.1
Psychology	21	19	90.5
Security	44	40	90.9
Skye	34	32	94.1
Social Work	9	5	55.6

The table below shows the compliance rate between clinical and non clinical staff.



The SIPCEP modules were introduced in 2018 and there is a 2 yearly refresher for clinical and non clinical staff. The Learning and Development staff will now commence the monitoring and recording of this. A report will be provided for the next Infection Control Committee in April 2020.

Hepatitis C Treatment
Funding had been secured for the 1 patient who was waiting for treatment during the quarter; however as he was being transferred it was deemed not appropriate by his RMO to commence him on treatment at this time. All communication will be passed on to the receiving hospital (which is located in his home board) where he will receive his treatment.

1 patient was diagnosed on admission and will be seen by the Infectious Diseases Service from NHS Lanarkshire.

Policies and Guidance
All infection control policies and procedures are being reviewed as per policy schedule and there are no outstanding policies.

Flu vaccination Clinics
All staff have received a letter advising them of the clinics and if they are unable to attend the clinic how they can make arrangements to receive their vaccine week commencing 21st October. The flu vaccinations for staff will commence on 28th October. There were 5 weekday clinics planned, all of which held in the family centre. It was felt that this area was most central and staff have to pass this building on route to/from their department.

In addition to the weekday clinics 4 clinics were held to cover other shift patterns

- 10th 630-9am, 8 vaccines given (1 nursing staff)
- 11th 630am onwards 0 vaccines given
- 12th 630am onwards 7 vaccines given (2 of which were day shift)
- 07th January 7am onwards 1 vaccine given

The Healthy Working Lives group have donated a 'misfit' fitness tracker as a raffle prize for those who received their vaccine. This included staff who notified us that they had received their flu vaccine from another source. The clinics were delayed due to a supply issue hence the reason some staff received this from their GP.

Total vaccinations to date - 290.

Influenza

Although not within this reporting period three patients were confirmed as having Influenza A, within one ward. One of the patients required hospitalisation; interestingly the other two patients only displayed symptoms of sore throat, their NEWS scores did not cause alarm. They were tested as a precautionary measure at the onset of symptoms. None of the patients received the flu vaccination when offered in November 2019 and again when offered in January 2020. A few patients and staff across the hospital have experienced cold like symptoms but their physical health has not been a cause for concern and therefore they have not been tested.

Pandemic Influenza Exercise

On 5th December 2019 an exercise was held to test the hospitals pandemic influenza contingency plan. There was representation from the following

Director of Security & Facilities	Procurement Manager	Consultant Microbiologist UHW
Deputy Director of Security	Housekeeping & Linen Services Manager	Senior Charge Nurse
Director of Nursing & AHPs	Lead Pharmacist	Occupational Health Nurse
Lead Nurse	Head of Communications	Head of Estates & Facilities
Skye Centre Manager	Estates Officer	Human Resources
Physical Security Manager		

This proved to be a very useful and positive exercise from which amendments were made to the State Hospital Pandemic Influenza Contingency Plan and approved at the Infection Control Committee in January 2020.

Healthcare Associated Infection (HCAI) and Antimicrobial Resistance (AMR) Policy Requirements – DL (2019) 23 23rd December 2019

Following the receipt of this correspondence from the CNO a review was undertaken by the Senior Nurse for Infection Control & Director of Nursing and AHPs to identify any gaps in practice. This information was fed back to Scottish Government in January 2020.

Water Safety Group Update

Water safety continues to be an area of concern within NHS Scotland. Water Safety has been incorporated into the Infection Control Committee agenda is discussed at each meeting. On 5th December 2019 an extraordinary meeting was called to seek assurance that the hospital was responding appropriately to external recommendations. The Infection Control Committee are satisfied with all action taken.

Water Risk Assessments Update

Within The State Hospital the two procedures used to control the water systems is temperature control and flushing. The hot water storage is monitored and kept above 55^{O}C and the cold water storage is monitored and kept below 20^{O}C. Both the hot and cold water systems prevent stagnation of the water via day to day usage, and where this not practical, a flushing regime is introduced.

Legionella Risk Assessments were carried out within all buildings in April 2018. These risk assessments raised a total of 338 recommendations across all buildings. The recommendations were further divided into categories, and the explanation of each category is provided below.

Category 1

Urgent Significant Investigation & Urgent Remedial Action Required. Carry out review of Control Procedures. Recommendations within this category should be carried out immediately / as soon as is reasonably practicable. Where appropriate remedial actions to rectify the faults cannot be taken immediately / as soon as is reasonably practicable alternative actions to reduce the risk should be carried out.

Within The State Hospital there were **no Category 1** recommendations

Category 2 – Significant Investigation & Remedial Action Required.

Recommendations within this category should be carried out as soon as is reasonably practicable. Where appropriate remedial actions to rectify the faults cannot be carried out quickly practicable alternative actions to reduce the risk should be carried out.

Within The State Hospital there were **138 Category 2** recommendations.

116 have been completed, with 22 to be addressed.

The outstanding Category 2 recommendations relate to the water expansion vessels installed throughout the site.

The recommendation is to change these for a 'flow through' type of expansion vessels. The vessels we have installed have the potential to hold stagnant water. However, the replacement cost for one vessel to change to the 'flow through' type is approximately £2000 and we have 22 on site. The cost for a like for like replacement is approximately £500.

There are currently no problems with the vessels, so there is no requirement to change them. The Estates Department have a monthly programme in place to flush the expansion vessels that alleviates the risk of stagnant water.

Category 3 – Investigate/Reduce.

Recommendations within this category should be carried out in a timely manner. Additional monitoring / inspection to ensure the risk does not increase should be carried out until actions completed.

Within The State Hospital there were **111 Category 3** recommendations.

85 have been completed, with 26 to be addressed.

Category 4 – Maintain Level.

Managed by routine planned preventative maintenance procedures.

Within The State Hospital there were **89 Category 4** recommendations

The Estates Department continue to work through all outstanding recommendations, and progress will be monitored through the Infection Control Committee.

4 PATIENT ADMISSION / DISCHARGES

A detailed report on admissions and discharges is provided to the Clinical Governance Committee on a 6 monthly basis.

The following table outlines the high level position from 1 October 2019 to 31 January 2020.

	MMI	LD	Total
Bed Complement (as at 31/01/2020)	126	14	140
Staffed Beds (i.e. those actually available) (as at 31/01/2020)	108	12	120
Admissions (from 01/12/2019 – 31/01/2020)	7	0	7
Discharges / Transfers (from 01/12/2019 – 31/12/2019)	4	1	5
Average Bed Occupancy December 2019 – January 2020	-	-	106 88.3% of available beds 75.7% of all beds

5 RECOMMENDATION

The Board is invited to note the content of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To provide the Board with specific updates on patient safety, infection control and patient admission and discharges as well as any other areas specified to be of interest to the Board.
Workforce Implications	As detailed within sections 2 and 3 of report.
Financial Implications	No financial implications identified.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Nursing and AHP Directorate / Health Records – Board requested information.
Risk Assessment (Outline any significant risks and associated mitigation)	Not identified for this report.
Assessment of Impact on Stakeholder Experience	Not identified.
Equality Impact Assessment	Not formally assessed.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not identified as relevant.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ✓ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2020
Agenda Reference:	Item: 10
Sponsoring Director:	Director of Nursing and AHPs
Author(s):	Interim Manager – Patient Advisory Service
Title of Report:	Patient Advisory Service Annual Report
Purpose of Report:	For Noting

1 SITUATION

The purpose of this report is to provide assurance to The State Hospitals Board the Patients' Advocacy Service (PAS) continues to meet the needs of the State Hospital Patients as set out in the Service Level Agreement.

2 BACKGROUND

The report highlights progress made in all aspects of the service including improvements and achievements within the year; these are detailed within the report.

3 ASSESSMENT

- Retention of full staff complement: Service Manager, Senior Advocate, 2 Part-time Advocates (2x4 days), 1 Part-time Administrator (3 days) and 1 Volunteer, ensuring continuity for patients.
- Achievements against the Key Performance Indicators (KPI) in the Service Level Agreement continue to be met.
- 1 year extension of Service Level Agreement ends 31st May 2019.
- Recruited 1 new Volunteer.
- Location in the Skye Centre increases the visibility of Advocacy and opportunities for patients to access Advocacy.
- Full and effective use is being made of the budget allocated by the Hospital for the service.

- Robust arrangements are in place for education and supervision of all Advocates and Volunteer Advocates.
- The service continues to be an integrated aspect of Hospital landscape with positive and respectful relationships existing between both organisations.
- The additional recurring £20,000 funding received from the Scottish Government following the introduction of the Patients Rights Bill continues to assist PAS to offer extra support required with hard to reach patients and new admissions.

Section 9 of the main report identifies both organisational and service developments planned for the current 12 months. Of particular note are:

- Recruitment of 2 new PAS Board Members.
- Continue to develop, in tandem with the Hospital, our monitoring and recording systems.
- To continue developing improved and meaningful recording of outcomes for patients and stakeholders.
- Support the Hospital in meeting the aspirations of the NHS Quality Strategy and The State Hospital Clinical Model, particularly of the principles/priorities of person centered care.
- Actively respond to relevant consultations by providing a unique perspective of the service in this setting.

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PATIENTS' ADVOCACY SERVICE ANNUAL REPORT

1st April 2018 – 31st March 2019

TABLE OF CONTENTS

1 INTRODUCTION

The Patients' Advocacy Service aims to provide an independent, highly skilled, responsible and professionally run service within The State Hospital. Whilst observing the safety and security of the Hospital, the service works independently within it to promote patients as individuals, support them and enable them to be fully informed and involved in their care and treatment.

"Independent advocacy is about speaking up for, and standing alongside individuals and groups, and not being influenced by the views of others. Fundamentally it is about everyone having the right to a voice, addressing barriers and imbalances of power, ensuring that an individual's rights are recognised, respected and secured.

Independent advocacy supports people to navigate systems and acts as a catalyst for change in a situation. Independent advocacy can have a preventative role and stop situations from escalating, and it can help individuals and groups being supported to develop the skills, confidence and understanding to advocate for themselves.

Independent advocacy is especially important when individuals or groups are not heard, are vulnerable or are discriminated against. This can happen where support networks are limited or if there are barriers to communication. Independent advocacy also enables people to stay engaged with services that are struggling to meet their needs."

Scottish Independent Advocacy Alliance, Independent Advocacy, Principles, Standards & Code of Best Practice (2019).

The Mental Health (Care and Treatment)(Scotland) Act 2003, establishes the right to access Independent Advocacy for those experiencing a mental disorder. The purpose of this report is to inform and evidence the key performance indicators, stipulated within the Service Level Agreement by The State Hospital, continue to be met. The report describes how the service provided by PAS has the ability to adapt to the ever changing needs of the patient population. This includes a focus on the outcomes achieved for patients through engagement with the service.

1.1 HIGHLIGHTS OF THE YEAR

This report relates to the period April 2018 – March 2019, reflecting on another successful year during which we continued to provide an Independent Advocacy service to all patients. This work includes:

- Support before, during and after Case Reviews, Mental Health Tribunals and Parole Board hearings.
- End of life care including external hospital visits, sharing information, ensuring patients comfort and contact with internal and external parties.
- Contact with other agencies and organisations.
- Drop-in sessions.
- Information gathering.
- Funeral arrangements.
- Wills.
- Ensuring patient understanding of both human and legal rights.
- Meeting with professionals both internal and external.
- Letter writing.

- Ward meetings.
- Raising complaints.
- One to one interviews.
- Contacting solicitors.
- Support at Adult Support and Protection (ASP) investigations.

PAS continues to support our patient representative to meaningfully engage at our board meetings; the patients' voice is invaluable to the service. This signifies the importance of hearing directly about patients' experiences, to meet the changing needs in the hospital environment. PAS will aim to recruit another patient representative ensuring a continuing patient voice on our board.

We are involved in the induction process of new staff, including students, within The State Hospital. This provides them with a knowledge and understanding of Advocacy and an insight into the role of an Independent Advocate.

We have advocacy representation attending the following groups where possible:

- Child and Adult Protection Forum; Involvement and Equality Steering Group; Patient Partnership Group; Patients Christmas Events; The State Hospital Research Conference; TSH3030; Corporate Parenting; Responded to consultations and The State Hospital policies; 'What Matters To You' and Mental Welfare Commission Visit.
- Mental Health Tribunal Advocacy Reference Group.
- Communications and Specified Persons (Short life working group).

The PAS Manager is a Board Member with the Scottish Independent Advocacy Alliance (SIAA) providing PAS with a voice in shaping the future of Independent Advocacy including the development of the new Principles in Practice for Independent Advocacy. The PAS manager also attended the SIAA Annual General Meeting and the SIAA National Outcomes.

On the 20th November 2019 PAS held their 10TH Annual General Meeting (AGM) where we delivered our Annual Report for 2018-2019. Our patient representative took part in the AGM by video conferencing along with 10 patients from the Patient Partnership Group.

2 GOVERNANCE ARRANGEMENTS

PAS has dual accountability. Firstly, as an independent company, limited by guarantee to PAS Board of Directors and secondly, as a service commissioned by The State Hospital. We report annually, and in doing so, provide assurance the service meets with the specification and performance targets set by the service level agreement. The Person Centered Improvement Group receives regular updates and the service manager meets with the Person Centered Improvement Lead monthly.

The annual cost of the service to the Hospital this financial year was £146,585 including the recurring funding of £20,000 initially received in April 2012 from the Scottish Government following the introduction of The Patients Rights (Scotland) Act, 2011.

2.1 Committee Membership and Role

The Board of Directors comprises:

- Danny Reilly, Chair
- Andrew Gardiner, Treasurer

Board Members:

- Francis Fallan, Secretary
- Heather Baillie
- Michael Timmons

2.2 Aims and Objectives

The Patients' Advocacy Service aims to provide an independent, highly skilled, responsible and professionally run service within The State Hospital. Whilst observing the safety and security of the hospital, the service works independently within it to promote patients as individuals, support them and enable them to be fully informed and involved in their care and treatment.

2.3 Meeting Frequency

The PAS Board of Directors held 8 Board Meetings during this year and an AGM.

2.4 Strategy and Workforce

In order to deliver our KPI's we have a small staff team with a variety of areas of expertise. Our knowledge and experience of engaging with patients continues to expand. This allows us to provide a person centred service for the patient. Securing and retaining skilled employees is challenging in such a unique environment. However, PAS has successfully maintained the staff group for a substantial number of years, which is beneficial to patients for continuity of care.

Currently PAS employs:

- 1 x full time Manager,
- 1 x full time Senior Advocate,
- 2 x part-time Advocates,
- 1 x part-time Administrator,
- 1 x Volunteer Advocate

2.5 Management Arrangements

The PAS Manager maintains regular contact with hospital professionals including the Person Centered Improvement Lead and the Director of Nursing and Allied Health Professions. This ensures effective communication whereby any issues can be dealt with promptly. In addition, the PAS manager attends other relevant meetings throughout the hospital.

2.6 Training

Staff and volunteers complete all mandatory training specified by the Hospital, including online modules. PAS welcomes the opportunity to take part in the training and development offered by

The State Hospital, to enhance knowledge and skills of staff. PAS strives to offer the opportunity to attend training as much as possible including external training such as, through the SIAA and training sourced by PAS.

Additional training completed this year:

- CPR Training
- Capacity Training
- Advanced Excel Course
- European Computer Driving License

We actively encourage staff and volunteers to apply for training and continue personal development. This year we contributed financial assistance to 2 staff members in Year 3 of an MSc Forensic Mental Health. Additionally, we have a staff member in year 5 of a BSc(Hons) Psychology.

2.7 Policies and Procedures

All PAS policies and procedures were reviewed and updated before the Independent Evaluation in 2017. We have since reviewed and made necessary changes to our policies in line with General Data Protection Regulations (GDPR).

2.8 Participation / Integration

PAS staff participated in a number of State Hospital groups to facilitate and support integrated ways of working benefitting patient care including:

- Person Centered Improvement Group
- Patient Partnership Group
- Child & Adult Protection Forum
- Complaints

PAS also participated in TSH3030, this initiative enabled PAS to improve the working environment within our office which was the catalyst for moving forward to becoming a paperless office.

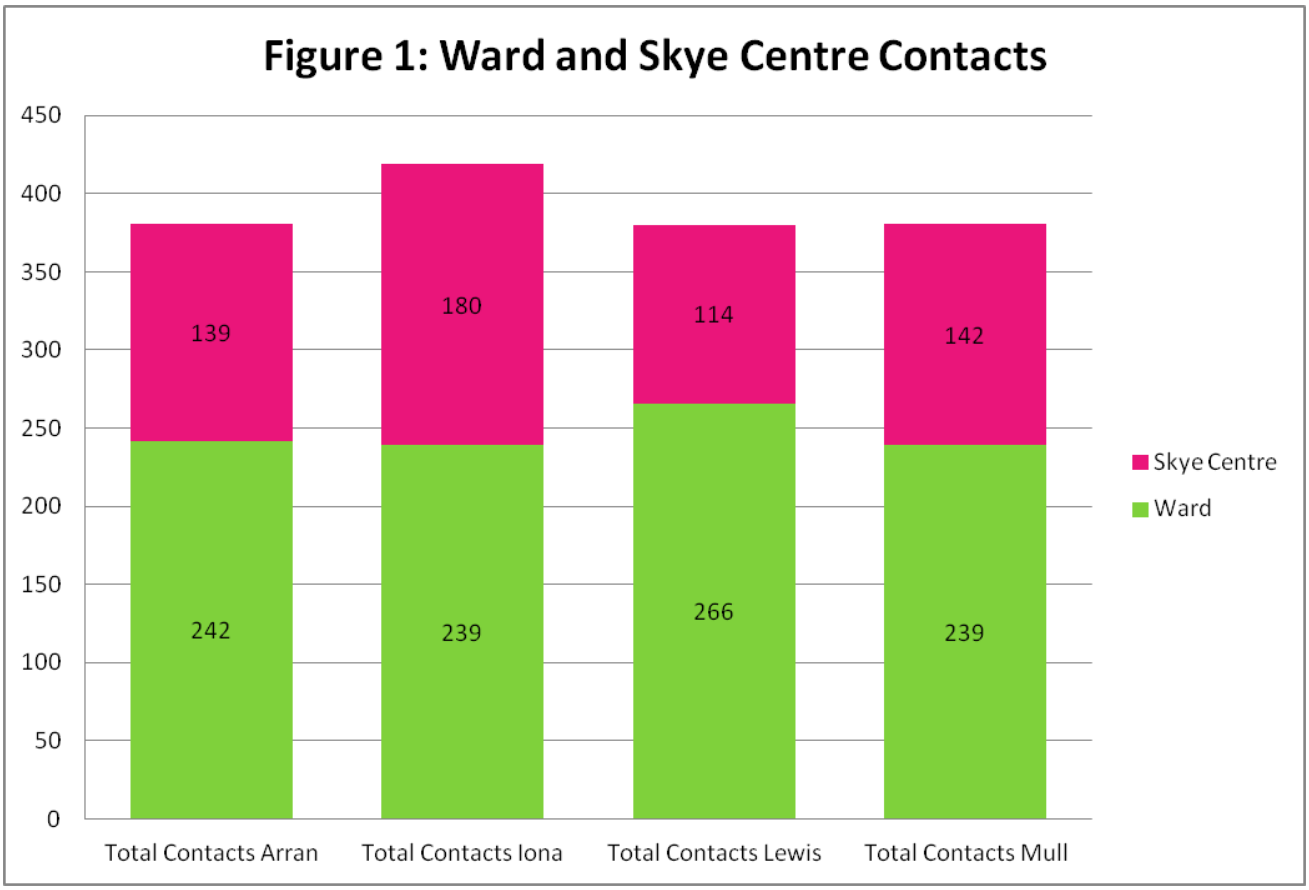
External working groups included:

- The Scottish Independent Advocacy Alliance Board Meetings
- Mental Health Tribunal Advocacy Reference Group
- Communications and Specified persons (short life working group)

3 Key Performance Indicators

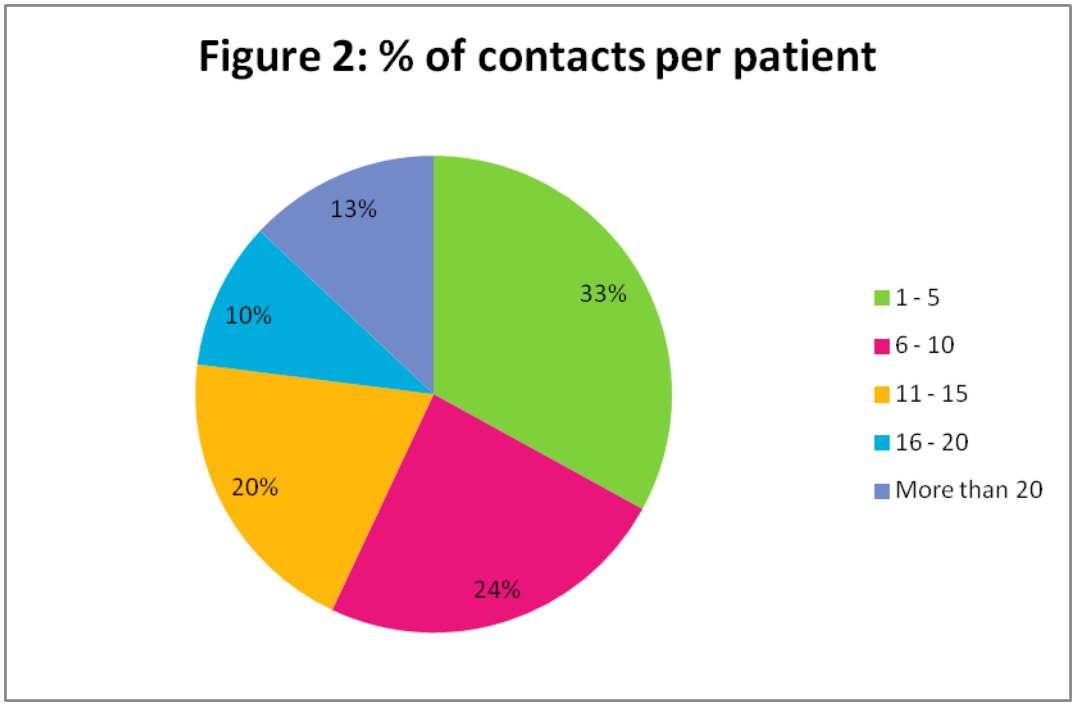
3.1 Ward and Skye Centre Contacts

The chart below shows an annual total of 1561 contacts spread among 137 patients; all patients' within The State Hospital were seen at least once by an advocate. Average contacts per patient equated to 11. These figures include 33 patients transferred to medium secure units or returned to prison and 34 admittances during this period.



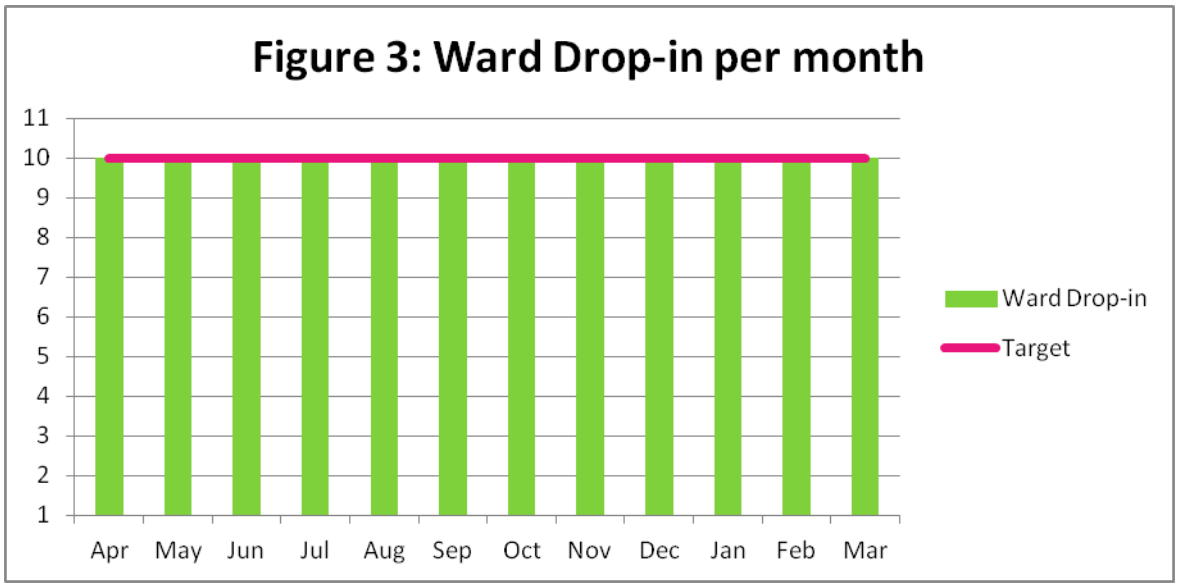
3.2 Contacts per Patient

This graph highlights 33% of patients were visited by an advocate between 1-5 times with a further 13% more than 20 times. We continue to monitor patient contacts to ensure these are reflective of the service we provide.



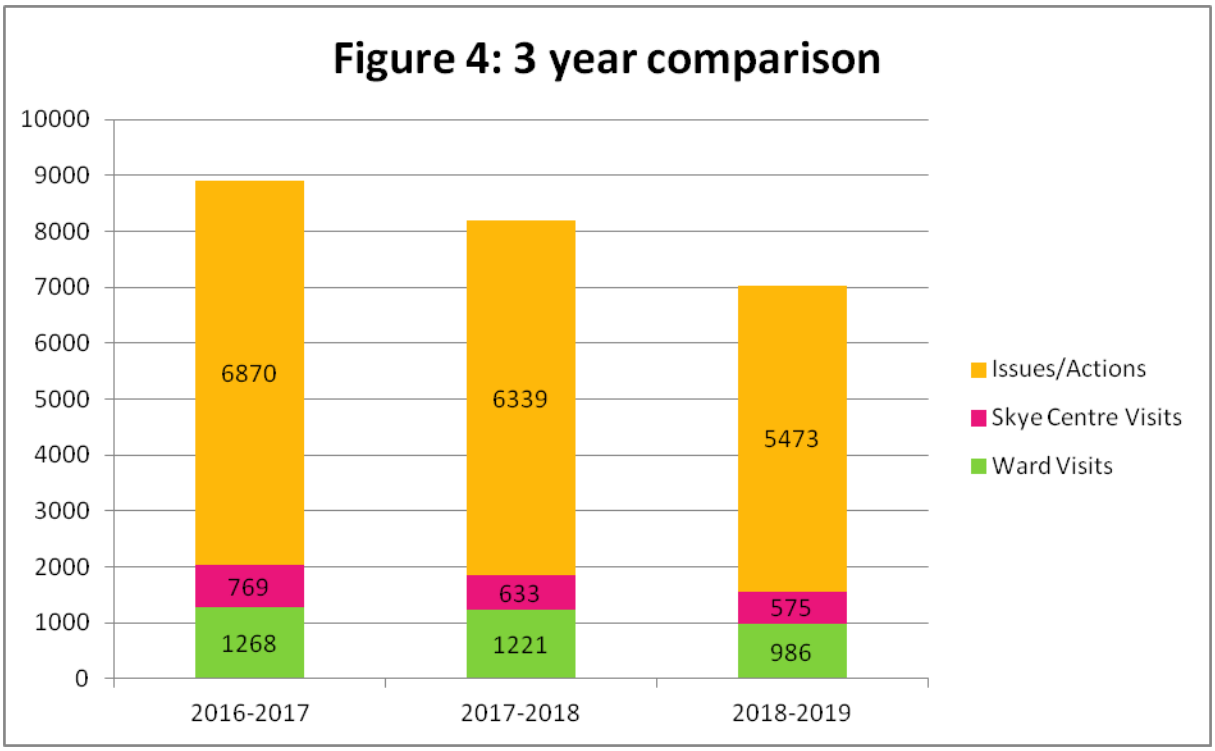
3.3 Attendance on Wards

The service level agreement requires PAS to provide a monthly drop-in to each ward. The following graph reflects this target was achieved.



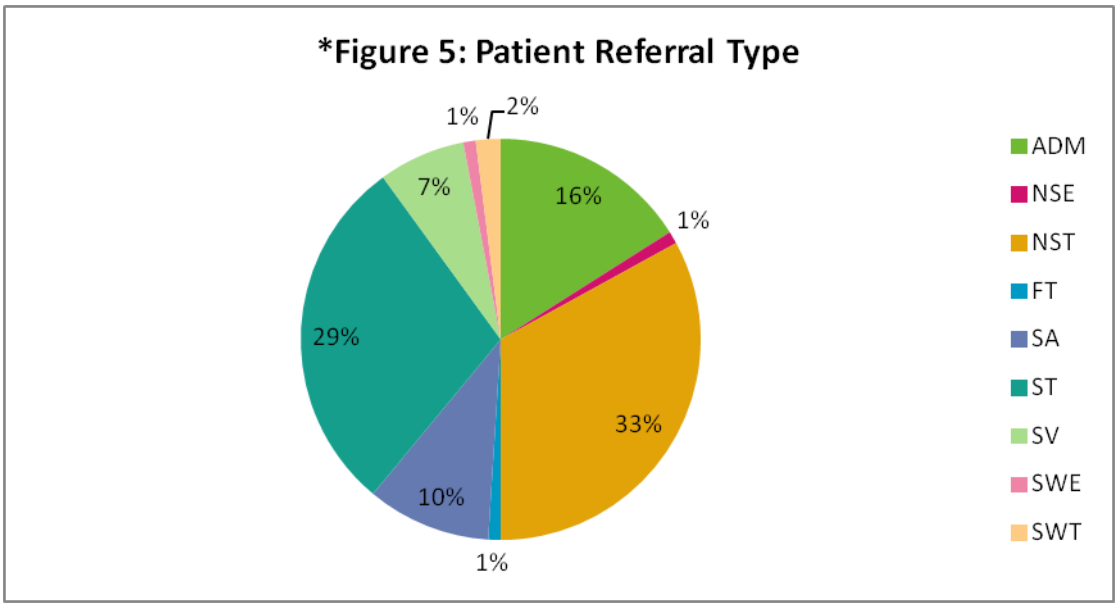
3.4 3 Year Comparison (2016-2017, 2017-2018, 2018-2019)

The figures below show a slight decline in issues raised by patients and actions. Part of the work PAS hopes to achieve is appropriately recording work completed to demonstrate more robust outcomes.



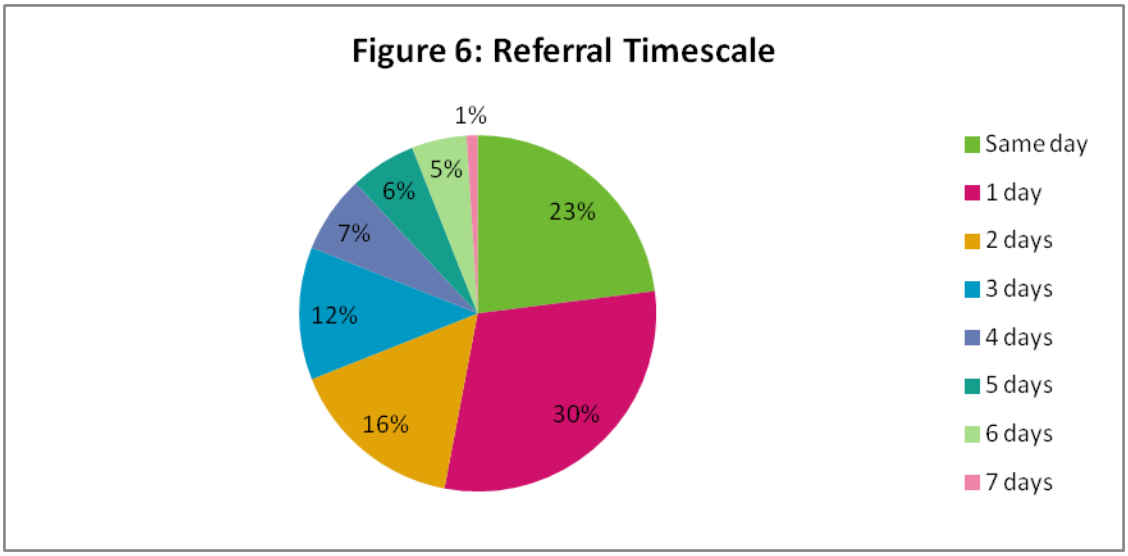
3.5 Formal Referral Routes

These statistics reflect formal requests for contact with an Advocate. 39% of referrals are from patients themselves via the PAS free phone including the answer phone.*See Appendix 1 for abbreviations.



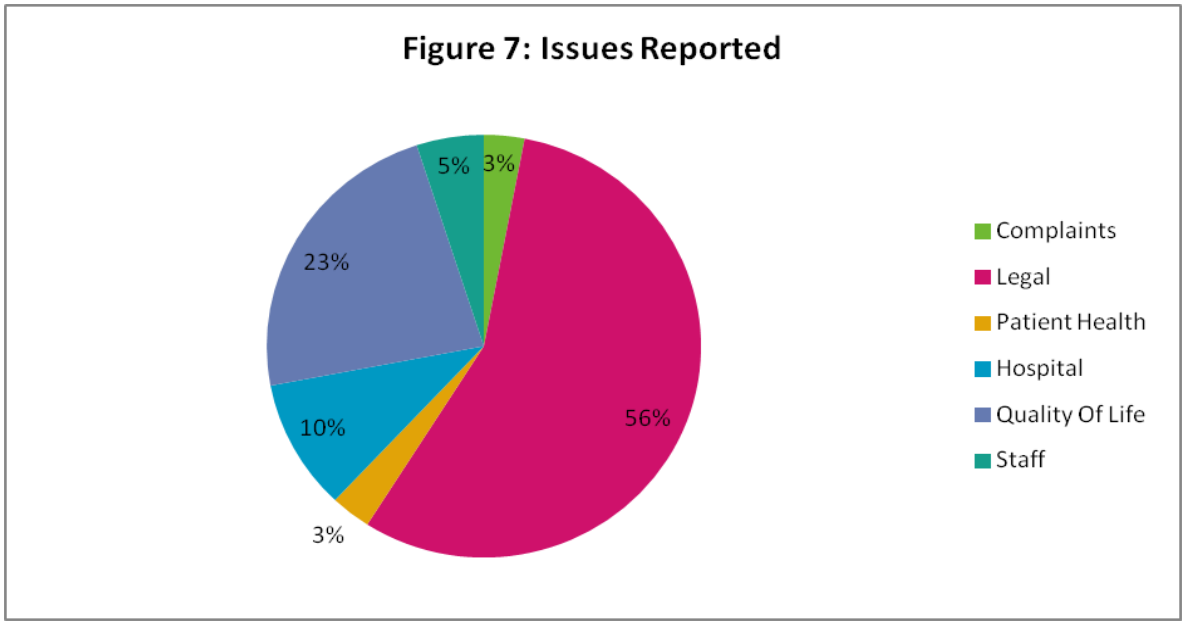
3.6 Patient Referral Timescales

The service level agreement stipulates all patients be seen within 7 working days of referral but PAS operates to a 5 working day timescale. 100% of patients were seen within the 7 working day target.



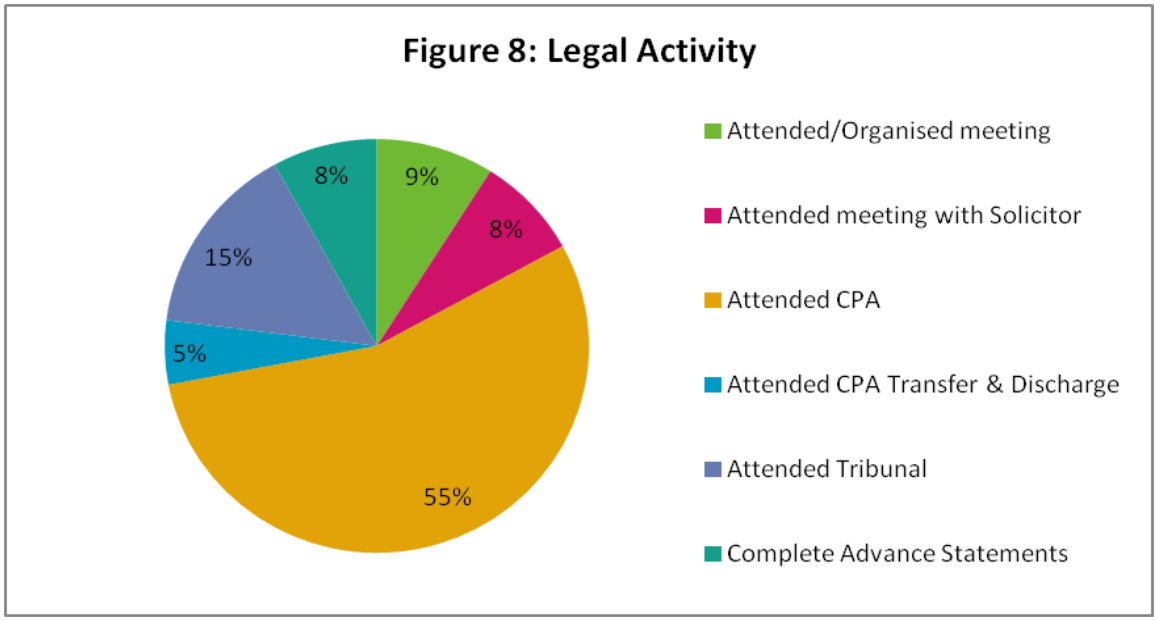
3.7 Issues

The service dealt with 2220 issues, with 'Legal' accounting for the majority with 56%.



3.8 Legal Activity

Activity classified as 'Legal' is categorised as supporting patients with advance statements, solicitor meetings, CPAs and tribunals.



4 COMPARISON WITH THE LAST ANNUAL REPORT

Action	Outcome
Organisational:	
Recruit volunteer	Complete
Organise AGM	Complete
Provide 2 days training for board members, staff and volunteers	Deferred to 2020 to allow new board members and volunteers to participate
Ongoing training for staff/volunteers	Complete
Complete annual report	Complete
Recruit additional patient representative for PAS board	Deferred to 2020
Complete tender paperwork for SLA	Deferred to June 2019 for paperwork to be available
Service:	
Develop improved recording system for statistical information and outcomes measures	Partially complete, remain on target to complete in 2020
Review and monitor how we deliver the service	Ongoing process to reflect changes with regards to policies, procedures and relevant legislation
Review of patient survey with PPG	Deferred to 2020, due to ongoing work for service level agreement
Achieve paperless office	Ongoing. Aimed completion 2020
Have an active twitter page	Partially, ongoing discussions with IT
Dedicated cloud based server	Deferred to 2020, awaiting outcome of SLA re funding.

5 AREAS OF GOOD PRACTICE

We continue to maintain good practice and meet requirements of the Service Level Agreement by:

- Review of Policies and Procedures
- Regular supervision and annual appraisals of staff/volunteers
- Ongoing staff development and training
- Approachable, unbiased and visible service
- Positive and professional relationships with stakeholders and other professionals relevant to patients
- A variety of expertise within PAS team providing knowledge and experience in a unique setting
- Consistency of staff team ensuring person centered care
- Flexibility to adapt and meet the needs of The State Hospital

6 OUTCOMES

We continue to work towards producing meaningful outcomes for the Hospital and the Patients. Reported outcomes centre on Care Programme Approach Meetings (CPA), Mental Health Tribunals and Parole Board hearings. We also support patients through the process of completing advance statements, funeral plans, wills and complaints.

The tables below reflect the work PAS engages in and the outcomes which follow.

Care Programme Approach Outcomes

Discussion	***Patient Outcome***	***Hospital Outcome***	***Total***
Total 361 (this includes prior discussions)	Patient supported to prepare for CPA for example by constructing Questions for the Clinical Team choosing to attend or not.	Patient involved and participating in CPA process with advocacy support.	**170 attended**
	Advocacy discussed CPA process with patient providing options to attend with advocacy support, on their own or not to attend at all. Patient felt confident enough to attend CPA without Advocacy support.	Patient involved and participating in CPA process, declining advocacy support at meeting.	**19 declined**
Total 34 (this includes prior discussions)	**Attend Discharge/Transfer CPA**: Patient supported to fully engage with CPA process should they wish.	Patient involved and participating in CPA process with advocacy support.	**17 attended**
	Decline Discharge/Transfer CPA: Patient able to choose to attend meeting independently without Advocacy support.	Patient involved and participating in CPA process, declining advocacy support at meeting	**4 declined**

Mental Health Tribunal Outcomes

Discussion	*Patient Outcome*	*Hospital Outcome*	*Total*
Total 176	Patients are provided with verbal and written information regarding their legal rights and the process of the Mental Health Tribunal. Ongoing discussion with patients to ascertain levels of understanding and support accordingly.	Patients were informed and supported with their legal rights i.e. their right to a solicitor and support from Advocacy.	**51**
	Patient able to attend tribunal with solicitor independently.	Patient declined Advocacy to attend tribunal but attended with solicitor.	**5 declined**
	Patients supported to have their voice heard and if they choose through a written personal statement.	Patient was supported by Advocacy to attend Tribunal and have their voice heard.	**46 attended**

Other Activity Outcomes

Discussion	*Patient Outcome*	*Hospital Outcome*	*Total*
Total 70 (including discussions)	**Formal complaint**: Patient able to express dissatisfaction and have issues addressed as per hospital policy.	Patient's complaint received and responded to accordingly.	**26**
	Local Resolution: Patients issue resolved informally via discussion. Advocacy attendance if requested by the patient.	Issues resolved at first level as per complaints procedure. Hospital quickly addresses issues saving staff time and issues resolved to patient satisfaction.	**35**
	Information search: Information gathered on behalf of a patient due to restricted internet access allowing them to exercise their rights.	Supporting nursing staff by providing information to patients which would otherwise be time consuming for staff to provide.	**56**

Discussion	*Patient Outcome*	*Hospital Outcome*	*Total*
Total 120	**Completion of Advance Statements**: Patients wishes expressed regarding future care and treatment giving a guarantee the RMO and care team will take these into account.	Fulfilling legal obligation, providing knowledge of Advance Statements and support to complete these. Advance Statements are person centered, taking into account patient's wishes. Accurately recording and storing Advance Statements with medical records.	**26 completed**
	New Admissions: Patient is informed of the role of Advocacy, their legal rights and how we can support them through their care and treatment.	Legal obligation to provide Advocacy is met.	**34 admissions**
	Patient supported during meeting (Solicitors, Independent Doctors, Social Worker, etc): Patient supported by Advocacy to attend meeting.	Patients supported as per their right to have Advocacy support as per the Mental Health (Care and Treatment) (Scotland) Act 2003.	**57 attended**
Total 30	**Parole Board Hearing**: Patients are provided with verbal and written information regarding their legal rights and the process of the Parole Board Hearing. Ongoing discussion with patients to ascertain levels of understanding and support accordingly.	Patients were informed and supported with their legal rights i.e. their right to a solicitor and support from Advocacy.	**2 attended**
Total 6	**Adult Protection Support (ASP)**: ASP referral made when patient feels or is deemed at risk.	Hospital fulfilling legal obligation to support patients through ASP legislation.	**2 attended**

Other Legal Outcomes

7 Patient Stories

Positive Future Outcomes

Patient A was very quiet; although polite he was unlikely to request support. Social work approached advocacy to discuss potential family contact as he lacked external support. Patient A was not forthcoming with his history and records for his past were missing. After engaging for a few weeks aiming to build a positive relationship, he divulged he wished to contact his Sister who he had lost contact with whilst in prison. He had basic information however when transferred to Social Work they were unable to locate her. The Clinical Team agreed we could pursue this through the Salvation Army and so initially we needed to gather identification required for the application. As the patient was a prisoner we worked on budgeting to save and purchase a birth certificate. After securing funds we completed forms, liaised with ward staff and finance to organise the cheque. Once he received the birth certificate we sent off an application to the Salvation Army. After a few months the advocate called the tracing service and was told the fantastic news the patients' sister had been located and her address provided for contact, unfortunately this information had been sent to the patient 2 months prior but he had been unable to read the letter and so the information was missed. It was put in the care plan for advocacy to be notified of incoming mail and ward staff also included a note in their mail book which has been beneficial for ongoing mail. After liaising with social work and them confirming his sister could be contacted, advocacy facilitated a few letters between the patient and his sister as he was not comfortable enough to phone her initially and with a lack of reading/writing skills he needed support with this. He then progressed to phone contact weekly which has continued since.

This work allowed the advocate to build a strong working relationship with the patient which has caused him to feel more comfortable asking for support. This led to him challenging his security level, contacting a solicitor, attending CPA's and writing an advance statement which has given him more of a voice than he had previously. In addition he now has an external support system which will be beneficial for his future. Throughout the course of working with this patient, positive working relationships have also been built with the clinical team allowing for the patients views to be upheld in a variety of situations.

2 Advance Statement - Discussion	4	**6 Read Over Forms**	2
2 CPA - Discussion	3	**9 Attended CPA**	2
2 Legal Aid Funding	1	**9 Attended meeting with Solicitor**	1
2 Level of Security	1	**9 Fill out Forms**	4
2 Prison	1	**9 Gathered Information**	9
2 Solicitor	1	**9 Letter/Mail**	4
2 Tribunal - Discussion	3	**9 Email**	10
2 Legal (Other)	1	**9 Phone Call**	11
5 Patient Finance	1	**9 Visit/Diary Note**	2
6 Clothes	1	**9 Skye Centre Drop-in.**	8
6 Family and Friends	8	**9 Informed Staff**	2
6 Quality of Life (Other)	2	**Totals:**	82

Patient Engagement with Advocacy

Patient B was admitted to The State Hospital from Prison and regularly utilised the Advocacy Service before being discharged. In the period of April 2018 to March 2019 Patient B was supported on a number of occasions with various issues. Patient B approached Advocacy regarding property he believed to be missing following his transfer. Advocacy supported Patient B by contacting the Prison and speaking to the relevant hall to have a copy of his property list sent across. Advocacy also liaised with Nursing Staff in The State Hospital to get a copy of his property list for comparison. Following this Advocacy met with Patient B to go through both property lists and identify any missing items. Patient B identified a few missing items however didn't wish to take forward a claim as there wasn't as many missing items as initially thought and also due to the length of time the process would take for making a claim to the Prison. Advocacy also supported Patient B regarding adequately fitting clothing. Patient B reported an increase in his weight and the clothes he had no longer fitted him. Patient B requested for Advocacy to contact finance on his behalf to ask if there was a budgeting loan available he could be considered for. Following a telephone call to finance and being advised there was no loan facility due to Patient B's legal status; Advocacy contacted Nursing Staff regarding the matter. Patient X was supported by the ward and provided with adequately fitted clothing.

2 CPA – Discussion	4	**6 Placements**	1
2 CPA Transfer and Discharge Discussion	2	**6 Quality of Life (Other)**	2
2 Legal Aid Funding	1	**8 Social Work**	4
2 Prison	4	**8 RMO**	1
2 Solicitor	1	**9 Attended CPA**	2
4 Treatment/Medication	2	**9 Attended CPA Transfer and Discharge**	1
4 Patient Health (Other)	1	**9 Fill out Forms**	2
5 Benefits	1	**9 Gathered Information**	14
5 Hospital/Policy/procedure	1	**9 Letter/Mail**	1
5 Patients Property	2	**9 Email**	7
5 Hospital (Other)	3	**9 Phone Call**	10
6 Clothes	2	**9 Visit/Diary Note**	6
6 Family and Friends	3	**9 Skye Centre Drop-in.**	7
6 Grounds Access	5	**Totals:**	90

End of Life Support

Patient C approached Advocacy regarding support in making a funeral plan. Advocacy contacted the relevant funeral directors on Patient Cs' behalf and requested for a funeral pack to be sent out. On receipt Advocacy met with Patient C on a number of occasions to thoroughly go through the information contained in the pack. This was required due to the sensitive nature of the task and required patience, understanding and compassion. Advocacy supported Patient C to complete the paper work and send back to the funeral directors. Advocacy liaised with the Patients RMO, Nursing Staff and Finance regarding the funeral plans and payments. Advocacy also supported Patient C to find out about cemetery spaces and prices where he wished to be buried. Contact was made with the local authority that was able to confirm space and prices and the process of purchasing a plot. Advocacy liaised with Patient Cs' RMO, Social Worker and Procurement on a number of occasions via telephone calls and emails regarding the purchase of a plot, which in time was fulfilled. Patient C received all funeral paper work in confirming the plans, Advocacy supported Patient C to go through the paperwork and ensure he was in agreement with the plan. Following completion of Patient C funeral plans Advocacy also supported a Will to be completed stating the patient's wishes.

2 CPA - Discussion	2	**9 Gathered Information**	5
2 Legal (Other)	1	**9 Letter/Mail**	1
2 Will discussion	2	**9 Read mail to patient.**	1
2 Funeral Plan Discussion	7	**9 Email**	5
4 Physical	3	**9 Phone Call**	6
4 Patient Health (Other)	3	**9 Referral to Other advocate**	1
5 Patient Finance	1	**9 Visit/Diary Note**	8
6 Outings/Rehab Visits	1	**9 Skye Centre Drop-in.**	6
6 Quality of Life (Other)	3	**9 Will completed**	1
8 Social Work	2	**9 Funeral Plan Completed**	1
9 Attended/Organised Meeting	1	**9 Informed Staff**	1
9 Attended CPA	1	**Totals:**	65
9 Fill out Forms	2		

Support at CPA

Patient D was reluctant to go on Clozapine medication due to regular blood testing and having a fear of needles. His RMO and care team were aware of his fear however, this was not the only reason. Patient E had informed his advocate he was of the belief if he was to agree to Clozapine medication it would prolong his treatment in The State Hospital and he would not be transferred as quickly as he would if he did not go on Clozapine. Advocacy brought this to the attention of his RMO at the CPA where his RMO was able to reassure him this was not the case and in fact the very opposite could quite possibly be true and all going well he could recover sooner which would mean he wouldn't need to spend as long in The State Hospital.

The above patient story shows the trust and relationship which has been built with the patient and advocacy worker enabling the patient to feel comfortable to divulge this information and subsequently take to the CPA where he was given the reassurance which enabled him to make an informed choice.

2 CPA - Discussion	4
2 Solicitor	2
2 Tribunal - Discussion	1
9 Attended/Organised Meeting	1
9 Attended CPA	2
9 Phone Call	1
9 Referral to Other advocate	1
9 Visit/Diary Note	2
9 Skye Centre Drop-in.	1
Totals:	15

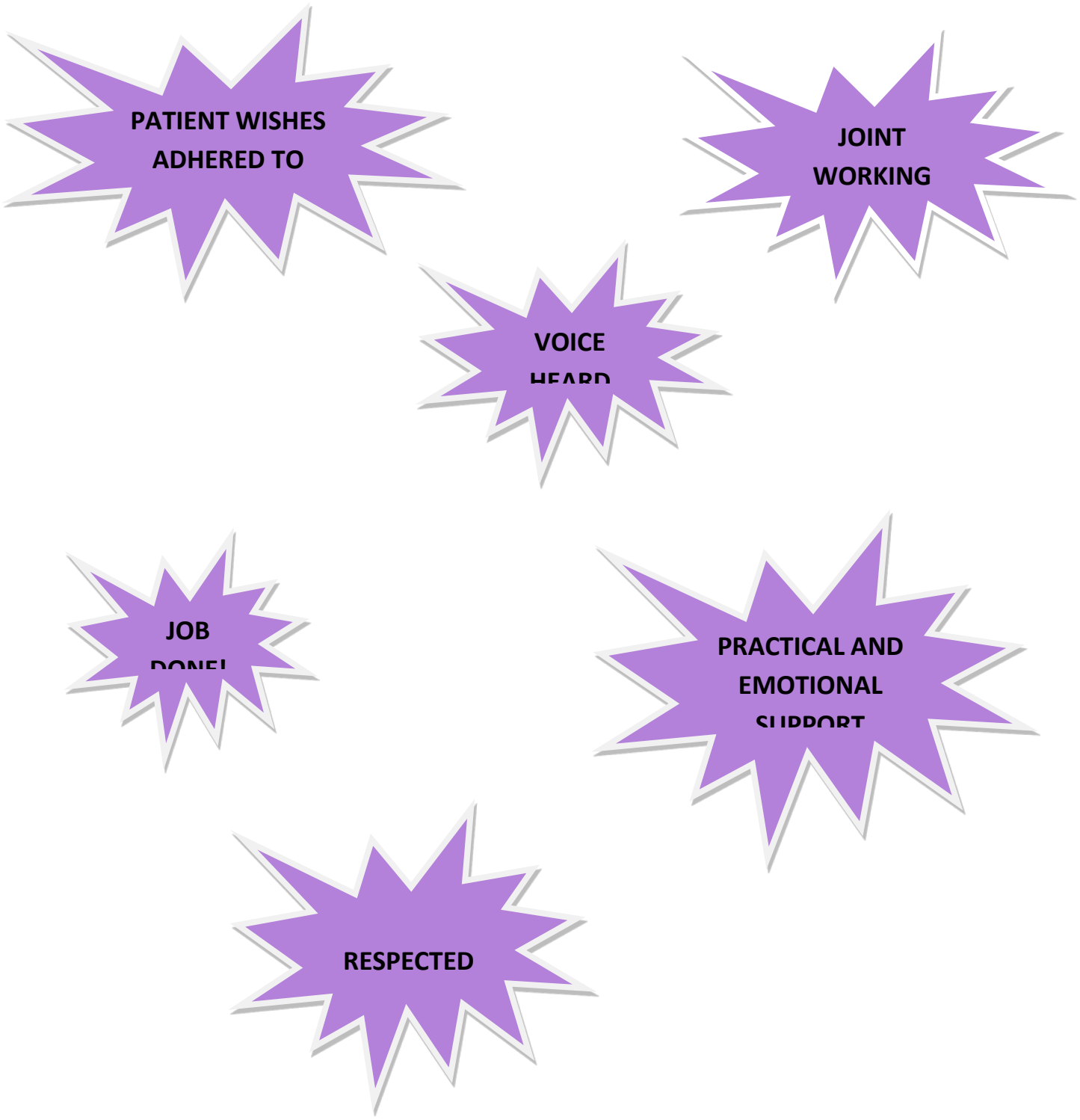
Patient Story from a Volunteer's Perspective

Throughout my time as a volunteer advocacy worker I have seen patients struggle with the idea of attending a CPA, let alone attend one with hearing difficulties. However, on one occasion Patient F had a CPA coming up. He had recently damaged his hearing aid which awaited repair and so he would require extra support through the review.

Attending a CPA can be anxiety provoking for a patient for many reasons, for example there can be a number of professionals in the room discussing their care plan and making decisions affecting their future. It was important for me to make sure Patient F was able to hear and take part in his care and treatment. Patient F although attending the full review, was not able to hear what was being said so I made sure to sit next to him and repeat what was being said in close proximity. This made sure Patient F was able to ask any questions during the review. This was a new challenge for me because I had not supported a patient in this way before and it made sure the patient had his views heard.

After the case review had finished I made sure I took extra time to sit down in a quiet environment with Patient F to go over some of the most important points of the CPA so I could make sure he understood what had happened.

Positive outcomes for patients and The State Hospital:



8 FUTURE AREAS OF WORK AND SERVICE DEVELOPMENTS

8.1 Organisational

PAS is committed to continue the quality and trusted service it is delivering at present within the hospital. PAS remains committed to providing the highest quality advocacy service to patients within The State Hospital. We continue to develop the service to meet the needs of the patients and the changing environment we work in. As an organisation we aim to develop in the following areas:

- Provide 1 training day for Board Members, Staff and Volunteers
- Ongoing training for Staff/Volunteers (including talking mats, wills and refresher of mental health law for all advocates)
- Actively respond to relevant consultations providing a unique perspective of the service in this setting
- Organise AGM
- Recruit Volunteers and Board Members
- Plan succession for Patient Representative on PAS Board

8.2 Service

As a service we continue to look at ways to improve in the following areas:

- Continue to develop an improved recording system for statistical information and outcome measures
- Continue to review and monitor how we deliver the service
- Continue to look at developing patient participation with PAS
- Continue monthly drop-ins on all wards
- Continue a positive relationship and open communication with The State Hospital Board and staff
- Review of patient questionnaire with the Person Centered Improvement team for 2019/2020
- Support the Hospital in meeting the aspirations of The NHS Quality Strategy and The State Hospital Clinical Model, particularly on the principle of person centered care

As a service we are:

- Continuing with our aim to be a paperless office
- Obtain complete independence from The State Hospital systems and have our own dedicated cloud based server. This meets the requirements of GDPR and the recommendations from the SIAA.

9 Ethnicity Group Contacts for all Patients, 1st April 2018 – 31st March 2019

This table demonstrates the service provides support to patients from all ethnic backgrounds equally and continually monitors this.

Ethnic Group	PAS Code	No. of Patients	Percentage	No. of Contacts	Percentage
Chinese, Chinese Scottish, Chinese British	3E	1	0.72%	10	0.64%
Asian, Asian Scottish, Asian British	3B	1	0.72%	29	1.86%
African, African Scottish, African British	4B	2	1.46%	21	1.35%
White Scottish	1A	61	44.53%	633	40.56%
White English	1D	4	2.93%	51	3.26%
White Irish	1C	3	2.19%	24	1.54%
White Other	1B	6	4.39%	87	5.57%
White British	2A	37	27.00%	527	33.76%
Other Ethnic Background	1E	4	2.92%	60	3.84%
Unknown		18	13.14%	119	7.62%
	Total	137	100%	1561	100.0%

10 FINANCIAL REPORT

Schedule to the Financial Activities
For the period from 1 April 2018 to 31 March 2019

	£	£
Gross Income	146,664	
Gross Expenditure	149,310	
		(2,646)
Incoming Resources		
Government Funding	146,585	
Bank Interest	79	
	146,664	
Cost of Charitable Activities		
Employment Costs	141,385	
Establishment Costs	1,540	
Print, Post, Stationery	7	
Subscriptions and donations	159	
	146,313	
Governance Costs		
Accountancy Fees	1,687	
Professional Fees	1,310	
	2,997	
Total Resources Expended as per Account		**149,310**
Cash & Bank Accounts	**44,370**	
Liabilities payable in one Year	5,007	
Net Current Assets	**39,363**	

11 NEXT REVIEW DATE

The Patients' Advocacy Service Annual Report will be available to The State Hospital Board from September 2020.

12 REFERENCE LIST:

Scottish Independent Advocacy Alliance (2019), Independent Advocacy, Principles, Standards & Code of Best Practice. [Online], Available at https://www.siaa.org.uk/wp-content/uploads/2019/10/SIAA_Principles_Standards_Best_Practice_report_2019.pdf (Accessed 15 January 2020).

The Patients Rights (Scotland) Act (2011), [Online], Available at https://www2.gov.scot/Topics/Health/Policy/Patients-Rights (Accessed 15 January 2020).

The Mental Health (Care and Treatment)(Scotland) Act (2003), [Online], Available at http://www.legislation.gov.uk/asp/2003/13/contents (Accessed 15 January 2020).

13 APPENDIX 1

Figure 5 Abbreviations:

ADM – Admission

NSE – Nursing Staff Email

NST – Nursing Staff Telephone

FT – Family Telephone

SA – Self Answering Machine

ST – Self Telephone

SV – Self Verbal

SWE – Social Work Email

SWT – Social Work Telephone

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the Clinical Governance Committee Meeting held on Thursday 14 November 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs

CHAIR:

Non Executive Director	Nicholas Johnston

PRESENT:

Non Executive Director	David McConnell

IN ATTENDANCE:

Chairperson	Terry Currie
Social Work Team Manager	David Hamilton (part)
Chief Executive	Gary Jenkins
Consultant Forensic Psychiatrist	Khuram Khan
PA to Medical & Associate Medical Directors	Jacqueline McDade
Finance and Performance Management Director	Robin McNaught
Head of Corporate Planning and Business Support	Monica Merson
Director of Nursing and AHP	Mark Richards
Clinical Effectiveness Team Leader	Sheila Smith
Medical Director	Lindsay Thomson
Lead AHP	Catherine Totten (part)
Lead Dietician	Frances Waddell (part)
Security Director	David Walker (part)

1 APOLOGIES AND INTRODUCTORY REMARKS

Nicholas Johnston welcomed those present to the meeting and apologies for absence were noted from John Marshall and Maire Whitehead.

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted in respect of the business to be discussed.

3 TO APPROVE THE MINUTES / ACTON NOTE OF PREVIOUS MEETING HELD ON 15 AUGUST 2019

The Minutes of the previous meeting held on 15 August 2019 were amended on page 3, second last paragraph to read:

"David McConnell commented on the usefulness of the vignettes throughout the report but this should also be broadened to include some areas of challenge; John Marshall agreed to continue with their inclusion. Nicholas Johnston highlighted the interesting content of the analysis from the Risk Needs section".

and were subsequently approved as an accurate record.

4 PROGRESS ON ACTION NOTES

- ***CIR 18/01***

Members received a verbal report on CAT 1 Review 18/01 – Ending of Seclusion which was presented by David Walker, Security Director. The purpose of this update was to inform the Committee of the progress made on the implementation of the action plan. David Walker advised that work is underway in relation to the information sharing protocol with the Scottish Prison Service.

Costs are awaited from Architects for seclusion room doors; these will then be discussed at the Capital group before feeding in to the clinical model proposal.

With regards to PPE, there are some final details to be ironed out in terms of agreement around the proposal. David Walker advised that there needs to be a safe system of entry into seclusion rooms and the PMVA Group do not feel it is appropriate if there are weapons. At present we do not use PPE as this is a police role and we have a Memorandum of Procedure with them to that effect. It is being Proposed that we have PPE and appropriate authorisation levels but with a scaled model to de-escalate to take a patient down to a position whereby we can safely enter a room but if we have a patient who is particularly violent and aggressive we need to provide a safe system of work with staff. Final discussions will take place next week before a paper goes to the senior team for wider discussion and then consultation with hospital staff. It is being recommended that staff engagement is led by the Nursing and AHP Director and Associate Medical Director as this is not a security led function.

Gary Jenkins advised that there has been a measured and considered approach taken on how the use of PPE may or may not be approached and it is hoped that this will be concluded for the next meeting.

David Walker left the meeting at this time.

- ***Visitor Experience***

Gary Jenkins asked that this be included on the agenda as a bring forward at the next meeting.

Action: Jacqueline McDade

- ***PTS 6 Monthly Update***

Members **received** and **noted** the PTS 6 monthly report presented by Lindsay Thomson in John Marshall's absence. The report summarises the current status of the psychology PTS service. A more extensive detailed annual report will be provided in February 2020.

PTS is a significant and important resource within TSH. There are similar numbers of PTS therapy staff in Broadmoor Hospital where a recent comparison was conducted between the services and a recent work force planning current position paper has been completed. The headline outcome from the comparison is that parity of significant resourcing is common among high secure PTS services given the complexity of the patient's risks and needs. The service is however working on reconfiguring to develop additional roles to support staff well-being, based on recommendations from a previous Category One review.

There are high proportions of patients engaged in treatment from PTS staff using a range of therapies. On average, over the 6-month review period, almost 90% of patients are in psychology treatment at a given point. This is remarkably high given the nature of the difficulties presented by patients in TSH. Details of therapies, outcomes, engagement levels will be provided in the annual report.

The report details some of the service developments during the 6 month reporting period including the delivery of VRAMP and HCR-20 training.

Lindsay Thomson advised that there has been an issue with the developing of a sex offender service and that this is a national issue, not only for high secure hospitals but also for the prison service; evidence shows that delivery of programmes is largely by untrained staff but it is highly skilled staff that are required and there is a proposal that only 1:1 work will be undertaken.

With regards to the comparison with last year's report, it is expected that a number of these will be

completed within the next 6 months.

Terry Currie questioned the financial information contained at point 3.3 in the report as the figures did not make sense. Gary Jenkins and Mark Richards were of the view that the information provided was for month one of the financial year rather than year to date figures.

Nicholas Johnston advised that clarity was required around the period covered by the financial information within the report and this should be made clear in the annual report that was coming to the Committee in February 2020.

Action: John Marshall

5 MATTERS ARISING

There were no further matters arising.

Catherine Totten joined the meeting at this time

6 REHABILITATION THERAPIES SERVICE 12 MONTHLY REPORT

Members **received** and **noted** the Rehabilitation Therapies Service 12 Monthly Report, which was presented by Catherine Totten, Lead AHP.

A new AHP Workforce Plan was agreed by SMT in October 2018. Successful recruitment to one of the vacant posts and further interviews are planned for later in November 2019.

An AHP Team Development poster was presented at the NHS Scotland event in May 2019.

There have been some challenges around staffing and there remain a number of vacancies which has led to gaps within the service; clinical input to patients and hubs has been provided but attendance at case reviews and report writing has not been maintained.

Commitments in previous reports have been achieved with the exception of the audit against secure standards for Occupational Therapist, this will be complete as part of Occupational Therapy week in November 2019.

Psychology, Occupational Therapy and Dietetics have been working in partnership with the Skye Centre to review the healthy living group and merge this with the healthy eating group. Plans for the new integrated programme are on track to be delivered in 2020.

Many AHP staff participated in the TSH3030 initiative; the events team won the award for best patient involvement. An events committee is now also functioning in Lewis Hub and the Skye Centre. The referral dam busters also won the best MDT prize for their work in streamlining the referral process to the Skye Centre. 'Open all hours' were also able to significantly increase the opening of the hub to facilitate activity. Presentations on these service improvement initiatives were presented at The State Hospital annual Clinical Effectiveness and Research Conference.

The appointment of an Occupational Therapist to the Skye Centre has delivered key results in the past 7 months. The ability to use standardised assessment to inform and influence the service delivered to patients whilst at Skye centre placements and to co-ordinate treatment goals with the clinical team and Occupational Therapists has proved extremely valuable. The formation of an events committee with patients has allowed the evening activity programme to be co-produced. The creation of patient volunteer roles has progressed with 3 volunteers currently in sports and cafe volunteer role currently being recruited to and plans to create a role in the shop. Joint work around qualifications is being developed with the patient learning centre. Professional support is provided by the lead AHP and operationally the post is managed by the Skye Centre. Patient and staff feedback have all been excellent.

Of the 9 recommendations from last year's report, 8 have been achieved and one partially achieved.

There have been three issues identified:

- There continues to be a challenge to safely staff treatment sessions on hubs. Impact of nursing staff deficits on ward staffing has significant impact on the capacity of Occupational Therapy staff to facilitate rehabilitation. Frequently sessions are cancelled and impacts are now being reported at SMT and will continue to be monitored. There is a significant variance in activity provision when there are 2 Occupational Therapists co located on a hub.
- This has also proven challenging in utilising the vocational room in the Skye Centre, particularly for the Arts Therapists.
- Gender mix continues to pose a challenge with staffing interventions.

Nicholas Johnston advised that he would be interested to see reporting on the assessment tools, completion rates and what they are telling us and would like to see narrative around the impact to the whole service and patient improvement.

The Committee were happy to note and approve the report. The next report to be available in August 2020.

David Hamilton joined the meeting at this time.

7 CPA / MAPPA 12 MONTHLY REPORT

Members **received** and **noted** a CPA / MAPPA 12 Monthly Report by David Hamilton, Social Work Team Manager. In summarising the report, David Hamilton highlighted the following points:

As part of the Local Delivery Plan, The State Hospitals Board for Scotland has adopted a target of 100% of all discharges and transfers from The State Hospital to be managed by the CPA process. This includes transfer/discharge, CPA meetings, CPA Reviews and CPA Contingency Planning meetings.

80% of patients, which equates to 35 patients, attended their CPA meeting, which is a slight decrease from the previous reporting period. For those patients who chose not to attend it is acknowledged practice that following the meeting, the care and treatment plan and notes of the meeting are shared with the patient. This ensures that the patient's views have been properly represented, and that the patient understands his own responsibilities as part of his recovery.

Carer attendance in transfer / discharge CPAs remains low. Carer attendance is encouraged, monitored and reviewed.

With regards to MAPPA, we continue to meet our obligations. During the review period no patients have been identified as potentially meeting the risk of serious harm category, however all patients remain under consideration in this regard, and consultation takes place with the relevant MAPPA Co-ordinators as appropriate. There has been 1 MAPPA referral during the reporting period.

The Committee discussed the LDP targets for attendance at pre-transfer CPA meetings and it was agreed that future reports would take out the LDP targets but include narrative that engagement has taken place throughout the year.

Action: David Hamilton

David Hamilton left the meeting at this time.

8 PATIENT MOVEMENT – STATISTICAL REPORT

Members **received** and **noted** a report by Lindsay Thomson, Medical Director on patient activity across admissions, discharges and transfers at 30 September 2019.

There have been 13 admissions and 21 discharges since 1 April 2019. This leaves us with 101 occupied beds. All of the patients admitted from beginning of April 2019 to the end of September 2019 were admitted within the 6 weeks' time limit between referral and admission.

Between 1 April and 30 September 2019 there were 4 admissions under the exceptional circumstances category (one has since been discharged).

Three patients are currently over the time limits set by their excess security hearings.

There have been 21 discharges in the last 6 months to various health boards, with a fairly even spread of patients returning to court/prison or hospital.

9 ADULT AND CHILD PROTECTION 12 MONTHLY REPORT

Members **received** and **noted** the Adult and Child Protection 12 monthly report presented by Mark Richards, Director of Nursing and AHPs.

Mark Richards advised that the State Hospital has Corporate Parenting responsibilities for any young people who have been in care; no patients to date have met the criteria but we continue to monitor this on a month to month basis.

72 child visits have taken place within the last 12 months, which is a decrease of 10 from last year; at the end of the reporting period, 56 children were approved for contact with patients.

4 notifications of child protection concerns have progressed appropriately through social work and have involved engagement with local authorities to progress any enquiries.

17 Adult Protection referrals were received during the reporting period spread across 16 patients. One referral was withdrawn by the RMO. 15 patients were referred on 1 occasion, 1 on 2 occasions.

There are no concerns with regards to training and the team are working towards a 100% target.

There was one partially completed action from last year's report relating to training and the use of Saturday morning sessions with nursing staff is being explored.

The Committee noted progress and supported the future areas of work identified.

10 WARD CLOSURES REPORT

Members **received** and **noted** a report on ward closures, presented by Mark Richards, Director of Nursing and AHP who advised that it had previously been agreed to bring a formal report on any ward closures that required to be implemented as a consequence of staff availability. From August to November 2019 there have been two occasions where we have had to use Business Continuity measures to support reduced staffing levels. 10 patients were affected in each ward. There have been no complaints or concerns received from patients affected and ward closures will continue to be monitored. There are still occasional staffing challenges and something different needs to be considered to maintain safety of patients and staff

A fuller report will be submitted to the next meeting.

Action: Mark Richards

11 LEARNING FROM FEEDBACK

Members **received** and **noted** a report on Learning from Feedback which was presented by Mark Richards, Director of Nursing and AHPs for the period 1 July to 30 September 2019.

Members noted that during the reporting period 105 pieces of feedback were received:

- 49 compliments relating to the Skye Centre evening events.
- 25 related to the patients' meal service.
- PPG contributed to 1 Policy Consultation.
- 9 outstanding actions relating to unresolved feedback.
- New feedback topics relating to Skye Centre induction and Patient Sports Volunteer roles.

Lindsay Thomson advised that on page 6 of the report, patients who undertake a volunteer role would like a reference when they are moving on. It is interesting to note that they want to have a reference for positive things they have done whilst here.

Terry Currie made reference to the length of time it takes to get through security and the lack of urgency in making improvements.

12 LEARNING FROM COMPLAINTS

Members **received** and **noted** a report on Learning from Complaints which was presented by Monica Merson, Head of Corporate Planning and Business Support, for the period 1 July to 30 September 2019. The report highlights the complaints, concerns and enquiries the Hospital has received, showing the main types of issues raised, outcomes and any emerging actions, SPSO contact and the results of evaluation and audits of the complaints process.

- 10 new complaints were received;
- 3 complaints were submitted by one carer;
- PAS continue to provide valuable input, supporting half of all complaints received;
- 9 complaints were closed in this quarter;
- 7 complaints were resolved at Stage 1;
- 5 complaints were upheld or partially upheld;
- The average time taken to respond to a complaint at stage 1 was 4 days;
- Communication and staff shortages accounted for the majority of issues raised;
- No new complaints were escalated to the SPSO in this quarter.

The Committee noted:

- Over the last 4 quarters, the number of complaints received has reduced by half;
- 7 complaints were closed during the period; 2 were escalated to stage 2
- 2 complaints were upheld and 3 partially upheld;
- No new complaints were escalated to the SPSO in this quarter.

13 INCIDENT REPORTING AND PATIENT RESTRICTIONS

Members **received** and **noted** a report on Incidents and Patient Restrictions which was presented by Lindsay Thomson, Medical Director and provided an overview of activity of incidents and patient restrictions for the period from 1 July until 30 September 2019.

There was a reduction in the overall number of incidents reported during this quarter, of note

- Behavioural incidents decreased from 109 to 72;

- Verbal Aggression incidents decreased from 48 to 24;
- Sexual incidents increased from 4 to 10;
- Attempted Assaults decreased from 22 to 12;
- Assaults decreased from 12 to 5;
- Self-Harming Behaviour incidents decreased from 34 to 12;
- Medication incidents decreased from 11 to 4;
- Prohibited or Restricted Items decreased from 33 to 7;
- Staff Resource incidents reported increased from 45 to 66

There were 2 patients secluded over the quarter resulting in a total of 2 seclusions lasting 15 and 20 hours respectively. This was a decrease from 9 seclusions in the last quarter.

David McConnell asked about the rise in staff resource incidents from 45 to 66; Gary Jenkins suggested including narrative in future reports.

Action: Lindsay Thomson

Nicholas Johnston asked when the Committee could expect to see an improvement in the timescales for Cat 1 and Cat 2 incidents. Monica Merson advised that there had been a gap within the risk management department that has now been filled but it is a small department and these are complex pieces of work but they are priorities for the department. Gary Jenkins advised that he was looking at resourcing and staffing for the next financial year as the risk department is a small department and if this is a priority for the Board and Committee then resourcing needs to be looked at.

Action: Gary Jenkins / Monica Merson

14 CAT 1 18/03

Members **received** and **noted** a redacted copy of the CAT 1 18/03 report in relation to a breach of confidentiality of a patients whilst on a rehabilitation outing, which was presented by Lindsay Thomson Medical Director. This patient was placed on the high profile list on admission due to threats to his safety; he has now moved on from TSH. All recommendations within the report have been discussed and agreed. The patient received the Hospital's apologies. Another patient, who was named in the article has put in a claim.

Mark Richards advised that another outing for a high profile patient was successfully managed due to the process being tightened up following this incident.

15 PHYSICAL HEALTH STEERING GROUP 12 MONTHLY REPORT

Members **received** and **noted** the Physical Health Steering Group 12 monthly report which was presented by Khuram Khan, Consultant Forensic Psychiatrist.

- 83 patients attended for Annual Health Review (90.2%); 8 patients declined (8.6%)
- The uptake for bowel screening was 57%. One patient with positive result attended for further screening
- There has been an increase in patients accepting the flu vaccination to 70% (77 patients)
- In August 2019, the prevalence rate for Diabetes within the hospital was 16.6% (18 patients), 1 patient with Type I Diabetes and 17 patients with Type II
- There have been 154 external clinical outings planned for 113 patients. 33 clinical appointments did not proceed.
- 100% of patients have a completed nutritional screening tool
- Over the last year the LDP target of 80% of patients participating in 90minutes Physical Activity over the course of week is not met. Physical activity continues

to be recorded and monitored through Rio and update reports provided to the PHSG on a quarterly basis.

New initiatives introduced over the last 12 months:

- An AHP initiative to encourage patients to walk 400 yards daily.
- Funding from the Scottish Government on the back of the Diabetes Framework (2015), has been secured for 2019/20 to commence staff training and delivery of the 'Counterweight plus' program
- 'Kick Start' is a health improvement programme developed within the Skye Centre service to offer targeted intervention to individuals who experience barriers to participation in physical activity. The programme is tailored to individual patient's needs, involving group or individual intervention, and participation will be supported by Patient Sports Volunteers.
- The introduction of the Health Eating Group

Areas of Good Practice

- Bowel Screening current uptake rate is 57%. The most recent Scottish figures 2017 report uptake of screening for males in Lanarkshire is 52.3%, within the most deprived areas uptake is below 50%.
- Increase in patients accepting flu vaccination to 70% (77 patients).
- 77.7% (14 patients) have fair to excellent control of their diabetes with the majority of HbA1c's below 59mmols. (Excellent control)
- E Health issues with SCI Gateway module for electronic referrals was resolved in May 2019. With all referrals are now processed electronically to Referral Management Services.
- To develop and implement to HWP which supports the Nutritional screening process and aims for long term holistic plans to support physical health care.
- Patient feedback regarding meals and menu, supported by the patient's partnership group and annual meal experience feedback survey.
- Establishment of improved and wider monitoring of physical activity
- Tiered approach to delivering nutrition related training and wider scope for education

Key physical health challenges for the next 12 months

- Continue to develop, supporting and monitoring the Supporting Healthy Choices agenda
- Continue with outstanding recommendations
- Establishing the remit of 'Counterweight plus' as an evidenced based weight loss intervention for obesity and those with pre diabetes (diagnosed up to 6 years).
- Embedding HWP into practice, monitoring implementation and robust evaluation and audit of compliance rates.
    - Developing HWP into practical resources for the ID patients, with support from the SLT, to make these purposeful for this patient group.
    - Use of case studies and 'test patients' to help understand and gain confirmation of the legal perspective regarding managing high risk patients
- Deliver the proposed 9 Health Improvement events as no events were delivered last year due to staffing challenges
- The amalgamation of the HLG and Healthy eating Groups (OT led) to streamline and support healthy eating and key nutritional messages with evaluating and outcome monitoring.
- Continue to work alongside the EHealth Department to develop the Tableau System to allow reporting on patient physical health

Frances Waddell joined the meeting at this point.

16 DISCUSSION ITEM
OUTCOMES OF THE IMPLEMENTATION OF THE SUPPORTING HEALTHY CHOICES PLAN

Leading on from the last item, Dr Khuram Khan, as Chair of the PHSG, and Frances Waddell, Lead AHP provided the Committee with a further presentation on the Supporting Healthy Choices 15 point action plan.

In starting off the discussion, Lindsay Thomson advised that the number one clinical priority is the physical health of our patients; in 2016 the Clinical Governance Group supported and approved the development of the 15 point action plan but this is not working in improving our patients BMI and comments from the Committee on a way forward are welcomed. Lindsay Thomson further advised that a workshop is being planned for January 202 to discuss the results of the 15 point action plan.

There is evidence that patients are being admitted with higher BMI than in previous years, patients have been putting on more weight after the external purchasing was stopped and the longer a patient is with us the more they gain weight. More non-food items need to be available in the shop and assurance has been given by the Skye Centre Manager that this is going to be prioritised.

Terry Currie stated that something more radical needs to be done around diet to make a difference. The Committee were in agreement with this.

Frances Waddell advised that there is a need for all patients to be more active and they Physical Health Steering Group are looking for support from clinical teams around what patients are purchasing, with respect to supporting healthy meal plans and there is a need to change the culture of physical activity; this needs to be every day whether it's 400 yards, the daily mile, or activities that contribute to weight management rather than an hour in the gym.

Mark Richards informed the Committee that some patients access the shop too often, with some patients having access up to 3 times a week; a paper has been submitted to the Senior Management Team with a recommendation that the shop be closed at the weekends and reinvest resources into activity. The new clinical model will help with that as there is potential to have 9-5 staff within new model. Mark suggested that there is a need to focus on success stories of some patients and looking at co-production options for patients in providing peer support by leading Scottish slimmer type model for example.

Lindsay Thomson advised that we must not get disheartened. This is an ongoing problem across society and we have done an awful lot of work, for example, the recording system for exercise was an enormous piece of work. We need to go back and look at what we have got and how we tighten up and get new ideas.

Feedback will be provided to the Committee following the workshop in January 2020.

Action: Khuam Khan

Frances Waddell left the meeting at this point.

17 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

One area of concern to be added to the log of good practice / areas of concern was the CAT 1 timelines. Two areas of good practice were 100% CPA and Vocational roles for patients

Action: Jacqueline McDade

18 WORKPLAN

Members received and noted the Workplan for 2020 and agreed that a paper on the visitor experience from David Walker be added to the workplan as a special topic, with a review period of 6 months. The Discussion Item for February would be the Clinical Model Implementation.

Action: Jacqueline McDade

19 ANY OTHER BUSINESS

There was no other business.

20 DAY, DATE, TIME AND VENUE FOR NEXT MEETING

The next meeting will be held on 13 February 2020 at 9.45am in the Boardroom.

The meeting concluded at 12.55pm

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL FORUM

Minutes of the meeting of the Clinical Forum held on Thursday 5 December 2019 which commenced at 10am in Boardroom, The State Hospital, Carstairs.

Chair: Dr Aileen Burnett	Consultant Clinical Psychologist

Present:

Alan Blackwood	Senior Charge Nurse
Josie Clark	Senior Nurse Practice Development
Sandie Dickson	Person Centred Improvement Lead
David Hamilton	Social Work Team Leader
Sarah Innes	Specialist Occupational Therapy
Dr Gordon Skilling	Consultant Forensic Psychiatrist
Fiona Warrington	Clinical Pharmacist

In attendance:

Margaret Smith	Board Secretary
Julie Warren	PA to Director of Nursing and AHP's and Clinical Operations Manager

Apologies:

Dr Jana De Villiers	Consultant Psychiatrist
Sheila Howitt	Consultant Psychiatrist
Julie McGee	Clinical Effectiveness Assistant
Sheila Smith	Clinical Effectiveness Team Leader
Carolin Walker	Professional Nurse Advisor

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

The Forum Chair, Aileen Burnett, welcomed everyone to the meeting and apologies were noted

NOTED

2. CONFLICT(S) OF INTEREST

There were no conflicts of interest declared.

NOTED

3 MINUTES OF PREVIOUS MEETING HELD ON 15 AUGUST 2019

The minutes of the meeting that took place on 15 August 2019 were approved as an accurate record.

NOTED

4 ACTION POINTS AND MATTERS ARISISING

The Rolling Action List was reviewed, and would be updated following today's meeting.

NOTED

5 BRIEFING FROM CHIEF EXECUTIVE

Mr Gary Jenkins attended the meeting and thanked the Clinical Forum for extending an invitation to him. He emphasised the importance and independence of the Clinical Forum. Mr Jenkins advised that he would be content to attend future meetings to provide an overview of what is happening in the organisation.

Mr Jenkins provided an update to Members in a number of areas. Firstly, he noted that Ms Merson would be in attendance at this meeting to provide Members with an update on the implementation planning for the new clinical model. Mr Jenkins added his appreciation and that of the Board for the involvement by the Clinical Forum in the options appraisal process – highlighting the impartiality and balance that the Clinical Forum brought.

Mr Jenkins advised that he had attended a session of the Health and Sport Committee with the Chair and Executive Leads, the Chair on 3 December 2019 as part of the Committee's sessions scrutinising NHS Health Boards. Members were advised that the Head of Communications would share the YouTube link from this meeting with staff across the site.

He noted that colleagues from Healthcare Improvement Scotland would be visiting The State Hospital on 6 December as part of the Sharing Intelligence workstream, and that their report would be available thereafter.

The next meeting of the Board would take place on 19 December 2019, and would be followed by a presentation from the Chief Nursing Office Health and Care Staffing Legislation Team. The Clinical Forum had been invited to attend this session.

Mr Jenkins also provided an update on his activities in chairing the National Prison Care Network and the Police Care Network, as well as leading the National Boards Estates Rationalisation workstream.

Mr Jenkins advised the Clinical Forum that the draft Annual Operational Plan for 2020/21 was due to be submitted to Scottish Government this month, and this was alongside continued review of the plan for the current financial year. He noted that the Annual Review for the Board was expected to take place in the summer of 2020. With arrangements still to be confirmed, Ms Dickson underlined how important it was for patients to be able to have the opportunity to meet with the Minister during the Annual Review.

The Forum Chair thanked Mr Jenkins for his attendance at today's meeting and the updates provided. Mr Jenkins left the meeting at this time.

Members considered that they would value continued contributions from the CEO or Chair as part of future meetings and this should be arranged.

Action – Julie Warren

NOTED

6 ELECTION OF VICE CHAIR

The Forum noted that the current Vice-Chair was currently on maternity leave and considered election of a vice chair for this period of time should be taken forward.

Mr Blackwood nominated Dr Gordon Skilling, and this nomination was then seconded by Ms Sandie Dickson. The Forum agreed to the election of Dr Skilling as Vice Chair to cover the period of Dr Howitt's leave.

AGREED

7 REVIEW OF THE CLINICAL MODEL

Monica Merson, Head of Corporate Planning and Business Support attended the meeting and provided an update on the review of the clinical model.

Ms Merson provided a handout during the meeting titled 'Leading Change – The State Hospital Clinical Model Implementation' which advised that the change model was a framework for any project or programme that was seeking to achieve transformational and sustainable change.

The model which was developed by NHS England provides a useful organising framework for sustainable change and transformation that delivers real benefits for patients and the public. It was created to support health and care to adopt a shared approach to leading change and transformation. The model had eight components, all of which should be considered when implementing change. The components act as a guide to ensure all elements of change are considered and implemented effectively, creating an environment where change programmes deliver transformational, sustainable change.

Ms Merson provided a detailed account of the work carried out in relation to the model – a Clinical Model Oversight Group would be established. Sub groups would then be formed to focus on clinical delivery, communication and engagement, workforce in terms of staffing, finance, leadership team work and culture, and security and environmental issues. The main priorities would be the delivery of care and the safety of patients and staff. Members received the update positively and there was detailed discussion around the table.

Ms Merson confirmed that the oversight group will be co-chaired by the CEO and Medical Director. The group would meet every four weeks and report to the Board to provide an update on progress and review of the clinical model. Ms Merson noted that the Clinical Forum would be invited to be part of this group. Discussion took place and members agreed that the Forum Chair and Vice Chair would attend the next four scheduled meetings.

Ms Merson highlighted that the transition to the new model would commence in April 2020 with phasing likely and detailed review planning in terms of the impact of the new model.

NOTED

8 TRIANGLE OF CARE UPDATE

Sandie Dickson prepared and presented a Triangle of Care report which was submitted for the Clinical Governance Group on 28 August 2019. Ms Dickson advised that a National Triangle of Care event took place in Glasgow last week which she presented at. Ms Dickson advised that she would be working closely with the Carer's Trust and that the Scottish Government were content with the work carried out so far and that this work remains valid.

Over the next twelve month period a carer strategy would be developed and updated to evolve in to a policy. In order to support the engagement process relating to the Clinical Model review, the focus of the Person Centred Improvement Steering Group meeting on 19 February 2020 would be dedicated to undertaking the Equality Impact Assessment (EQIA). Ms Dickson advised that this process supported the organisation to ensure that all stakeholders were enabled to meaningfully contribute their views to the development of a robust engagement process which covered all stages of the project.

Ms Dickson welcomed input from Senior Charge Nurses who were willing to be involved in this group and take on this role. Alan Blackwood advised that he would take this opportunity to the Senior Charge Nurse group for discussion and would inform Ms Dickson of the outcome of uptake.

Action: Alan Blackwood

NOTED

9 TSH3030 – 2019

Gordon Skilling advised that the 30 days of the project had come to an end. There were 38 projects at the outset resulting in 28 final posters being submitted. The level of engagement was reported as having been tremendous with 146 staff and 64 patients involved across the site. The focus of many of the projects was on engagement and activity and also staff health and wellbeing. These were felt great themes to build on.

The TSH3030 Oscars will take place on 18 December 2019. Presentations would take place in the Skye Centre then across all four hubs to ensure patient involvement.

NOTED

10 DISCHARGE PLANNING PROCESS

The Discharge Report on Variance Breakdown from April 2018 until March 2019 which was prepared by Julie McGee, Clinical Effectiveness Assistant, and was presented by Sandie Dickson.

Ms Dickson advised that this report was previously submitted to the Clinical Governance Group where Professor Thomson highlighted that she was concerned with amount of times the reason for the Variance Report not being available was “no reason”. Ms Dickson reported that the Clinical Governance Group were seeking reassurance that the reports will be completed in time and for the Clinical Forum to address this concern.

Members were in agreement that this issue would sit under the Mental Health Practice Steering Group (MHPSG) to respond. Forum Chair and or Vice Chair agreed to take this to the MHPSG.

Action: Aileen Burnett / Gordon Skilling

AGREED

11 UPDATES FROM EACH ADVISORY COMMITTEE ON SALIENT BUSINESS POINT / APPROVED MINUTES TO NOTE

Members were advised that Margaret Smith and Julie Warren would work on preparing a list of relevant committee minutes that the Clinical Forum should obtain sight of going forward.

Action: Margaret Smith / Julie Warren

NOTED

12 UPDATE FROM NATIONAL CHAIRS ACF GROUP ON 4 DECEMBER 2019

Margaret Smith provided an update from the National Platform for the area Clinical Forum meeting on 4 December 2019. Ms Smith provided an update of notes of interest from the meeting for the benefit of the Clinical Forum, in place of the Forum Chair who had been unable to attend on this

occasion. The Clinical Forum Chair and Vice-Chair noted their intention to attend this group is possible going forward.

Ms Smith advised that she would circulate to members the Realistic Medicine update from the ACFCG, as well as the Public Health – Inequalities presentation which had been delivered at the meeting.

Action: Margaret Smith

NOTED

13 CLINICAL FORUM – FORWARD PLANNER

The Forum reviewed the forward planner. Going forward, this will be continued as a live document to be reviewed at each meeting.

NOTED

14 DATES OF FUTURE MEETINGS

Dates of future meetings were confirmed.

NOTED

15 ANY OTHER BUSINESS

There were no other items of competent business.

NOTED

16 DATE AND TIME OF NEXT MEETING

The next meeting will take place at 10am on Tuesday 4 February 2020 in the Boardroom.

Board Paper 20/06

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 20
Agenda Reference:	Item No. 13
Sponsoring Director:	Interim HR Director
Author(s):	Head of Human Resources
Title of Report:	Attendance Management Report
Purpose of Report:	For Noting

1 SITUATION

The State Hospital (TSH) sickness absence level in-month figure for December 2019 was 6.41%; with an average rolling 12 month figure of 5.89% for January 2019 to December 2019. The rolling 12 month figure is 2.85% lower than the January 18 to December 2018 figure (8.74%).

The Board should note the local target level is 5%.

2 BACKGROUND

Over the last 3 years, TSH monthly absence levels have frequently been between 8% and 10%. Consequently absence management and monitoring have been areas of particular focus.

Absence data reported is extracted from both the SWISS, the national source and SSTS local information system to provide this report.

3 ANALYSIS

The December 2019 sickness level of 6.41% is the lowest December figure recorded by TSH in the last 4 years. However, this does exceed the 5.0% target and the NHS Scotland level of 5.85% for the same period (Appendix IV).

Long/short term absence split is 4.66% and 1.75% respectively. These figures were recently recalibrated and therefore make comparison with historic data irrelevant. (Appendix II).

The in-month absence level equates to a loss of 66440.87 hrs /34.07 WTE.

The current average rolling 12 month sickness figure is 5.89% for the period 1 January 2019 to 31 December 2019. This represents a 2.85% lower figure than January 18 to December 18 (8.74%). The current national target is to achieve a 0.5% reduction in sickness absence per annum over 3 years.

The main reasons for absence continue to be Anxiety/Stress/ Depression/Other Psychiatric Disorders (37%), Musculoskeletal (13%) Gastro-intestinal (8%) and Fractures (6%) (Appendix I).

4 RECOMMENDATION

The Board is asked to **note** the content of the report.

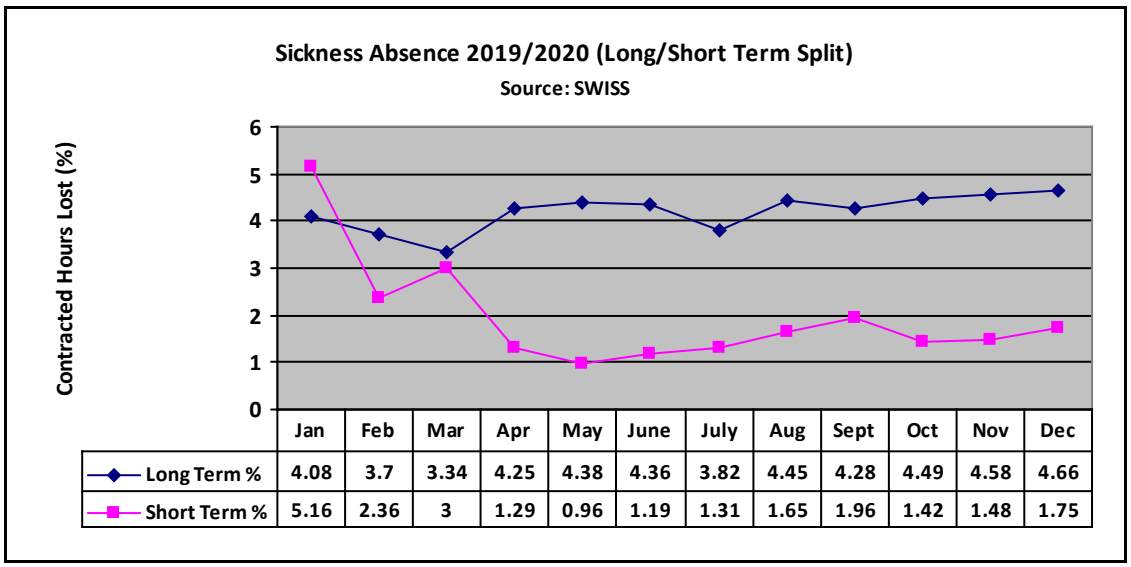
Appendix I : Absence Reasons

Absence Reason Description	Short Term Sick %	Long Term Sick %	Total (SL+Il) Working Hours Lost	Total Sick Leave inc. Industrial Injury %
Anxiety/stress/depression/other psychiatric illnesses	8.25 %	47.48 %	32891.36	37.34 %
Other musculoskeletal problems	9.26 %	10.58 %	11582.67	13.15%
Injury, fracture	4.33%	4.63%	4860.15	5.52%
Gastro-intestinal problems	19.85%	5.30 %	6923.98	7.86%
Heart, cardiac & circulatory problems	1.29 %	5.93 %	4129.78	4.69%
Cold, cough, flu - influenza	20.03%	1.66 %	4554.12	5.17%
Other known causes - not otherwise classified	3.69%	6.27%	4975.28	5.65%
Back problems	6.79%	2.24%	3005.51	3.41%
Chest & respiratory problems	4.21%	1.50%	1718.86	1.95%
Ear, nose, throat (ENT)	4.74%	1.37%	1722.07	1.96 %

Details all absences amounting to greater than 2%. Source: SSTS

LONG / SHORT TERM ABSENCE BREAKDOWN - NATIONAL DATA (SWISS)

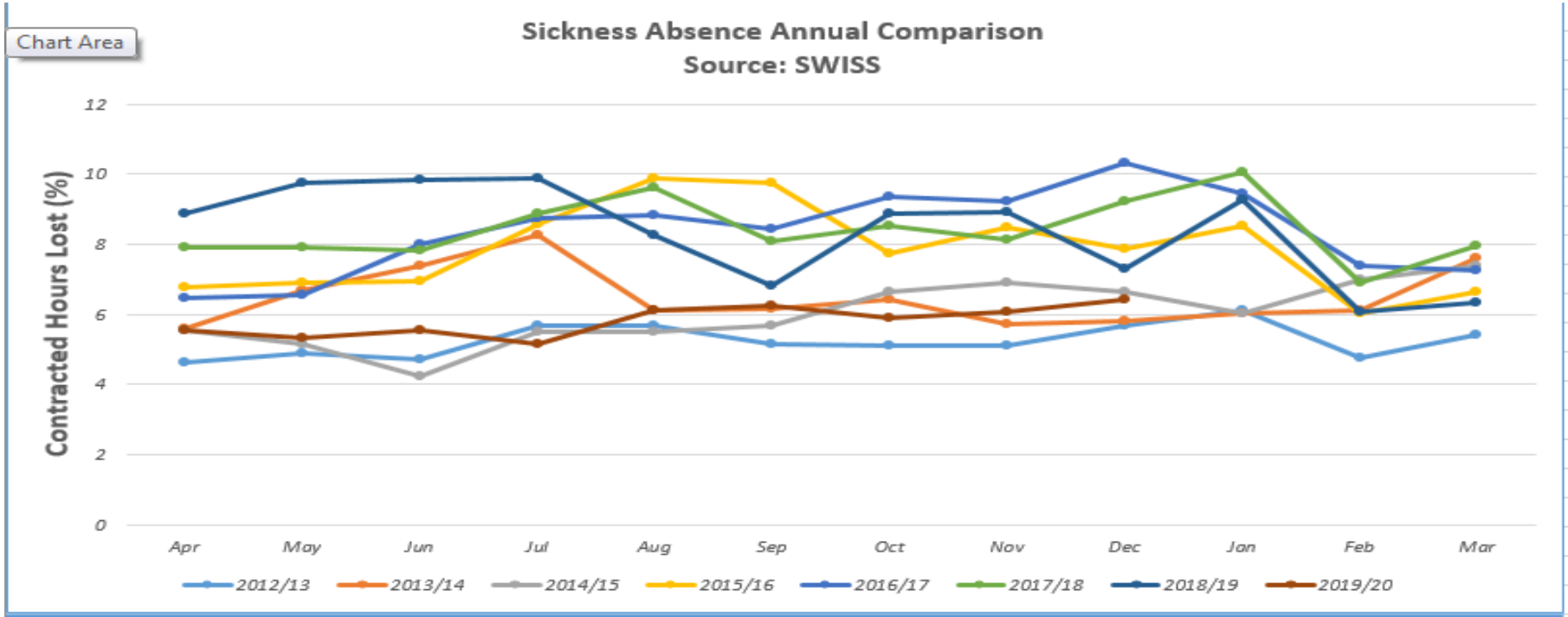
Chart 1



	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Long Term %	4.08	3.7	3.34	4.25	4.38	4.36	3.82	4.45	4.28	4.49	4.58	4.66
Short Term %	5.16	2.36	3	1.29	0.96	1.19	1.31	1.65	1.96	1.42	1.48	1.75

Chart 1 provides a rolling monthly comparison of long and short-term absence from SWISS for the State Hospital only.

Appendix III : Chart 2 - YEARLY AND MONTHLY COMPARISON - details the breakdown in percentage of sickness absence for the financial years 2012/13, 2013/14, 2014/15, 2015/16, 2016/17, 2017/18, 2018/19, 2019/20. This data is derived from SWISS.



Year/Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2012/13	4.64	4.88	4.72	5.69	5.69	5.17	5.11	5.09	5.67	6.1	4.74	5.42
2013/14	5.6	6.67	7.4	8.26	6.1	6.17	6.42	5.74	5.81	6.01	6.13	7.59
2014/15	5.54	5.13	4.21	5.49	5.52	5.68	6.66	6.91	6.65	6.02	6.98	7.38
2015/16	6.78	6.91	6.94	8.58	9.9	9.75	7.73	8.47	7.87	8.51	6.04	6.66
2016/17	6.46	6.56	8	8.75	8.83	8.42	9.34	9.23	10.32	9.46	7.38	7.26
2017/18	7.89	7.93	7.81	8.89	9.64	8.07	8.53	8.13	9.23	10.06	6.92	7.94
2018/19	8.87	9.73	9.84	9.9	8.27	6.83	8.88	8.93	7.3	9.25	6.06	6.34
2019/20	5.55	5.34	5.56	5.13	6.1	6.24	5.91	6.07	6.41			

Appendix IV: National Comparison with NHS Scotland and The State Hospital - December 2019

	Absence Rate			Instances			Absence Reason	
	Total	Long Term [1]	Short Term [2]	Total	Long Term [1]	Short Term [2]	Yes	No [3]
Scotland	**5.85**	**3.71**	**2.15**	**31,490**	**8,299**	**23,191**	**27,418**	**4,072**
NHS Ayrshire & Arran	5.62	3.56	2.06	1,831	476	1,355	1,646	185
NHS Borders	5.73	3.20	2.54	698	145	553	608	90
NHS National Services Scotland	4.69	2.94	1.75	577	133	444	552	25
NHS 24	10.59	6.34	4.25	597	142	455	537	60
NHS Education For Scotland	2.11	1.20	0.91	129	20	109	87	42
NHS Healthcare Improvement Scotland	2.87	0.85	2.03	61	4	57	59	2
NHS Health Scotland	3.14	2.11	1.03	39	10	29	38	1
Scottish Ambulance Service	9.31	6.66	2.65	1,073	431	642	988	85
The State Hospital	6.41	4.66	1.75	129	57	72	114	15
National Waiting Times Centre	4.97	2.74	2.23	338	89	249	297	41
NHS Fife	5.85	4.08	1.77	1,429	485	944	1,316	113
NHS Greater Glasgow & Clyde	6.19	4.07	2.11	7,712	2,350	5,362	7,007	705
NHS Highland	6.05	3.79	2.26	2,068	487	1,581	1,420	648
NHS Lanarkshire	6.22	4.38	1.84	2,216	715	1,501	1,924	292
NHS Grampian	5.19	2.94	2.25	3,048	605	2,443	2,339	709
NHS Orkney	5.35	3.14	2.21	125	24	101	121	4
NHS Lothian	5.14	2.81	2.33	4,823	938	3,885	4,229	594
NHS Tayside	5.57	3.61	1.96	2,224	584	1,640	1,929	295
NHS Forth Valley	6.68	4.49	2.20	1,198	356	842	1,153	45
NHS Western Isles	5.43	3.14	2.29	207	44	163	173	34
NHS Dumfries & Galloway	5.76	3.31	2.45	859	189	670	781	78
NHS Shetland	3.45	1.63	1.83	109	15	94	100	9

NITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Links to the Attendance Management Policy and aids monitoring of 5% attendance target set by the Scottish Government
Workforce Implications	Failure to achieve 5% target will impact ability to efficiently resource organisation.
Financial Implications	Failure to achieve 5% target results in additional spend to ensure continued safe staffing levels
Route To Board Which groups were involved in contributing to the paper and recommendations.	SMT, Partnership Forum
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	Failure to achieve the 5% target will impact on stakeholder experience
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	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

Minutes of the meeting of the Staff Governance Committee held on Thursday 28 November 2019 at 9.45am in the Boardroom, The State Hospital, Carstairs.

Present:

Non-Executive Director	Bill Brackenridge ***(Chair)***
Employee Director	Tom Hair
Non-Executive Director	Nicholas Johnston

In attendance:

Organisational Development Manager	Jean Byrne (part)
Occupational Health Secretary	Caron Casey (part)
Board Chair	Terry Currie
Training and Professional Development Manager	Sandra Dunlop (part)
Principal OH Advisor, Head of Commercial Services	Kay Japp (part)
Chief Executive	Gary Jenkins
Unison Representative	Anthony McFarlane
Occupational Health Advisor	Karen McGurk (part)
Head of Corporate Planning & Business Support	Monica Merson
Clinical Operations Manager	Brian Paterson
PA to Human Resources Director	Rhona Preston (minutes)
Interim HR Director	Kay Sandilands
Organisational Development & Learning Advisor	Gayle Scott (part)
Consultant Occupational Health Physician	Dr Sergio Vargas-Prada (part)

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Bill Brackenridge welcomed everyone to the meeting and noted apologies from Maire Whitehead. Members of the Occupational Health department were in attendance to present the Occupational Health Annual Report (SALUS).

5 OCCUPATIONAL HEALTH ANNUAL REPORT 2018-2019 AND PRESENTATION (SALUS)

Kay Japp, Principal OH Advisor, Head of Commercial Services introduced members of her department most who were in attendance to assist with the presentation highlighting the key priorities for the State Hospital.

- Competence of OH staff
- Quality systems, processes and advice
- Service provision including EASY
- Key Performance Indicators, although not a full year to report at today's meeting this will be available at the next report to the May meeting.
- Measures of performance
- Reducing Absence
- Price

Members were advised of the close working relationship between Occupational Health, Human Resources and Management, this incorporates the EASY service, mental health case management and absence management training.

Members received and noted the presentation and OHS Annual Report as presented by Kay Japp.

The following was detailed during the presentation;

- There is a 25% increase in management referrals and OHP utilisation is at capacity therefore this will need to be monitored in the coming year.

- The revised Service Level Agreement is in place until March 2021.

- Key Performance Indicators were implemented in April 2019 and will be monitored through the Occupational Health database. It was recognised that this is only a part report however a fuller detailed analysis for one complete year will be provided in the next annual report coming to the May meeting.

- The EASY service has been incorporated into the core service at no additional cost to the State Hospital.

- Compliance with notifying absence to EASY is good; however use of the Case Management Mental Health service could improve. Members were advised of a decrease in recent compliance. HR are currently tasked with exploring this data.

- Sickness absence % in the State Hospital ended the year at 6.34% in March 2019, a significant decrease from the start of the year at 8.87%. The reduction was noted as very positive, the continued work and focus given to reducing the absence levels is proving to be successful.

- Mental health and musculoskeletal conditions remain the commonest disorders seen in TSH staff and mental health disorders now exceed musculoskeletal as the highest reason for absence and referrals. Gary Jenkins expressed his surprise at mental health being the highest reason recorded due to the very low uptake in support offered. He asked whether the Hospital should re-focus and asked what more can be done as an organisation. Kay Japp advised that she is hopeful that the work currently being carried out is educating staff and managers alike to ensure they are fully aware of all services that staff can access which should show an increased uptake. Unfortunately many staff do not seek this information until actually required. Additional promotion and sign-posting of these services will continue. It was also recognised that the cases being referred onto the Keil Centre are more complex and complicated than before. This could be a result of staff feeling more comfortable to talk about and seek the support they require, it is doubtful this is different to anywhere else. This service was recognised as excellent in its level of care to service users.

- Spinal conditions remain the largest causation of referral to physiotherapy however these have decreased over the last year.

- Exploration of numbers attending physiotherapy who are absent at assessment and those who have absence due to apparent work related issues.

- Iona and Lewis hubs have had the largest number of referrals to OH during this period. This is in line with previous years.

- A decrease in follow up requests following traumatic incidents should be reviewed. Further work required around this area to ensure the correct support is being offered.

- The evidence base for, and they type of PMVA screening should be reviewed. This is a significant demand on the service with 251 over the last year. This is an area that may require to be looked into further looking at whether this could be done a different way, maybe by staff self disclosing at training. It was suggested the Health, Safety and Welfare Committee should look into whether this is required, paying attention to employer liability, we need to ensure we are complying fully. Kay Sandilands agreed to take forward this action with the Co-Chairs of the Health, Safety & Welfare Committee.

ACTION: KAY SANDILANDS

Currently the flu vaccinations are underway the across the site. In 2018-19, 35%, (233) TSH staff received their influenza vaccination an increase of 3% from the previous year however this remains lower than the Scottish Government target for frontline staff.

Occupational Health staff together with the Senior Nurse for Infection Control are actively campaigning across all disciplines in the Hospital encouraging the uptake of this vaccination. Numerous clinics are being held at varying times to help make this more accessible due to the unique challenges presented here. Vaccinations are offered in the Wards should staff be unable to leave their workplace and are also being offered at weekend times to help cover all requirements from staff. If staff are immunised from another source they are asked to notify the OH Secretary who will record this information.

Tom Hair, Employee Director reiterated the continued focus the flu vaccinations are being given across the site and the various ways and times these are made available to staff. He thanked those involved for their proactive ways of working. He also complimented the service received from all Occupational Health staff.

There was discussion and concern raised on the low uptake of the flu vaccination by staff, however the Committee noted the efforts being made to encourage staff to receive this vaccine. Kay Japp advised members of a possible initiative that could be introduced called 'Peer Immuniser', she explained Managers are asked to nominate an immuniser colleague, someone who already has the following skills, immunisation / anaphylactic / life saving skills, they would be briefed on what is expected and then provided with the materials required. It would be hoped that by introducing this it would add to the existing efforts that are made to ensure there is an increased uptake from staff.

Members received and noted the concise report and presentation, acknowledging the improvement and comments made to previous reports. It was noted and agreed that this report and presentation will now come to the May meetings, this will allow for a more current and meaningful reporting format.

Although it was a very comprehensive report in terms of services, Nicholas Johnston asked that additional information is included in future reports. He asked that the following is included to show a clearer representation;

- What are the future Challenges and Priorities?
- Are we doing the right things?
- Is the service any good?

ACTION: KAY JAPP, SALUS

Bill Brackenridge again thanked the Occupational Health team for their valued service advising that to provide this level of service is at a high cost to the State Hospital therefore we need to be certain we are getting value for money and the services being provided are correct.

Kay Sandilands advised the committee of a conflict of interest around this Occupational Health Service with SALUS as she will be responsible for managing when she takes up her promoted post of NHS Lanarkshire Human Resources Director, effective from 1 April 2020. She also confirmed the definite change and appetite to provide definitive data and does not anticipate any issues in providing this.

Members of the Committee agreed that having Kay Japp, Principal Occupational Health Advisor prepare and present the Annual Report added value to the presentation and discussion.

Following discussion around promoting the services available for staffs Mental Health and Wellbeing, Kay Sandilands will take this to the SALUS team to promote information sessions across the Hospital for all staff to engage. Any work will be done in Partnership and in conjunction with the Health Working Lives Group.

ACTION: KAY JAPP, SALUS

2 CONFLICTS OF INTEREST

Kay Sandilands advised members of a conflict of interest due to her being successful in a recent promotion with NHS Lanarkshire to Human Resources Director. The SLA between NHSL and The State Hospital to provide an Interim Human Resources Director continues to 31 March 2021.

3 MINUTES OF THE PREVIOUS MEETING HELD ON 29 AUGUST 2019

The Committee approved the Minutes of the previous meeting held on 29 August 2019 as an accurate record.

4 ACTION POINTS AND MATTERS ARISING FROM THE PREVIOUS MEETING

Members noted that each item either had been completed or was included in the workplan for future meetings.

5 OCCUPATIONAL HEALTH ANNUAL REPORT

As noted above.

STANDING ITEMS

6 ATTENDANCE MANAGEMENT REPORT

Members of the Committee received and noted the Attendance Management Report to 30 September 2019 as presented by Kay Sandilands, Interim Human Resources Director. It was reported that the 12 month position is 6.53% which is favourable compared to the previous year. The reduction in EASY compliance was highlighted and members informed that as an action from the partnership forum this information is being explored further, early indicators show anomalies within the data.

Members were happy with the figures recorded however there was discussion around ensuring this area remains a priority and a focus ensuring these improved figures continue. Gary Jenkins advised the Committee of the Attendance Management Improvement Working Group (AMIWG) although this group was stood down it can be revisited at any time should this be required.

The Committee noted the report and asked for continued focus in this area.

7 HR PERFORMANCE – EMPLOYEE RELATIONS ACTIVITY

Members of the Committee received and noted the Employee Relations Activity Report to 31 October 2019 as presented by Kay Sandilands, Interim Human Resources Director. The Committee were reminded that this report is presented for information and discussion due to the historic time delays experienced with HR cases. As highlighted in Appendix 1 and 2 this shows an improved position however this area requires continued work and focus. The Committee were asked to note that the areas reporting the longest delays were as a result of information being required nationally and also due to a staff member having a significant sickness absence issue resulting in lengthy delays to processes.

The support offered to staff during these cases was recognised as good and if managed well they do not need to end up as dismissal cases, the systems in place are not about punishing those suffering ill-health but are about supporting and assisting staff.

The Committee discussed the improvements made and being made from previous years, particularly around compliance with policies. A lot of work has been undertaken and will continue to remain a focus for the Hospital.

The Committee noted the report and discussion.

8 PERSONAL DEVELOPMENT PLAN REPORT

Members of the Committee received and noted the Personal Development Plan Report (PDPR), presented by Sandra Dunlop, Training and Professional Development Manager.

With effect from 18 November 2019, 85.4% of staff met the standard of having a review meeting conducted within the past 12 months this was a decrease of 1.9% from the previous month. Staff with an out-of-date PDP was 12.2% and staff who have not had a review conducted and have no PDP in place was 2.4%. These are new staff who have an overdue initial set-up meeting, which should take place at the end of their initial 3-months in post.

Sandra Dunlop advised there are no current benchmarks or statistics available however it was recognised that from discussion with her colleagues from across other Boards, The State Hospital compares very favourably.

The Committee recognised and noted the continued effort to achieve the high compliance levels recorded.

9 STATUTORY AND MANDATORY TRAINING COMPLIANCE

Members of the Committee received and noted the Bi-Annual Statutory and Mandatory Training Compliance Update up to 30 September 2019, presented by Sandra Dunlop, Training and Professional Development Manager.

It was noted that from the data presented in the report although variable across different programmes, overall compliance for statutory and mandatory training remains high and has increased over the past 6 months.

It is important to note that, following NHS Circular PCS(AFC)2019/3 (Appraisal and Incremental Progression), work is currently being progressed at a national level to introduce a standardised (Once for Scotland) approach to statutory and mandatory training across NHS Scotland. In future, incremental pay progression will be contingent on completion of core statutory and mandatory training. A national project group is currently leading on this work stream. A plan has been developed to support implementation of the changes, however, due to delays in securing funding required for development of the new training modules, it is likely that the proposed implementation date of 1 April 2020 will be need to be revised. Further details and information will be circulated on receipt and the Committee will be kept appraised of progress.

Sandra Dunlop advised that changes have been made to the Induction Process with staff being targeted to undertake their manual handling training, this commenced in November 2019 and will take a few months to see the impact of this change. She went on to summarise the report advising that there are no areas for concern.

There was discussion around food hygiene training compliance, the report showed that there had been a slight increase however this is an area that continues to be difficult to secure the release of nursing staff to attend. Following discussions at the Partnership Forum it was agreed that to help assist with the compliance levels for REHIS, Brian Paterson was asked that support and focus is given in releasing SCNs and Charge Nurses. Sandra Dunlop advised that this training session has been reduced from previous years to help with securing nursing staff to complete as required.

The Committee noted the report and thanked Sandra Dunlop for her continued effort in ensuring the compliance levels remain high.

10 CORPORATE RISK REGISTER HD111; DELIBERATE LEAKS OF DATA

Members of the Committee received and noted the Deliberate Leaks of Data, Corporate HD111 as presented by Kay Sandilands, Interim Human Resources Director. This report is being brought to this Committee further to the Finance, Risk and Performance Committee having requested that Governance groups/committees routinely review risks in their scope that are categorised as "High". This is to ensure that the Governance Committee has oversight of the risk, an opportunity to review control measures and identify any further action/controls that may further mitigate the risk.

The existing control measures;

- All staff are made aware of their obligations regarding confidentiality upon commencement with the Hospital
- A confidentiality statement is signed by all staff/volunteers who may have access to staff and patient data
- Existing formal mechanisms are in place to support staff who may wish to highlight patient / staff safety issues via the national confidential alert line and also internal whistleblowing arrangements
- To ensure that appropriate formal action is taken against any individual who may deliberately leak sensitive data regarding staff or patients to an external third party

Further control measures required;

- Annual reminder to all staff of their contractual responsibility not to deliberately leak to the media or others sensitive information regarding staff or patients
- Promote the uptake of training relating to the information governance module and annual refresher module
- Cluster access to RiO by ward rather than hub
- Review staff members that have access to all patients within RiO without requiring to identify on each occasion why they are accessing a patient's record.
- Review HR provision of information provided:
    - Ensure marked sensitive / confidential
    - Delivery methods
    - Remind at HR meetings / hearings of confidentiality
- Publish annually special bulletin on the risks associated with social media and highlight policy
- Record attendees at the Clinical Team Meetings

It was noted however that even with this, the risk impact is still considered "major" and likelihood "possible", with this the risk rating is "high".

The Committee were asked if they have any other additional measures. Gary Jenkins suggested looking at the Special Boards and Prison Service to check for different ways to mitigate measures identified that we do not have here. Nicholas Johnston asked if the annual reminder makes reference to consequences. Kay Sandilands agreed to take forward.

ACTION: K SANDILANDS

The Committee noted the risk report and control measures in place. Further controls were suggested and will be taken forward.

11 iMATTER UPDATE NOVEMBER 2019

Members of the Committee received and noted the iMatter Update at November 2019, presented by Jean Byrne, Organisational Development Manager and Gayle Scott, Organisational Development and Learning Advisor.

In general, The State Hospital is performing above average with visible improvements in the scores, it was highlighted that the scores are their highest in five years. It was also noted that focus needs to remain to ensure continued improvement. This focus is undertaken by both Jean Byrne and Gayle Scott who carry out numerous staff engagements processes, these are face to face, series of bulletins, prompts by email/phone.

Jean Byrne summarised the report advising members that over the past year the top strengths and areas for improvement remain about the same with the weakest performing areas remaining as organisational. It was recognised that this area will always be more difficult and challenging. Scores show however that on a team basis staff appear positive.

For the 2018/19 iMatter cycle, all three nursing lines within one ward were amalgamated so that one report was generated for the ward, this resulting in all three teams in a ward get a single report, each ward can agree an overall action plan that is consistent, decreased workload as it reduces the number of meetings required and it is easier to support 13 SCNs/CNs with their action planning compared to 33 separate nursing lines.

There were numerous ways for staff to engage, this could be, face to face session leading up to completion of the questionnaire, series of dedicated bulletins issued during the different stages of the cycle and in addition the induction programme now includes an iMatter session.

Across NHSScotland, 34 stories have been submitted overall, five of these (14.7%) are from teams at The State Hospital who wrote up their team story and submitted these to the national team. It is hoped that a couple of these will feature in the national report.

Concern was noted from Bill Brackenridge in relation to the information shown in Appendix 2 for areas of improvement relating to the top of the organisation. Jean Byrne explained that this is very similar across all Boards.

Jean Byrne advised she is currently preparing a report to be issued via the staff bulletin which will provide the iMatter update, highlighting the areas of concern, note the improvements and will also include the five team stories.

The Committee received and noted the iMatter update and thanked Jean Byrne and Gayle Scott for their continued focus.

12 STAFF GOVERNANCE COMMITTEE WORKPLAN 2020

Members received and noted Staff Governance Committee Workplan for 2020. The workplan assists in outlining the key areas from the various groups that report into the Committee.

Further to earlier discussions with members of the Occupational Health Department it was agreed that future annual reports will come to be May meetings. The workplan will be updated accordingly.

The Committee noted the workplan and agreed the amendment.

ITEMS FOR INFORMATION

13 FINAL INTERNAL AUDIT REPORTS (RSM)

PAYROLL and SICKNESS ABSENCE MANAGEMENT

Members received and noted the Audit Reports for Payroll and Sickness Absence Management as presented by Kay Sandilands, Interim Human Resources Director. These internal audits were conducted in September 2019, the Payroll audit provided Partial Assurance and the Sickness Absence audit Reasonable Assurance.

From the Payroll audit various areas of weakness were identified however actions have been identified in response to the findings.

The Sickness Absence Management audit noted what has been traditionally a challenging area for the Hospital however the reduction in the absence rate from 9.9% in June 2018 to 5.34% in May 2019 was recognised as a result of the continued effort both by Human Resources staff and hospital Line Managers.

The Committee noted the reports.

14 SCOTTISH GOVERNMENT: NHSSCOTLAND WORKFORCE POLICIES

Members received and noted the letter received from the Scottish Government dated 1 November 2019, outlining NHSScotland Workforce Policies and the continued work in progress. A soft launch of the Phase 1 policies will note take place between 1 November 2019 and 29 February 2020, this is a preparatory period for HR Departments and Staff-side to ensure NHS Boards readiness for launch with staff and managers effective 1 March 2020.

At the November Partnership Forum members were advised that Tom Hair, Employee Director and Linda McWilliams Head of HR will work in partnership to plan awareness sessions commencing January 2020.

The policy development for Phase 2 of the programme will then commence to address the remaining policies. Regional engagement events will be held, it is proposed that the consultation is staggered due to the number and size of the policies in this phase. It is anticipated that three consultations will be held during 2020.

The Programme is working to have the 'Once for Scotland' Workforce Policies substantially concluded by April 2021.

The Committee noted the update provided.

15 HEALTH, SAFETY AND WELFARE COMMITTEE - DRAFT MINUTES OF MEETING HELD 10 OCTOBER 2019

Members received and noted the draft Health, Safety and Welfare Committee minutes from 10 October 2019. The Committee recognised the lengthy and informative minute and were pleased that all issues can be addressed and dealt with at the meeting. However there was discussion around the current membership and whether the representation was correct from across the various disciplines. Gary Jenkins agreed to speak to David Walker to ensure all areas are involved. Monica Merson raised the issue of these meetings often not being quorate which can cause delays.

The Committee asked that the importance of these meetings taking place regularly with a full quorum was notified to the Chairs.

ACTION: G JENKINS

16 PARTNERSHIP FORUM – MINUTES OF MEETING HELD 22 OCTOBER 2019

Members received and noted the draft Partnership Forum minutes from 22 October 2019. The Committee identified and welcomed the range of issues being discussed and dealt with at this Forum.

ANY OTHER COMPETENT BUSINESS

17 ANY OTHER BUSINESS

There were no other items of business for consideration.

18 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 20 February 2020 at 9.45am in the boardroom, The State Hospital, Carstairs.

Board Paper 20/07

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2020
Agenda Reference:	Item No: 15
Sponsoring Director:	Chief Executive Officer
Author(s):	Chief Executive Officer
Title of Report:	Corporate Objectives 2020-21
Purpose of Report:	For Decision

1 SITUATION

This document sets out the draft Corporate Objectives for The State Hospitals Board for Scotland for the period 2020/21.

2 BACKGROUND

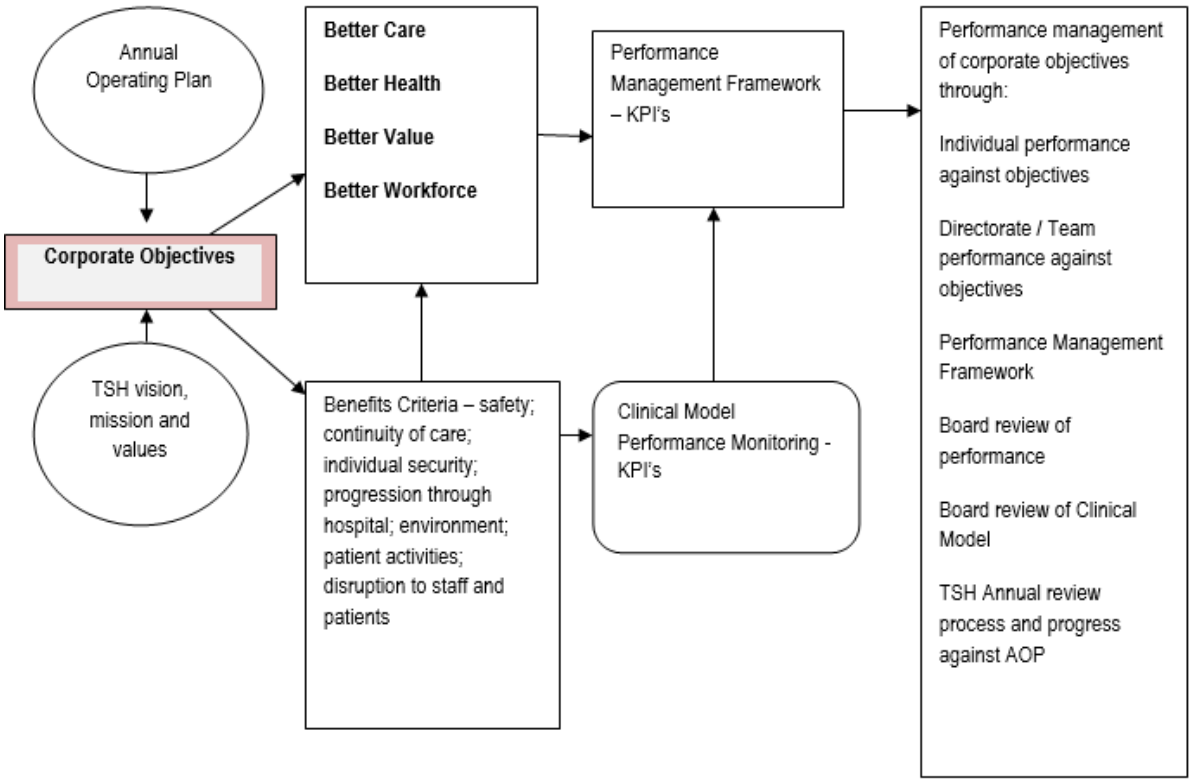
The draft Corporate Objectives were developed in collaboration with the Executive Directors, taking account of the current priorities across the organisation.

3 ASSESSMENT

Objectives are grouped around the key themes of Better Care, Better Health, Better Values and Better Workplace.

Diagram 1 shows the alignment of the Corporate Objectives within the context of the operational business model for The State Hospital.

Diagram 1:



The Corporate Objectives set out to:

- Improve the quality of care for people by targeting investment and focus at improving services with the high security environment and for providing the most effective support for all. **(Better Care)**

- Improve health and wellbeing by promoting and supporting healthier lives and choices, addressing inequality and adopting an approach based on recovery, care and treatment. **(Better Health)**

- Increase the value from, and financial sustainability of, care by making the most effective use of available resources through efficient and effective service delivery **(Best Value)**

- Improve the engagement of staff and opportunity for development through effective values based leadership resulting in a culture of quality and accountability **(Better Workplace)**

4 RECOMMENDATION

The Board is asked to review the draft Corporate Objectives and **consider approval,** subject to views and amendments from Non-Executive Directors.

Diagram 2:

Better Care	▪ Deliver the reconfigured Clinical Model enabling TSH to provide a progressive care approach for patients treatment and recovery ▪ Ensure the principles of the patient active day are delivered across all service areas ▪ Deliver care and treatment within the framework of least restrictive practice ▪ Sustained organisational resilience, able to identify and respond to risk ▪ Monitor the use and recording of seclusion practice in accordance with the revised definitions published by the Mental Welfare Commission ▪ Collaborate with the Forensic Network in the delivery of quality care guidance and standards applicable to the Forensic Mental Health Environment ▪ Be accessible to patients, their family and visitors whilst accessing care and treatment at TSH ▪ Work with stakeholders and Scottish Government representatives to enhance the reputation and develop the healthcare profile of TSH ▪ Take forward national collaboration with the newly formed Health in Custody Network ▪ Deliver a programme of Infection Control related activity in line with national policy objectives
Better Health	▪ Tackle and address the challenge of obesity within TSH ▪ Improve the Physical Health opportunities for patients under the care of TSH ▪ Ensure the delivery of tailored mental health and treatment plans individualised to the specific needs of each patient ▪ Address the overall social wellbeing issues for patients undergoing treatment ▪ Ensure the organisation is aligned to the values and objectives of the Mental Health Strategy ▪ Utilise connections with other health care systems to ensure patients receive a full range of healthcare support during their with TSH ▪ Align TSH with the aims and ambitions of Medium Secure and other treatment pathways to provide cohesive care and treatment for patients transferring to other services

Better Value	▪ Meet the key finance targets set for the organisation and in line with Standard Financial Instructions ▪ Develop a sustainable three year finance model which supports the sustainability of the organisation ▪ Enhance and strengthen the digital infrastructure and I.T. processes in use within TSH ▪ Deliver the security upgrade planned across 2020/21 and 2021/22 for the safety of staff, patients and the general public ▪ Work collaboratively across public sector bodies to ensure that best value is achieved in service planning, design and delivery ▪ Strengthen the corporate governance blueprint to ensure transparency and clear direction, within and external to, the organisation ▪ Ensure quality improvement is embedded within TSH ▪ Collaborate with national review process
Better Workforce	▪ Promote and deliver the culture change framework emerging from the Values, Behaviours, Culture and Leadership work stream ▪ Building on i-matter and staff governance principles to deliver an inclusive staff engagement programme in partnership to support the wellbeing of all employees ▪ Agree an assurance model to support the implementation of the Health and Care (Staffing) (Scotland) Bill (2019) across TSH ▪ Sustain a safe working environment for staff with a focus on risk management across all aspects of the organisation ▪ Continue with the Healthy Working Lives programme and activities for the benefit of staff ▪ Ensure accessibility to support to internal and external services for staff who require them ▪ Review and action absence related issues and staff wellbeing measures throughout the implementation of the revised Clinical Model ▪ Continue to provide flexible working patterns for staff including ‘retire and return’ and prospective employees wishing to work at TSH ▪ Ensure partnership working is embedded across the organisation ▪ Consider introducing a ‘you suggested, we listened’ initiative ▪ Encourage innovation and participation in the running of the organisation through the TSH3030 programme

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To present the draft corporate objectives 2020 to the NHS Board for their consideration and approval.
Workforce Implications	As outlined in paper
Financial Implications	As outlined in paper
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)	As outlined in paper
Assessment of Impact on Stakeholder Experience	As outlined in paper
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).	No issues identified
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.

Board Paper 20/08

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2020
Agenda Reference:	Item No: 16
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Draft Annual Operational Plan Update
Purpose of Report:	For Noting

1 SITUATION

The Board submitted a draft Annual Operational Plan for the financial year 2020/21 to Scottish Government in November 2019, with work in this regard has been further progressed through the Chief Executive and colleagues at the Mental Health Directorate.

2 BACKGROUND

A second draft was submitted to Scottish Government on 14 February 2020, with a further review meeting scheduled for 24 February 2020.

3 ASSESSMENT

The draft Annual Operational Plan has been circulated to Board Members for their information, and assurance is given that subject to further review a final draft will be submitted to Scottish Government on 28 February 2020.

The Board will consider a paper from the Chief Executive Officer outlining the Corporate Objectives for 2020/21, as part of the Board meeting on 27 February 2020, and this will inform the draft Annual Operational Plan.

4 RECOMMENDATION

The Board is asked to note progress to date in work progressed to draft the Annual Operational Plan 202/21. The final draft will be submitted to Scottish Government on 28 February 2020 with further reporting to the Board thereafter.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	AOP agreed in conjunction with Scottish Government
Workforce Implications	As indicated within draft AOP
Financial Implications	As indicated within draft AOP
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)	As indicated within draft AOP
Assessment of Impact on Stakeholder Experience	As indicated within draft AOP
Equality Impact Assessment	Not formally assessed
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No impact identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2020
Agenda Reference:	Item No: 17
Sponsoring Director:	Director of Security, Estates and Facilities
Author(s):	Programme Director; Head of Estates and Facilities
Title of Report:	Perimeter Security and Enhance Internal Security Systems: Project
Purpose of Report:	For noting

SITUATION

The re-tendering of the project has taken place, the resulting bids evaluated and a preferred Contractor identified. This paper summarises the status of the project, and the process to be followed moving forward with the successful Contractor.

BACKGROUND

Previous papers to the Board have given a detailed explanation of the nature of this project and the rationale behind it; an evaluation of the existing security measures coupled with a threat assessment of current and potential future threats identified the need for a programme of replacement and additional security measures.

ASSESSMENT

The successful Contractor is Stanley Security Solutions Limited, and the finalised contract was signed on Thursday 6 February 2020. A contract pre-start meeting was held with Stanley on Friday 7 February 2020.

A draft Project Programme was submitted by Stanley at the pre-start meeting and discussed. It was agreed that a Programme Workshop would be held to further discuss and agree a finalised programme of works. This has been arranged for 24 & 25 February 2020. There then will follow two days of survey work by Stanley on 26 & 27 February 2020.

Following these two pieces of work, a finalised programme will able to be circulated, and will be used to inform the hospital of the impact and timescales related with the Project.

The Project Oversight Board is being led by the Chief Executive and the Director of Security, Estates and Facilities, and a draft terms of reference are attached at Appendix A. The Project Oversight Board was due to meet on 12 February 2020 but this meeting required to be re-scheduled due to inclement weather at The State Hospital. This is being re-scheduled and will include review of the draft terms of reference in detail. Further reporting will be brought back to the NHS Board at its next meeting in April 2020.

RECOMMENDATION

That the Board note the current status of the Project.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Maintain / improve safety and security
Workforce Implications	Admin support and Director costs to be addressed through revenue, though this is under discussion
Financial Implications	Overall reduction in maintenance cost if approved Significant increase in revenue requirement if not approved Capital expenditure if approved
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Project Oversight Board and Corporate Management Team
Risk Assessment (Outline any significant risks and associated mitigation)	Risk to service if not approved
Assessment of Impact on Stakeholder Experience	Addresses request from patients for introduction of CCTV in clinical areas
Equality Impact Assessment	N/A

The State Hospitals Board for Scotland

Perimeter Security and Enhanced Internal Security Systems Project

Project Oversight Board - Terms of Reference

1. Purpose

The NHS Board has established a Project Oversight Board to provide the required degree of assurance on the progression of the Perimeter Security and Enhanced Internal Security Systems Project in accordance with the Corporate Objectives of The State Hospitals Board for Scotland, and the appropriate statutory and mandatory standing orders and regulations.

The Project Oversight Board (POB) will provide oversight and assurance, and make recommendations to the NHS Board in line with its remit.

2. Membership

Members:

Gary Jenkins: Chief Executive Officer (Co-Chair)
David Walker: Director of Security, Estates and Facilities (Co-Chair)
Robin McNaught: Finance and Performance Management Director
Mark Richards: Director of Nursing and AHPs
Doug Irwin: Project Director
Tom Hair: Employee Director
Bill Sinclair: Scottish Prison Service

In Attendance:

Wesley Bathgate: Senior Project Manager, Thomson Gray
Derek McDonald: Security Advisor, D4
Kenny Andress: Head of Estates and Facilities
Mary Frame: Procurement Manager

The NHS Board Chair is not a member of the POB, but may attend any meetings of the POB.

3. Reporting Arrangements

The POB will report to the NHS Board following each meeting – this will be through the submission of the approved Minutes as well as a summary report of the key issues.

The POB will submit an Annual Report to the NHS Board, in June, and this will include: the name of the POB, membership and attendees and officer support, the frequency and dates of meetings, the activities of the POB during the year, any matters of concerns to the POB; confirmation that the POB has fulfilled its remit and of the adequacy and effectiveness of internal controls.

The POB will undertake an Annual Workplan aligned with the Project programme and this will be submitted with the Annual Report.

The POB will undertake an annual review of the Terms of Reference. If this review results in amendment, the revised Terms of reference should be submitted to the NHS Board for endorsement.

4. Key Responsibilities

1. To endorse the scope of the Project, and the benefits to be realised in development, including the clinical service delivery model of the NHS Board.
2. To ensure that the completed facilities are delivered on programme, within budget and are compliant with the NHS Board's corporate objectives and requirements.
3. To ensure that the resources required to deliver the project are available and committed.
4. To ensure appropriate governance through the procurement process and through the Capital Investment Group at Scottish Government.
5. To assure that the project remains within the framework of the overall project strategy, scope, budget and programme as set out in the business case.
6. To review and report changes to the scope of the project e.g. time, cost, quality, to the NHS Board.
7. To promote financial governance and monies and report the adherence within affordability parameter set out by Scottish Government and the NHS Board.
8. To review the risk management plan, ensuring all risks are identified; that appropriate mitigation strategies are actively applied, managed and escalated as necessary, providing assurance to the NHS Board that all risks are being effectively managed.
9. To ensure that staff, partners and service end users are fully engaged in designing operating policies that inform the detailed design and overall procedures that will apply, ensuring that the facilities are service led, not building led.
10. To ensure that communication planning enables the appropriate involvement of and communication with all stakeholders, internal and external, throughout the project.
11. To ensure that appropriate systems of assurance are in place for the functional commissioning of the facilities and operation of the project systems.

5. Conduct of Business

Meetings:

The POB will normally meet monthly. The Co-Chairs may convene additional meetings or change the frequency of meetings as deemed necessary.

The POB may ask any or all of those who attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

The NHS Board may ask the POB to convene further meetings to discuss particular issues on which they want the POB's advice.

Quorum:

A minimum of four members of the POB will be present for the meeting to be deemed quorate.

In the event of a meeting becoming inquorate once convened, the Co-Chairs may elect to continue receiving papers and to allow those present to ask questions and discuss particular matters. The minute should state the point at which the meeting became inquorate but notes of any discussion can be included. Every item discussed and noted in this way will be brought to the next meeting of the POB, under matters arising, for ratification.

Absence of Co-Chairs:
In the event of the Co-Chairs being absent, another member can be designated the chair for the meeting, and this should normally be arranged by the Co-Chairs in advance of the meeting.

Agenda, Papers, Workplan and Minutes:
The POB should have a workplan for the year mapped to the remit of the POB.

The Co-Chairs will set the agenda.

Papers should be submitted to the Project Administrator at least seven working days prior to the meeting. The finalised agenda and papers will be issued to members at least three working days before the date of each meeting.

The meeting will be minuted and will record decisions, actions and responsibilities, actions against identified risks and follow up. Minutes will be submitted to the NHS Board, and published on The State Hospital website as part of the NHS Board papers.

Annual Report:
The POB will prepare and submit an Annual report to the NHS Board in June each year, and this should include:

- The name of the POB, the Co-Chairs, Membership, Executive Leads and Officer supports.
- Frequency, Dates of meetings and attendance.
- The activities of the POB over the year, including confirmation of delivery of the workplan and review of the terms of reference. Should the terms of reference be revised, these should be submitted to the NHS Board for approval.
- Improvements that have been overseen by the POB
- Any areas of concern to the POIB, including Risk.
- Confirmation that the POB has fulfilled its remit, and of the adequacy and effectiveness of internal control.

6. Information Requirements

For each meeting the POB will be provided with a report which will include as a minimum:

Progress Update (business, design and construction)
Current status against key programme elements
Current status against cost planning
Project Risk Register with description of mitigating actions

Communications planning with internal and external stakeholders
7. Executive Leads
The Chief Executive Officer and the Director of Security, Estates and Facilities will co-chair the POB. Accountability for ensuring the longer term security needs of The State Hospital are aligned to the Director of Security, Estates and Facilities, within the project governance structure. Accountability for the financial aspects of the project are aligned to the Finance and Performance Management Director.
8. Access
POB Members will have free and confidential access to the Co-Chairs of the POB.
9. Rights
The POB may procure specialist advice at the expense of the organisation, subject to budgets agreed by the NHS Board or the Chief Executive Officer as Accountable Officer.

Author(S):	Margaret Smith, Board Secretary
Ratified by The State Hospitals Board for Scotland:	February 2020 Meeting
Review Date:	February 2021

THE STATE HOSPITAL BOARD FOR SCOTLAND

Date of Meeting:	27 February 2020
Agenda Reference:	Item No 18
Sponsoring Director:	Director of Finance and Performance Management
Author(s):	Head of Management Accounts
Title of Report:	Financial Position as at 31 January 2020
Purpose of Report:	Update on current financial position

1 SITUATION

The Board is asked to consider the Revenue and Capital Resources spending plans, and monitor financial outturn. This report provides information on the financial performance to 31 January 2020, which is also reported to the Senior Management Team and Partnership Forum, and is issued monthly to Scottish Government (SG) along with the statutory financial reporting template.

2 BACKGROUND

Scottish Government are provided with an annual Operational Plan and 3-year financial forecast template, which was confirmed at the 20 June 2019 Board meeting, setting out a balanced budget for 2019/20 based on achieving £2.103m efficiency savings, as referred to in the tables in section 4.

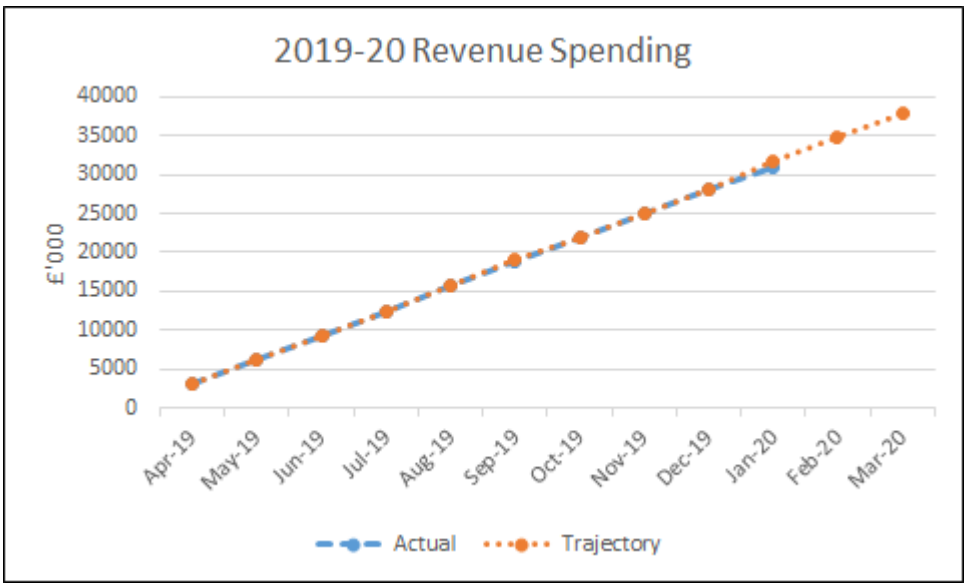
The annual budget of £37.645m is primarily the Scottish Government Revenue Resource Limit allocation, now augmented with the addition of part funding of the costs of the recent Pay As If At Work ("PAIAW") agreement).

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The Board is reporting an under spend of £0.236m to 31 January 2020 – which is a year-to-date variance of 0.8%.

Per the chart below, the current spending position is therefore closely aligned with the forecast trajectory / budget. It is currently anticipated that the forecast break-even position will be achieved for the 31 March 2020 year-end, although certain pressures are highlighted in paragraph 3.2, and outstanding savings pressures remain to be addressed per para. 4.



At this stage in 2018/19, there was an overspend of £0.223m. Much of the improvement is due to the reduction in Nursing ward overtime costs of £0.720m.

Specific nursing controls were introduced in 2019 with the aim of reducing overtime – e.g. increasing the number of new start staff working on a five over seven day shift pattern and the use of pool staff to cover clinical activity. These controls are being monitored by nursing with the aim of evaluating their impact on 2019/20, and to provide meaningful comparisons for the future evaluation of the impact of the new clinical model in 2020/21.

However, while overtime levels are reduced, they continue to be affected by nursing staffing recruitment challenges, similar to other patient facing NHS Boards, but also sickness absence and clinical activity associated with the high numbers of 'exceptional circumstances' patients in our care.

3.2 **Key financial pressures / potential benefits.**

	PRESSURES	Risk	Best estimate £'k
(i)	Holiday Pay - Lock v British Gas - PAIAW - Full Year 19/20 (NB Received RRL for £141k for Aug 17 to Mar 18 retrospection)	High	140
(ii)	Rebandings arrears (some already paid to date)	High	tbc
(iii)	Clinical Model Review	High	tbc
(iv)	Legal Fees	High	101
(v)	Office 365	High	250
(vi)	3 yr up for opt out sup'an end Nov 19 (approx 100 staff not sup'an)	Med	112
(vii)	EU Exit (may get guidance from sub group)	Low	tbc
(viii)	Perimeter Fence - FBC - Additional Staff (Capital funding pending)	Low	170
	BENEFITS	**Risk**	
(ix)	Exceptional Circumstance Patients (new - recharging host Board)	Med	290
(x)	VAT element on Utilities in our favour (v HMRC) (some already paid to date)	Low	50

i – PAIAW
This was a ruling from the courts following the Lock v British Gas case, for payment as if at work, so in effect staff at TSH now get a % payment for overtime when on annual leave. Payments in 2019/20 to date comprise (SG funded) Aug 2017- Mar 2018 £141k, and TSH funded Apr 2018 - Mar 2019 £210k. In addition, the value for 2019/20 was originally estimated as £212k (first tranche paid December 19, £101k, and is to be funded by TSH).

However, because overtime has reduced considerably this financial year the payment is much less than planned (based on prior year's amounts).
There has been a thorough review of central reserves, and finance for this has been identified. However, there may be claims going further back, but nothing definite yet.

ii - Rebandings
There was a number of rebanding appeals for certain posts within the hospital, the most recent of which was backdated to 2015; costs of these require to be recognised in the year of settlement.
This year to date (Dec 19) we have paid £25k of arrears (this excludes PAIAW arrears). HR have taken action to improve this process and reduce the number of outstanding grading appeals.

iii – Clinical Model review
The review of the clinical model has identified potential recurring savings in ward nursing, - values to be confirmed – which would be beneficial from early 2020/21 and will be monitored as part of the overall evaluation of the model. There are, however, potential unidentified 2019/20 costs yet to be determined subject to the steps required to prepare for the implementation of the model e.g. Estates costs.

iv – Legal fees
These are currently higher than budgeted due principally to individual one-off cases requiring significant CLO input. All use of CLO is scrutinised to ensure it is essential and their advice is taken at all times regarding potential settlement of cases.

v – Office 365
NHS Scotland are directing all Boards to the implementation of Office365 in 2020. This will require input from all directorates and much staff commitment. While the plan is likely to be underway in early 2020, the potential costs are being evaluated and should additional funding be required to meet the demands of this, a specific business case will be developed.

vi – Superannuation opt-out
Staff who are not superannuated will be automatically enrolled at the end of November 2019 (this happens every three years), for those who do not choose to opt out (within 4 months – this will be tracked), the Board will incur sup'ers on costs. The hit in December pay is £28k.

vii – EU Exit
While there are no specific costs currently identified, this aspect will continue to be monitored.

viii – Perimeter Fence project
While we have had authorisation by email that certain additional staff costs (facilitation / support staff) directly related to the project will be able to be included in the final capital settlement, this remains noted as a potential risk in case there is any change in the application of the allocation by SG.

ix – Exceptional Circumstance patients
Six boards are due to pay TSH for patients who are at the Hospital under "exceptional circumstances" from other territorial boards – generally due to lack of bed availability. The six boards have all been written to formally regarding o/s payments and while one board has responded positively to date (£50k approx.), responses from the others remain (£290k approx.) This matter will be escalated between Finance Directors to Chief Executives.

x – HMRC
HMRC has settled in our favour to reduce VAT on utilities to 5% from 20%, providing a windfall payment, which has benefitted TSH in 2019/20 (£64k). This has concluded the process re Electricity costs, with details now awaited re Gas.

3.3 **Year-to-date position – allocated by Board Function / Directorate**

Directorates	Annual Budget 19/20 £'k	YTD Budget Jan 20 £'k	YTD Actuals Jan 20 £'k	YTD Variance (budget - actual) (adverse) / favourable Jan 20 £'k	Budget wte	Actual WTE
Nursing And Ahp's	19,856	16,614	16,293	321	378.53	371.48
Security And Facilities	5,952	4,992	4,903	89	123.63	117.77
Medical	3,732	3,096	2,872	225	36.58	32.93
Chief Exec	1,844	1,537	1,493	44	22.45	21.16
Human Resources Directorate	836	697	693	4	13.38	13.38
Finance	2,977	2,513	2,524	(12)	37.53	36.92
Cap Charges	2,857	2,381	2,379	2		
Misc Income	(224)	(187)	(90)	(96)		
Central Reserves	(186)	(341)		(341)		
Under / (over) spend	**37,645**	**31,302**	**31,066**	**236**	**612.10**	**593.64**

Nursing & AHPs - see further detail below

Security & Facilities – see further detail below

Medical – There is in–year pressure due to cross-board costs for Senior Trainee Doctors, although there is an overall underspend of £0.063m due to changes in staffing. Continuing vacancies in Psychology gives rise to an underspend of £0.129m. Drugs also has an underspend of £0.033m.

Chief Executive – There is a small underspend resulting from the current interim HR director being with TSH on a 0.5 WTE basis against a full-time budget.

HR – While there is no overall significant variance, there are in-year pressures from Occupational Health due to backdated invoicing for 2018/19, and for additional physiotherapy sessions (for which funding was in fact then released in September). These pressures have been offset by underspends in course fees through the Learning Centre.

Finance – The main overspend is the result of the higher legal fees for the year to date (as noted in para 3.2.iv.

Capital Charges – These relate to depreciation for the period and have no significant variance.

Miscellaneous Income – The benefit is noted of the forecast saving for VAT benefits on utilities, now partly realised per para. 3.2. x. However, the income was offset with a payment of fees, which has an adverse impact on the variance.

Central Reserves – Balance of unidentified savings are higher than reserves, giving a credit balance, remaining reserves are mainly for apprenticeship levy and provisions that hit the ledger at the year-end. Other reserves are for additional funding from SG for specific projects (many are Nursing), however there are timing delays and some of this helps fund some of the pressures noted in 3.2 above.

3.3.1 **Nursing & AHPs** – further breakdown as below –

Nursing & AHP's	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 10	Budget WTE	Actual WTE
Advocacy	147	123	121	2	0	0
AHP's & Dietetics & SLA'S	653	542	495	46	13	13
Hub & Cluster Admin & Clinical Operations	831	691	651	40	23	20
PCI & Pastoral	220	183	141	42	3	2
NPD & Infection Control & Clin Gov	416	347	328	19	6	3
Skye Centre	1,738	1,451	1,297	155	38	35
Ward Nursing	15,851	13,277	13,261	16	295	299
Total Nursing and AHP's	**19,856**	**16,614**	**16,293**	**321**	**378.53**	**371.48**

Underspends (apart from Advocacy) are due to staff vacancies.

Ward Nursing – further breakdown as below -

	2019/2020	Ward Nursing overtime						
Prior Year Variance £'k	Ledger Ward Nursing	Annual Budget £'k	In month / Year to Date Budget £'k	In month / Year to date Actuals £'k	YTD Variance (budget less actuals) £'k	Budget WTE	Actual WTE	Contracted/ conditioned wte's
23	Total April 19		1,286	1,350	(65)	295.00	318.77	289.30
(43)	Total May 19		1,286	1,343	(58)	295.00	315.33	289.30
(117)	Total June 19		1,286	1,282	3	295.00	309.54	286.30
(84)	Total July 19		1,286	1,286	(1)	295.00	303.18	288.28
(194)	Total Aug 19		1,577	1,583	(6)	295.00	309.99	281.72
(116)	Total Sept 19		1,293	1,301	(8)	295.00	312.86	291.55
(90)	Total Oct 19		1,287	1,264	23	295.00	296.78	285.70
(28)	Total Nov 19		1,322	1,244	78	295.00	302.54	287.00
4	Total Dec 19		1,369	1,335	34	295.00	301.23	290.64
(61)	Total Jan 20		1,287	1,272	15	295.00	299.25	293.14
(705)	Cumulative	15,851	13,277	13,262	15			
^ slot in								
	Variance analysis:		PAIAW arrears Aug 19 and Dec 19					
	Overtime for vacancies backfill				(309)			
	Phased savings (not yet realised)				(125)			
	'Nursing Resource' to analyse			*	448	New control measures in place		
					15			

The underspend to date, in comparison to the previous year's overspend £0.705m, is vastly improved, this is due to various management control measures now introduced and in place. It is hoped that this stabilisation since June 2019 will continue for the remaining months of 2019/20, although this will continue to be carefully monitored in order to prepare for meaningful comparison to levels under the new clinical model in 2020/21.

3.3.2 **Security and Facilities** – further breakdown as below –

Security & Facilities	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 10	Budget WTE	Actual WTE
Facilities	4,206	3,516	3,399	117	84	75
Security	1,640	1,368	1,396	(28)	40	38
Perimeter Security	107	107	107	(0)	0	4
Total Security & Facilities	**5,952**	**4,992**	**4,903**	**89**	**123.63**	**117.77**

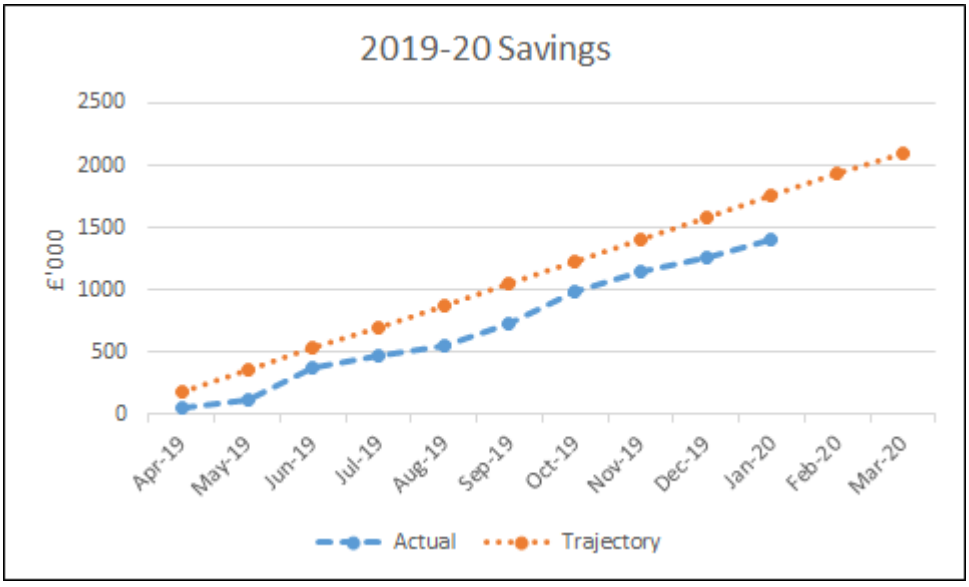
Facilities – The favourable variance for the period is due to vacancies in Estates & Housekeeping, and an underspend in the utilities costs for the year. Utilities costs remain difficult to forecast due to unpredictable weather through the year, and can vary significantly between months. The income for the dining room has far exceeded the plan this year.

Security – The overspend is due to changes in staffing structure. However, a workforce review should address this within the Directorate.

Perimeter Fence – The potential pressure of the costs of project staffing are currently recognised within unidentified savings pressures, pending final confirmation of their inclusion in capital funding (per para. 3.2. viii).

4 ASSESSMENT – SAVINGS

4.1 While there have been strong efforts across all directorates towards achieving a challenging savings target, the board at 31 January remains behind trajectory on the planned savings to date.



There remains a major focus through all directorate budget-holder reviews to identify the means of addressing this shortfall, and this will continue as the main financial priority.

The following table shows the target savings from the Operational Plan, with savings achieved to date and the remaining balance still to be achieved by the year-end.

Savings Annual Target LDP	Savings Annual Target LDP			Savings (Achieved), as at Jan 20			Savings still to be achieved by year end		
	2019-20 Rec £'k	Non-Rec £'k	Total £'k	2019-20 Rec £'k	Non-Rec £'k	Total £'k	2019-20 Rec £'k	Non-Rec £'k	Total £'k
Efficiency & Productivity Workstreams:									
Service redesign (Clinical)	(22)	(95)	(116)	0	70	70	(22)	(25)	(46)
Drugs & Prescribing	0	(20)	(20)	0	46	46	0	26	26
Workforce	(57)	(481)	(538)	22	841	863	(34)	360	326
Procurement	0	0	0	0	0	0	0	0	0
Infrastructure *(e.g.facilities mgt, IT, other support services)*	(56)	(309)	(365)	5	199	204	(51)	(110)	(161)
Other	0	(100)	(100)	0	0	0	0	(100)	(100)
Financial Management / Corporate Initiatives	0	0	0	0	0	0	0	0	0
Unidentified Savings	0	(965)	(965)	0	223	223	0	(742)	(742)
Total In-Year Efficiency Savings	**(134)**	**(1,969)**	**(2,103)**	**27**	**1,379**	**1,406**	**(107)**	**(591)**	**(697)**
Trajectory (1/12ths of LDP)				**112**	**1,641**	**1,753**			
(under) / over achieved against trajectory				**(84)**	**(263)**	**(347)**			

It remains a key target to reduce the over-reliance on non-recurring savings. While the extensive work on the clinical model review was not undertaken with the aim of savings, it is anticipated that the planned model's implementation will however result in some being achieved – and this would provide a key contribution to improving the recurring / non-recurring balance.

While an improved level of the proportion of recurring savings is a national focus that has been highlighted by audit, it should be noted that of the Hospital's budget, nearly 85% of costs are pay/staff-related. The remaining non-pay cost element from which recurring savings are being pressured is therefore only 15%.
By comparison, many territorial boards have a non-pay cost element of around 65%, and other National boards have non-pay costs ranging from around 80% (NSS, NES) to 30/40%.

4.2 National Boards Contribution

The eight National Boards (formerly Special Boards) continue to work towards joint efficiencies and collaborative working. With a challenging £15m collective savings target to be achieved per annum, there is pressure on each board to contribute towards any shortfall. The State Hospital's share of this in 2017/18 was £440k, and when this was proposed again in 2018/19 it was resisted due to other costs and savings pressures, and a contribution was agreed of £220k as then approved by the Board. We have anticipated the return of the £0.127m from SG.

While the level to which the Board have agreed for 2019/20 has remained at £220k, there continues to be pressure due to the £15m not yet being fully attained. However, the position presented by both the Finance & Performance Management Director and the Chief Executive at their respective National Board sessions is that £220k remains our maximum contribution, subject only to any significant underspend should it be the position after final year-end audit, and while also noting that there is currently no contribution for 2019/20 from another, larger board.

5 CAPITAL RESOURCE LIMIT

The capital allocation from Scottish Government for the year is £0.269m, from which as noted below a part-contribution is agreed each year towards the perimeter fence project.

The Capital Group meets regularly to monitor capital spend and demands across the site, and it is anticipated that the allocation will be fully utilised in the year, with projects identified for the remaining unspent balance.

	Annual Plan £'k	YTD Plan £'k	YTD Actual £'k	YTD Variance £'k
Estates	165	30	30	-
IM&T	104	104	104	-
Vehicles	-	-	-	-
Other equipment	-	-	-	-
Security Fence Dvpt	-	45	45	-
TOTAL	**269**	**179**	**179**	**-**

6 RECOMMENDATION

Revenue
Year-to-date: £0.236m under-spend; year-end projection: break-even
Capital
Year-to-date: break-even; year-end projection: break-even

Quarterly Financial Review meetings across all directorates, over and above the regular monthly Management Accounts meetings, help maintain accurate revenue budgeting in the accounts and support forecasting the year-end outturn. A strong emphasis on the management of savings remains the priority for the Board.

TSH Board members are asked to note the content of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of Financial Position
Workforce Implications	No workforce implications – for information only
Financial Implications	No workforce implications – for information only
Route to SG/Board/SMT/Partnership Forum Which groups were involved in contributing to the paper and recommendations.	Head of Management Accounts
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ☑ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed. ☐ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2020
Agenda Reference:	Item No: 19
Sponsoring Director:	Finance and Performance Management Director
Author:	Head of Corporate Planning and Business Support
Title of Report:	Performance Report Q3 2019/2020
Purpose of Report:	For noting

1 SITUATION

This report presents a high-level summary of organisational performance for Q3 October - December 2019. A summary table and run charts for the performance indicators may be found in Appendix 1. We have added Q2 red, amber, green data to this table to give some trend data.

The only national LDP standards directly relevant to the State Hospital are as follows: Psychological Therapies Waiting Times and Sickness Absence. Additional local KPIs are reported to the Board and included in this report. Going forward, the LDP process has been replaced by a requirement for each Board to submit an Annual Operational Plan for 2018-19. A review of the broader LDP standards is also being undertaken at a national level.

2 BACKGROUND

Members receive quarterly updates on Key Performance Indicator (KPI) performance as well as an Annual Overview of performance and a Year-on-Year comparison each June.

3 ASSESSMENT

We have maintained good levels of performance in many areas but performance in the following areas merit comment:

No 1 Patients have their care and treatment plans reviewed at 6 monthly intervals.

On 31 December 2019 there were 105 patients in the hospital. Eleven of these patients were in the admission phase. Five CPA documents had not been reviewed within the 6 month period. All 5 were out of date (however all have either been held and are not in RiO yet or are due shortly). This gives a compliance of 94.7% which is a slight rise from September's 91.7% compliance. This indicator remains amber.

Health Records staff continue to send reminder emails to RMOs and medical secretarial staff to advise that a patient's review or renewal of detention is due. The renewal of detention ties in with the annual CPA document being completed.

No 3 Patients will be engaged in off hub activity centres

For Q3, 80% of patients were involved in off-hub activities. This is a slight decrease from 84% in Q2.

This percentage doesn't include patients planned to attend the hospital shop, patients scheduled to attend the Health Centre or those who regularly attend the Café Area. This means that patients engaging in off hub activities remains in the amber zone.

No 4 Patients will be offered an annual physical health review

This indicator maintained at 100% in Q3. This indicator remains green.

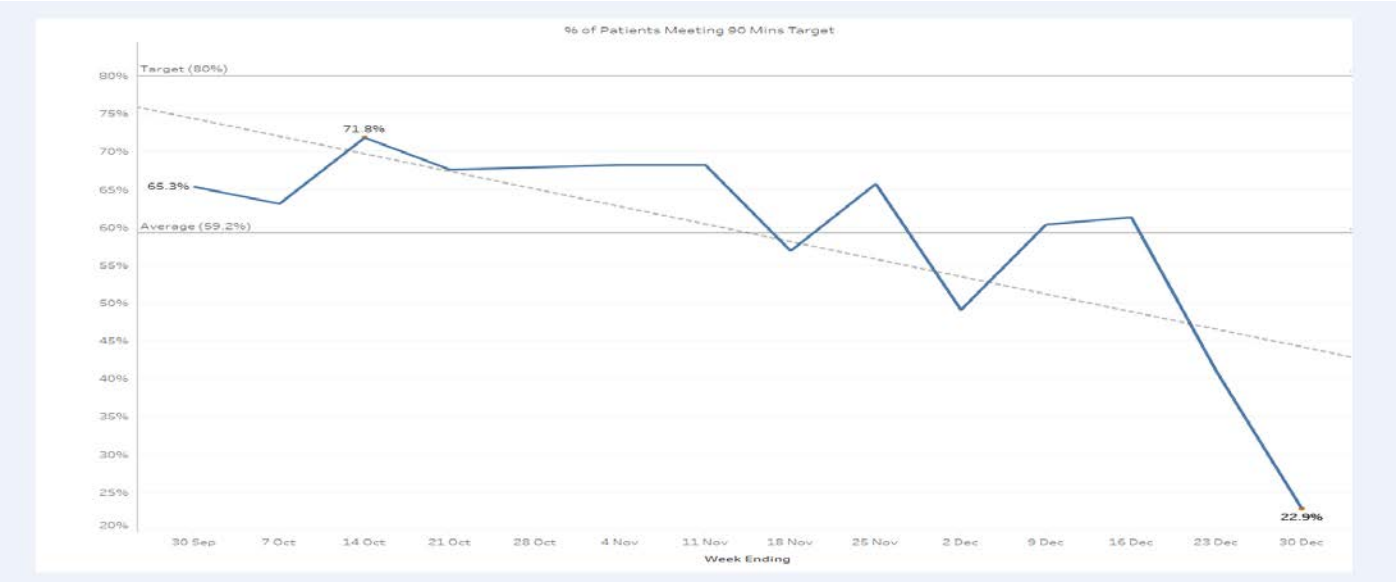
No 5 Patients will undertake 90 minutes of exercise each week

The Physical Activity levels over the second quarter have averaged 59.2%. This is a decrease from 66.4% in the last quarter. The contributing factor to this decrease is due to the Christmas period whereby the Sports and Fitness and the Gardens Departments were closed for several days due to the Public Holidays and the shortened ground access times allowing patients to utilise the grounds. It is important to note there was an increase of patients participating in moderate physical activity through the month of November 2019 due to the number of TSH 30:30 projects which involved increasing patient's physical activity.

The Physical Health Steering Group are currently reviewing data over the last year to look at trends and possible ways of improving the uptake of Physical Activity. Due to the 80% target this indicator remains in the red zone.

To ensure robustness of the data, spot checks were carried out to ensure a minimum of 2 physical activity entries were being completed in a 24 hour period. The spot check showed that there were 2 entries consistently being made per day and the data is therefore robust.

Data recorded is patient participation in moderate physical activity intervention, this data includes patients participating at the Sports and Fitness, Gardens, ward and hub based activities, escorted walks and Walking Groups. This data also includes patients using Ground Access as a means of physical activity. Caution should be used to the data however, as this is based on patient self-reporting.



No 6 Healthier BMI.

The RiO report shows that 7% of patients have a healthy BMI in December 2019. This is a reduction from 8% in September 2019. This is concerning as there has been a steady decline since June 2018. The data collection has moved to monthly in December 2018 for this indicator with nursing staff taking measurements as opposed to the Dietetic Technician measuring on a 6 monthly basis. This means we have more data being collected more regularly for all patients. This indicator remains in the red zone.

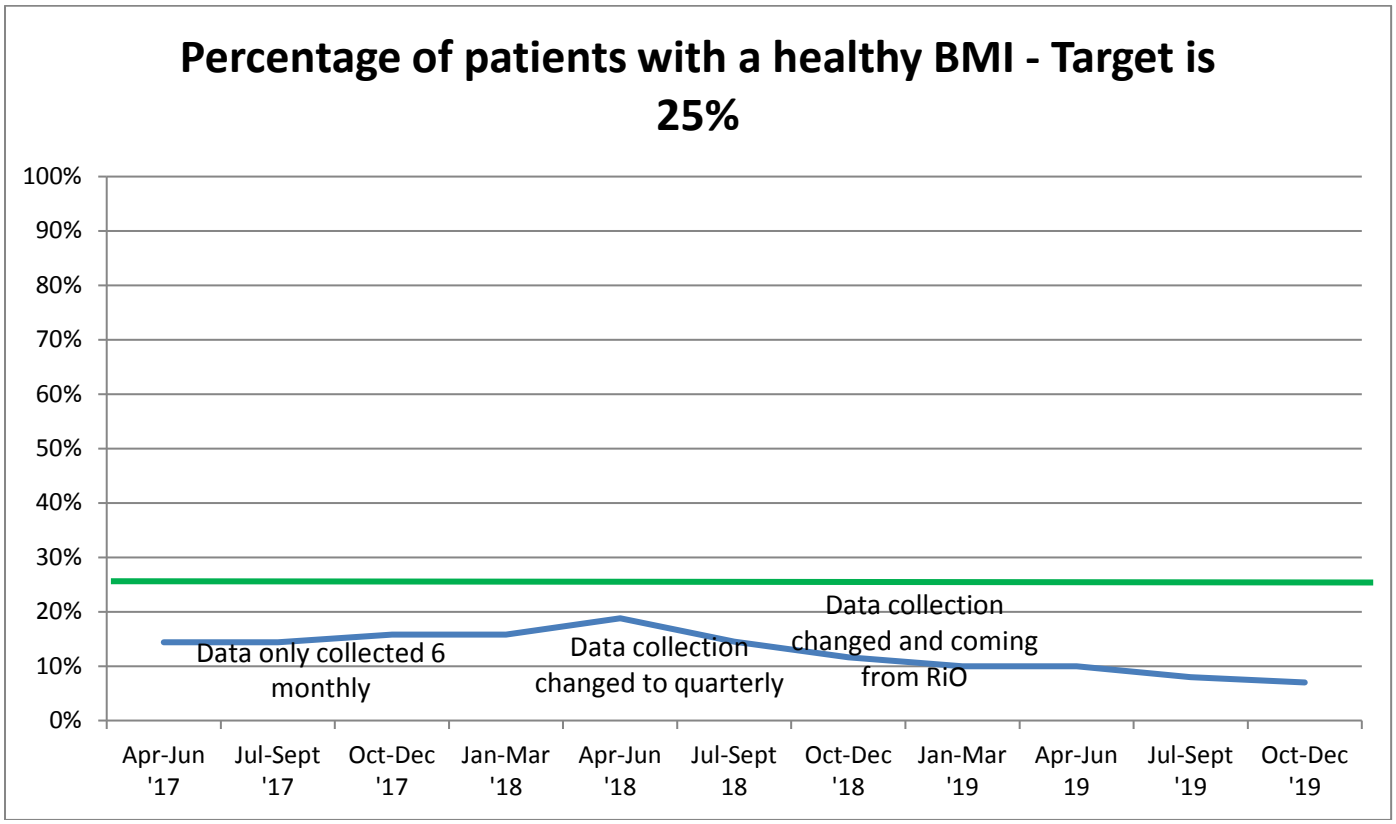


Table 1

Weight Range by BMI	Number of Patients (Q3 2019/20)	% (Q3)	Number of Patients (Q2 2019/20)	% (Q2)	Number of Patients (Q1 2019/20)	% (Q1)	Number of Patients (Q4 2018/19)	% (Q4)
<18.5 underweight	0		0	0	0	0	0	0
18.5-24.9 healthy	7	7	8	8	11	10	10	10
25-29.9 overweight	45	93	38	92	38	89	39	90
30-39.9 obese	47		46		48		46	
>40 obese	6		8		6		8	

Over the last Quarter

- There were 12 admissions; 4 patients had a BMI 18.5-24.9 healthy. 6 patients had a BMI 25-29.9 overweight and 2 patients had a BMI 30.39.9 Obese.
- There were 8 discharges; 5 patients had a BMI 30.-39.9Obese. 1 patient had a BMI 25.29.9 overweight), 1 patient had BMI 18.5-24.9 healthy. 1 patient BMI was not available due to timescale between admission and discharge.
- From the 6 patients with an identified BMI >40 Obese category; 5 patients identified in the >40 Obese Q2 remain in this category for the Q3. 1 patient has moved from the 30.39.9 Obese identified in Q2 to the >40 Obese within Q3.

- 2 patients identified in the >40 Obese in Q2 have moved to the 30.39.9 Obese in Q3
- The highest BMI is 45.4.
- 1 patient identified in the 25-29.9 Overweight category moved into the 18.5-24.9 Healthy

No 7 Sickness absence.

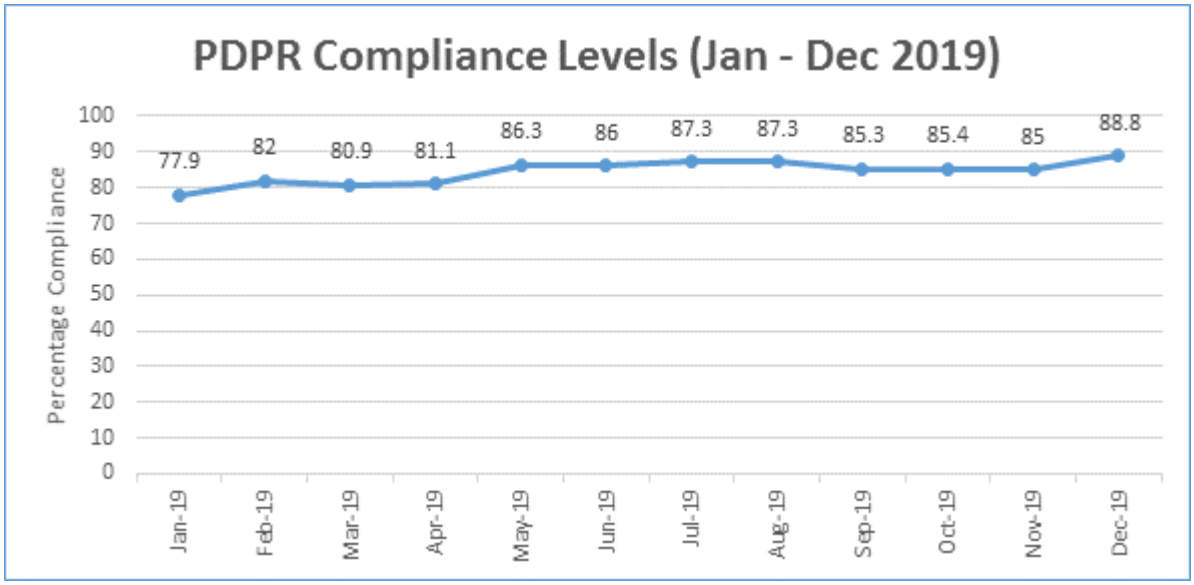
The sickness absence rate for the quarter was 6.13%. This is a slight increase from Q2 5.82%. October's figure was 5.91%, November 6.07% and December 6.41%. Within the quarter there was a month on month increase.

This moves this indicator from amber to red as the hospital is over 1% away from their target.

No 8 Staff have an approved PDR.

The PDR compliance level over the period October – December averaged 86.4%. This is a decrease of 0.5% from the last reporting period (i.e. 30 September 2019).

Although this indicator remains in the red zone, monthly monitoring indicates that performance has remained consistently high over the last 6 months and shows an increase in organisational compliance at 31 December 2019 (up to 88.8%).



No 15 Attendance by clinical staff at case reviews.

Key Worker attendance has increased slightly to 82% from 81% in Q2. This indicator remains in the green zone.

Occupational Therapy attendance has increased from 79% in Q2 to 93% in Q3 against a target of 80%. This indicator remains in the green zone.

Pharmacy has decreased from 63% in Q2 to 57% in Q3 against a target of 60%. They remain in the green zone at present.

Clinical Psychologist attendance increased from 61% to 80% in Q3. This is against a target of 80%. This has moved them to the green zone. The Psychology attendance decreased further from 86% in Q2 to 84% in Q3. This indicator remains in the red zone against a target of 100%.

Security attendance has increased further from 56% in Q2 to 68% in Q3 against a target of 60%. This indicator remains in the green zone.

Social Work attendance increased from 72% in Q2 to 75% in Q3 against a target of 80%. This indicator moves from the amber to green zone.

Dietetic attendance has increased from 45% in Q2 to 67% in Q3. There is no target against dietetics at the moment.

4 RECOMMENDATION

The Board is asked to **note the contents of this report.**

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of Key Performance Indicator Performance in the TSH Local Delivery Plan (2017-2020) and the Operational Plan.
Workforce Implications	No workforce implications-for information only.
Financial Implications	No financial implications-for information only.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Risk, Finance and Performance Management Group
Risk Assessment (Outline any significant risks and associated mitigation)	There is a dependency on the Business Intelligence project. While we can identify other ways of obtaining and analysing data there will be continue to be limitations on the timeliness and granularity of the information reported.
Assessment of Impact on Stakeholder Experience	The gaps in KPI data which make it difficult to assess.
Equality Impact Assessment	No implications identified.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	n/a
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Appendix 1

Item	Principles	Performance Indicator	Target	RAG Q2	RAG Q3	Actual	Comment	LEAD
1.	8	Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	A	94.7%	The figure for October 2019 was 91.7%	LT
2.	8	Patients will be engaged in psychological treatment	85%	G	G	81.9%	Figure is an average of 84.7% in October, 77.1% in November and 83.8% in December	JM
3.	8	Patients will be engaged in off-hub activity centres	90%	A	A	80%	Excludes shop / health centre information (brief visits). This also doesn't include patients who are regularly attending the Café Area	MR
4.	8	Patients will be offered an annual physical health review	90%	G	G	100%	All patients eligible for an annual physical health review were offered for Q2.	LT
5.	8	Patients will undertake 90 minutes of exercise each week	80%	R	R	59.2%	For this quarter the indicator remains in the red zone	MR
6.	8	Patients will have a healthier BMI	25%	R	R	7%	There has been a steady decline since June 2018.	LT
7.	5	Sickness absence rate(National HEAT standard is 4%)	** 5%	A	R	6.13%	6.13% for the quarter. This is a slight increase from Q2 5.82%. October's figure was 5.91%, November 6.07% and December 6.41%.	KS
8.	5	Staff have an approved PDR	*100%	R	R	86.4%	This indicator has been showing a steady improvement since October 2018.	KS
9.	1, 3	Patients transferred/discharged using CPA	100%	G	G	100%	This indicator maintained at 100% in Q3. All patients had a CPA meeting prior to transfer/discharge.	KB
10.	1, 3	Patients requiring primary care services will have access within 48 hours	*100%	G	G	100%	This indicator maintained at 100% in Q3.	LT
11.	1, 3	Patients will commence psychological therapies <18 weeks from referral date	**100%	G	G	100%	All patients referred and not already in treatment met the standard	JM
~~12.~~	~~1, 3~~	~~Patients will engage in meaningful activity on a daily basis~~	~~100%~~	-			~~*New indicators and business processes in development as reported to the June Board.*~~	~~MR~~
13.	2, 6, 7, 9	Patients have their clinical risk assessment reviewed annually.	100%	G	G	98.9%	105 patients. 11 new admissions, 93 patients with current risk assessments and 1 risk assessment out of date (due to section change)	LT
~~14.~~	~~2, 6, 7, 9~~	~~Hubs have a monthly community meeting.~~	-	-		-	~~*New indicators and business processes in development as reported to the June Board.*~~	~~MR~~
15.		Refer to next table.						All Clinical Leads

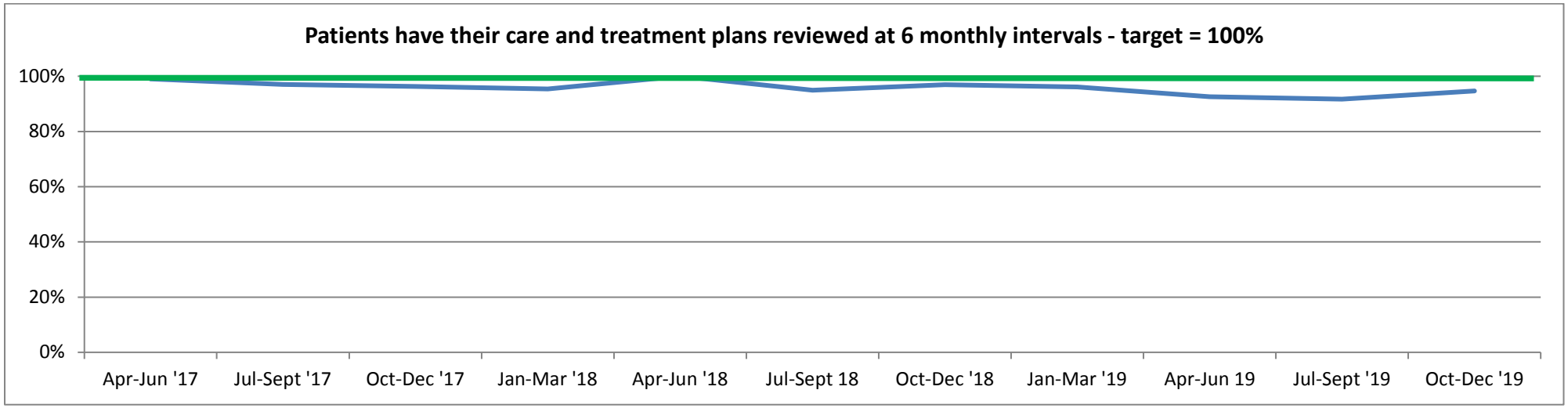
Item	Code	Principles	Performance Indicator	Profession (Lead)	Target	RAG Q2	RAG Q3	Overall attendance Oct-Dec 2019 (n=44)	Overall attendance July-Sept 2019 (n=43)	Overall attendance April – June 2019(n=50)	Overall attendance Jan-Mar 2019 (n=53)
15	T	2, 6, 7, 9	Attendance by all clinical staff at case reviews	RMO **(LT)**	90%	G	G	86%	91%	93%	93%
				Medical **(LT)**	100%	G	G	98%	95%	96%	98%
				Key Worker/Assoc Worker **(MR)**	80%	G	G	82%	81%	72%	74%
				Nursing **(MR)**	100%	G	G	98%	98%	100%	98%
				OT**(MR)**	80%	G	G	93%	79%	83%	52%
				Pharmacy **(LT)**	60%	G	G	57%	63%	57%	71%
				Clinical Psychologist **(JM)**	80%	R	G	80%	61%	77%	79%
				Psychology **(JM)**	100%	R	R	84%	86%	91%	98%
				Security**(DW)**	60%	G	G	68%	56%	42%	41%
				Social Work**(KB)**	80%	A	G	75%	72%	74%	86%
				Skye Activity Centre **(MR)** (only attend annual reviews)	tbc	-	-	4%	5%	0%	0%
				Dietetics **(MR)** (only attend annual reviews)	tbc	-	-	67%	45%	67%	59%

Definitions for red, amber and green zone

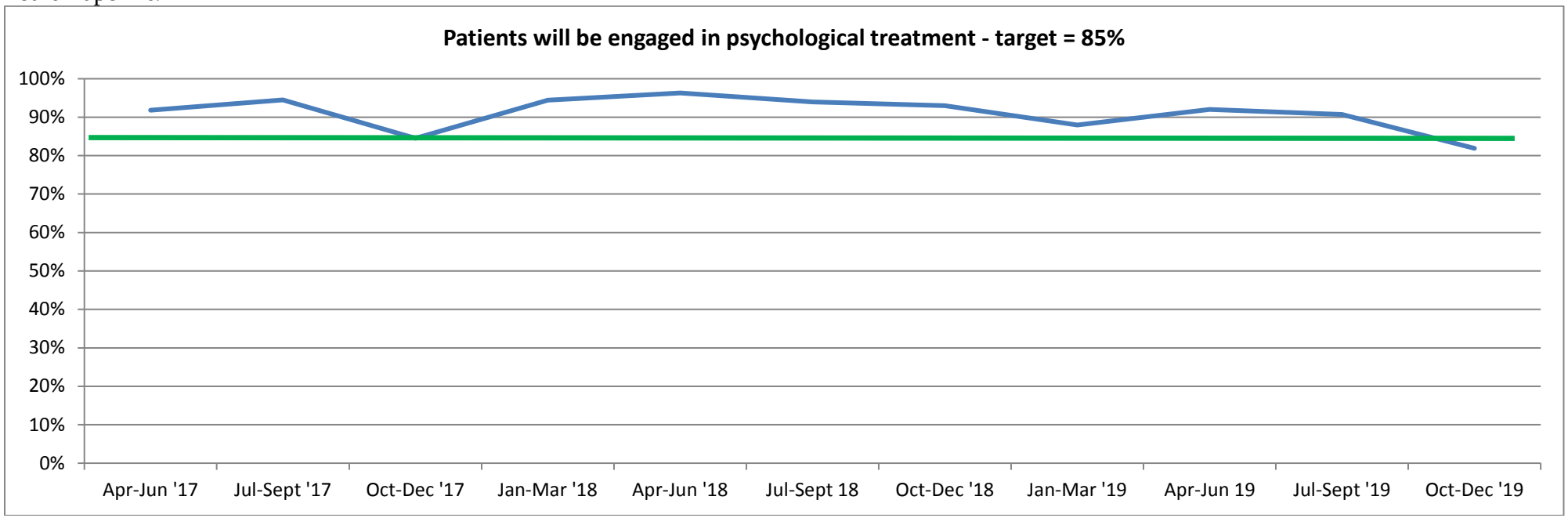
- For all but item 6 and 7 green is 5% or less away from target, amber is between 5.1% and 10% away from target and Red will mean we are over 10% away from target
- For item 6 'Patients have a healthier BMI' green will be 3% or less away from target, amber will be between 3.1% and 5% away from target and red will be over 5% away from target
- For 7 'Sickness absence' green is less than 0.5% from target, amber will be between 0.51% and 1% away from target and red will be over 1% and away from target

Trend Graphs for Performance Management Data

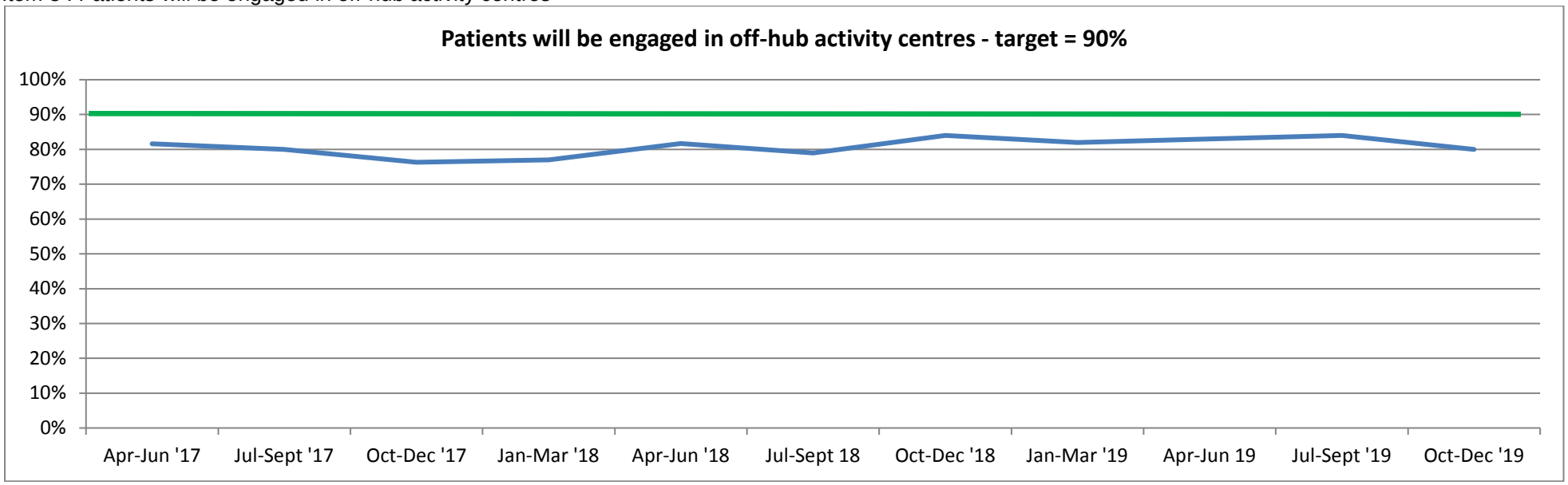
Item 1 : Patients have their care and treatment plans reviewed at 6 monthly intervals



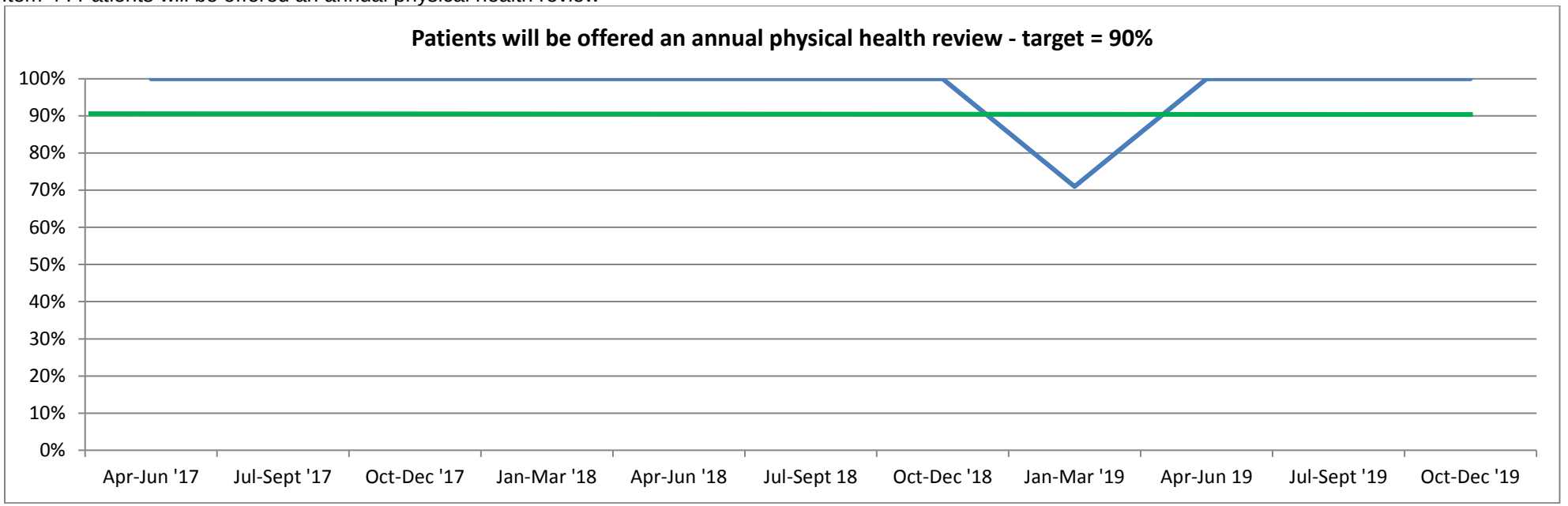
Item 2 : Patients will be engaged in psychological treatment



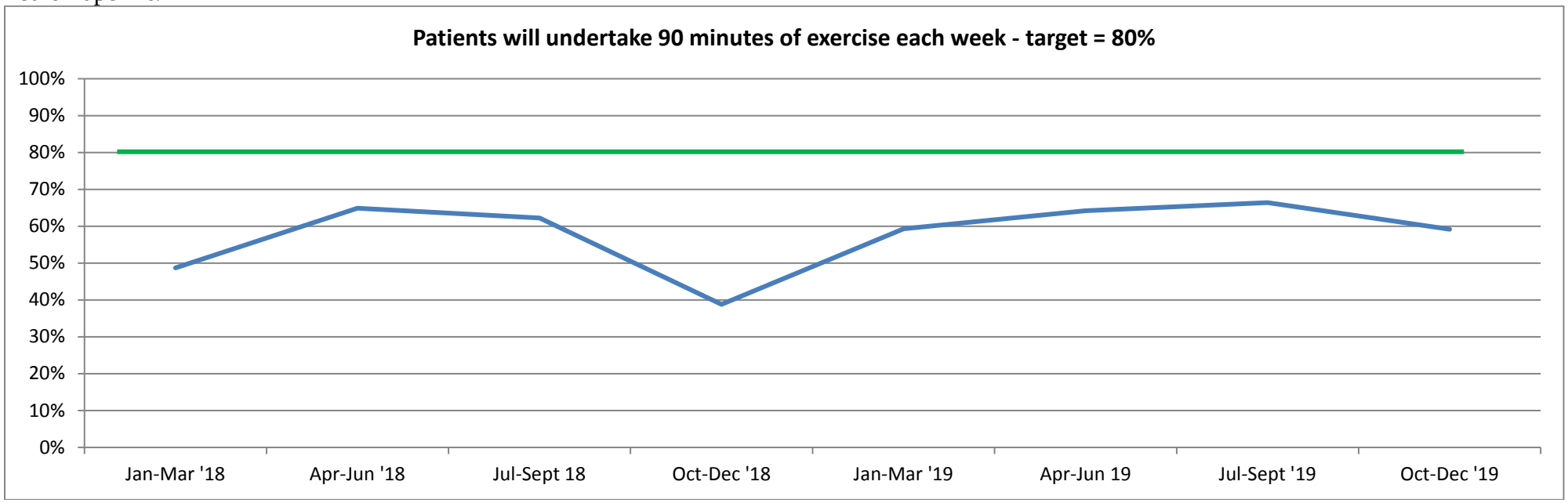
Item 3 : Patients will be engaged in off-hub activity centres



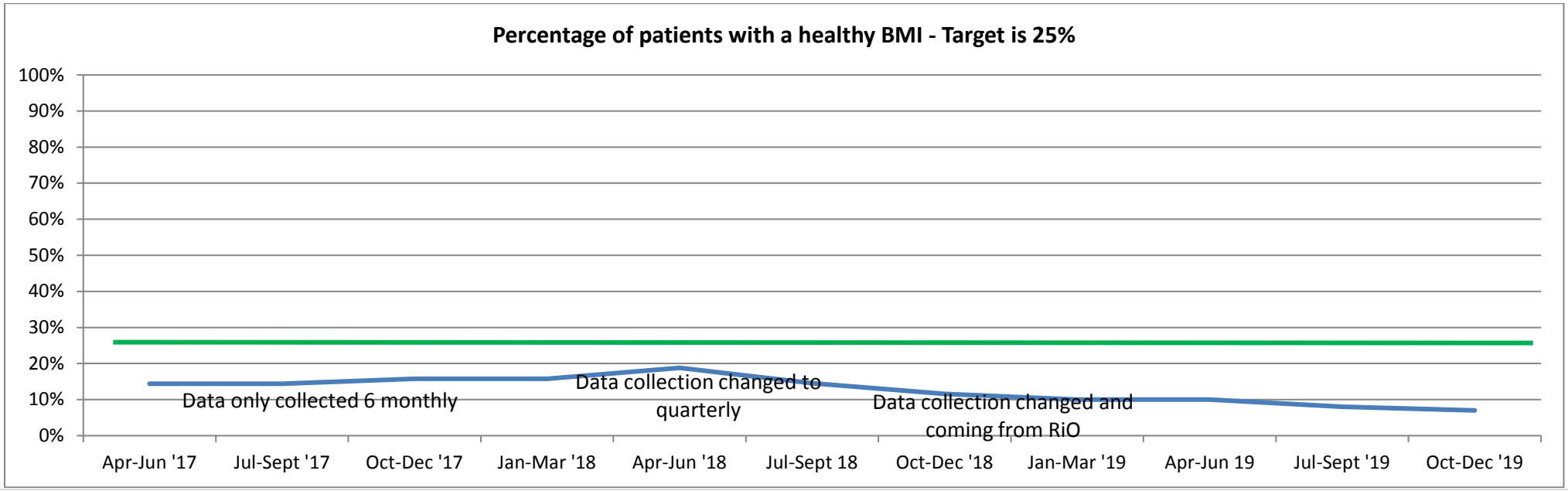
Item 4 : Patients will be offered an annual physical health review



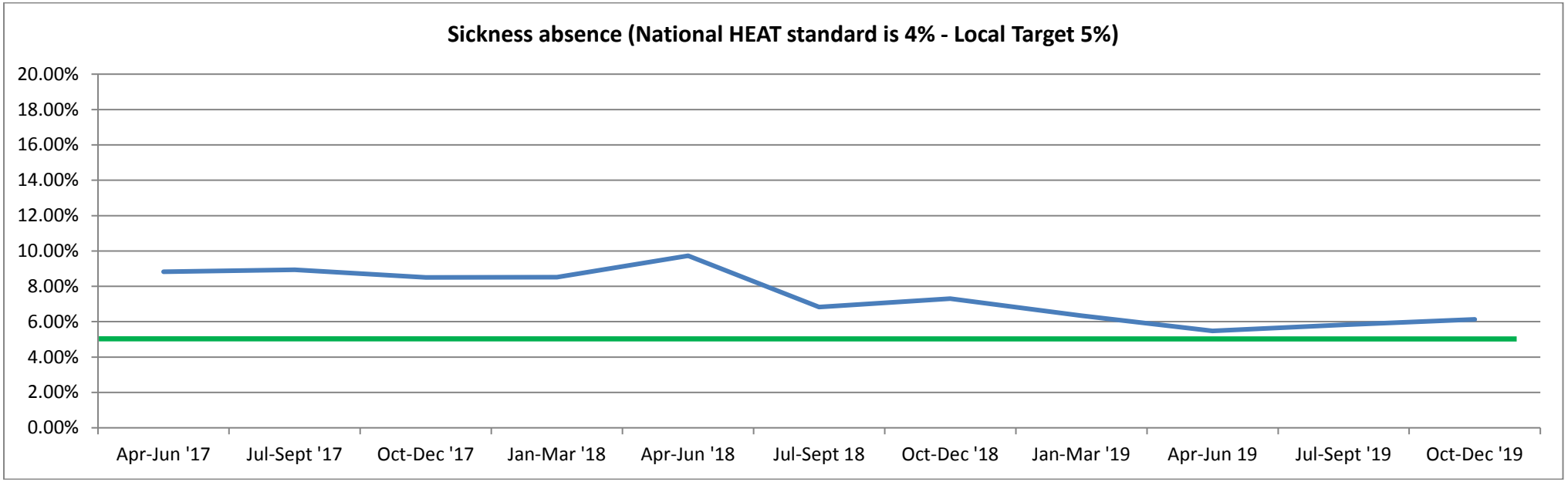
Item 5: Patients will undertake 90 minutes of exercise each week



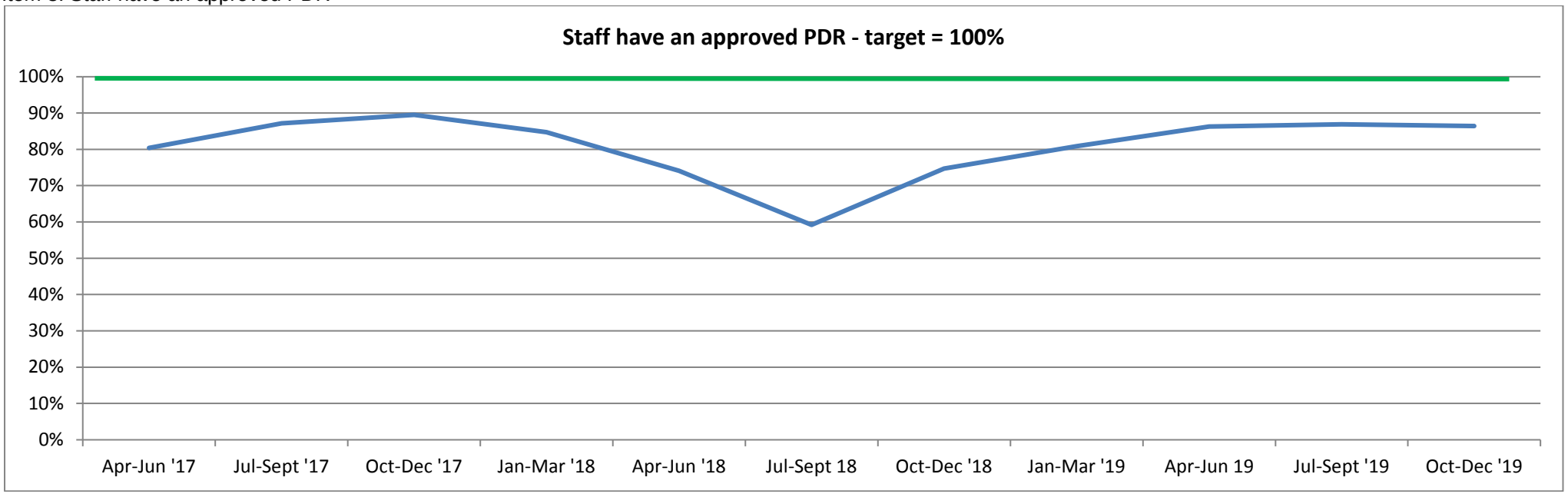
Item 6: Patients will have a healthier BMI



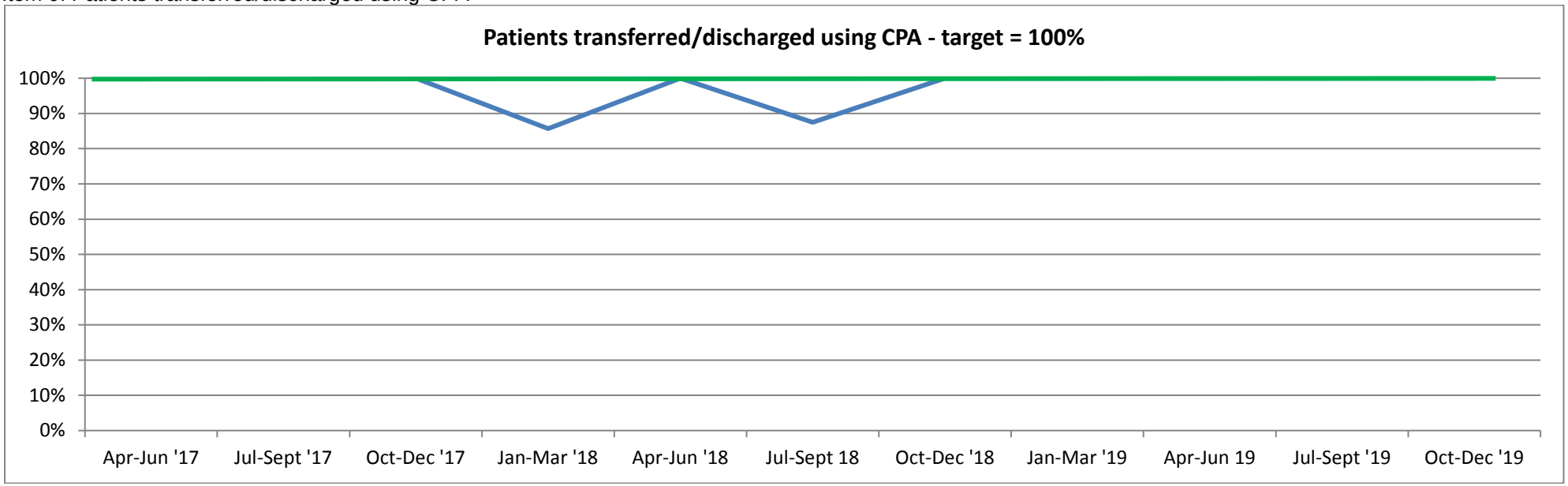
Item 7: Sickness Absence



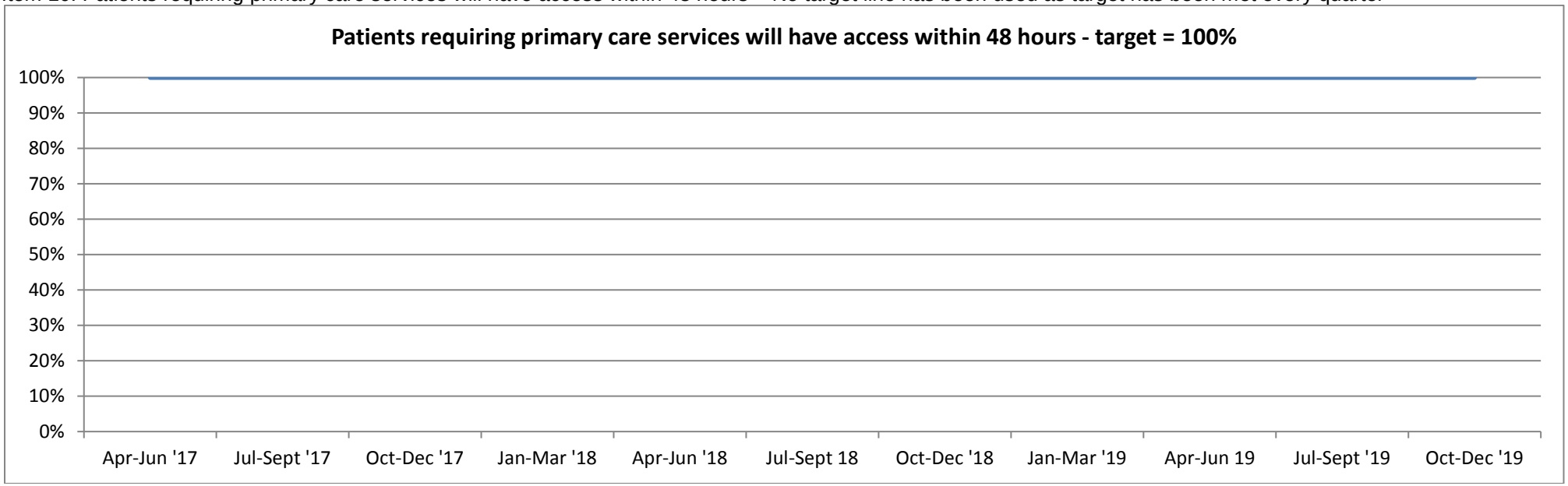
Item 8: Staff have an approved PDR



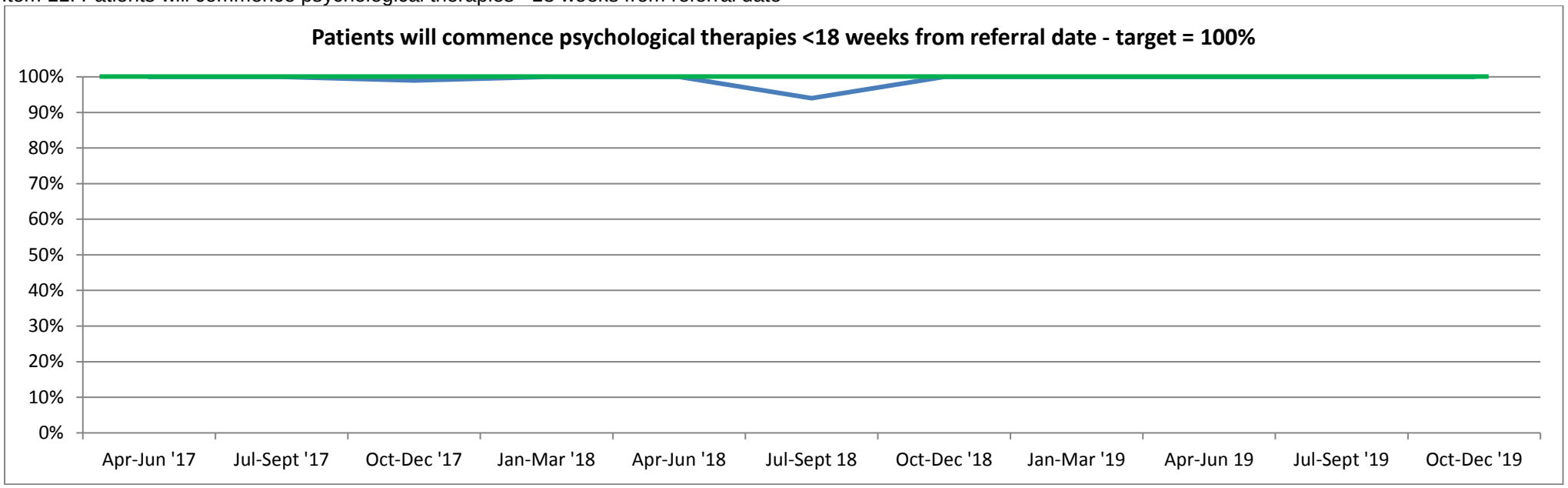
Item 9: Patients transferred/discharged using CPA



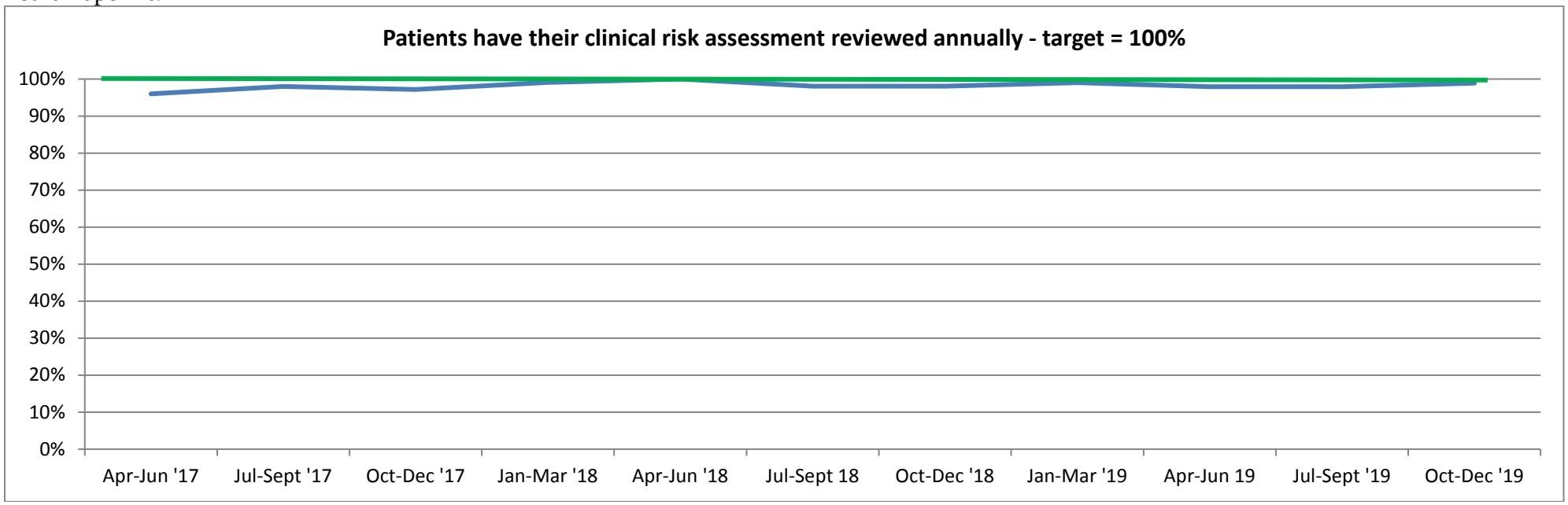
Item 10: Patients requiring primary care services will have access within 48 hours – No target line has been used as target has been met every quarter



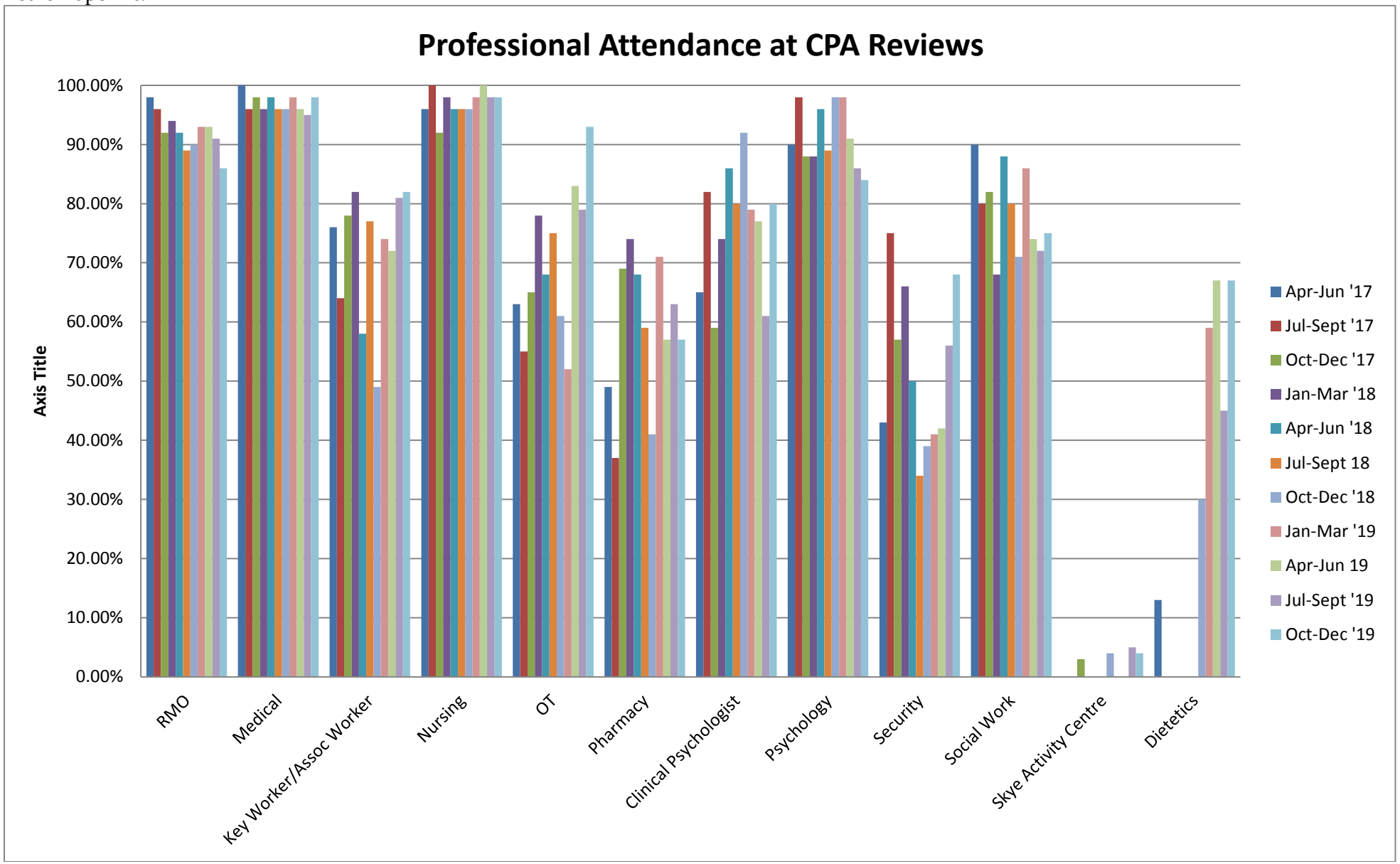
Item 11: Patients will commence psychological therapies <18 weeks from referral date



Item 13: Patients have their clinical risk assessment reviewed annually



Item 15: MDT Attendance at Case Review


Professional Attendance at CPA Reviews
Axis Title
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
RMO
Medical
Key Worker/Assoc Worker
Nursing
OT
Pharmacy
Clinical Psychologist
Psychology
Security
Social Work
Skye Activity Centre
Dietetics
Apr-Jun '17
Jul-Sept '17
Oct-Dec '17
Jan-Mar '18
Apr-Jun '18
Jul-Sept 18
Oct-Dec '18
Jan-Mar '19
Apr-Jun 19
Jul-Sept '19
Oct-Dec '19

Board Paper 20/12

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2020
Agenda Reference:	Item No: 20
Sponsoring Director:	Director of Security, Estates & Facilities
Author(s):	Risk Management Team Leader
Title of Report:	Resilience Update
Purpose of Report:	To update Board on Resilience activity undertaken and planned

1 SITUATION

This paper is prepared to provide an update of resilience related activities recently undertaken and planned for the next few months.

2 BACKGROUND

This is the first Resilience update provided to the Board. This work is monitored by the Resilience Committee which last met on 20 December 2019.

3 ASSESSMENT

EU exit on 31 January
Work remains ongoing to plan for TSH representation at forthcoming Beyond EU Exit: Integrating Resilience Across Health & Social Care on 21 January 20.

Level 2 table top
5 December 2019
Multi-disciplinary pandemic influenza tabletop exercise with resultant Loss of Staff plan review. Work ongoing to update plans.

Level 3 – Fire exercise
Scottish Fire and Rescue Service (SFRS) exercise held on 20 January 20. This involved 3 fire appliances on scene with an incident command structure established. Level 3 plan in process of being reviewed with SFRS.

Level 3 Multi Agency Contingency Plans (MACPs)
Police, South Lanarkshire Council, NHS Lanarkshire sections updated. Date planned with SFRS to review and update.

Coronavirus Outbreak

Continue to monitor external information, intranet updated and staff bulletin communication with all staff.

Golden Hour
Golden Hour training for new SCNs was undertaken on 28 January 20.

Standards for Organisational Resilience
Work ongoing with section owners to review and update prior to April self assessment submission.

Future activity

Loggist Training
Applications requested for new Loggists to support IC arrangements. Training programmed for early February 20.

Decant
Work with wider Forensic Network, including National Secure Adolescent in-patient service around accommodation contingency.

COPS 26 9 – 20 November 2020
Difficulty organising further multi-agency Level 3 exercises due to COPS 26 conference taking place in November. Upwards of 90,000 visitors to Glasgow, including 197 heads of state anticipated.

4 RECOMMENDATION

Board members are invited to note the update on Resilience activity. The Resilience Committee will next meet on 20 March 2020.

Board Paper 20/12
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.	Resilience Committee
Risk Assessment (Outline any significant risks and associated mitigation)	As per paper
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.

Board Paper 20/13

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2020
Agenda Reference:	Item No: 21
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Corporate Governance Improvement Action Plan
Purpose of Report:	For Noting

1 SITUATION

Following Board self-assessment, an improvement plan was developed to support key corporate governance priorities as part of the Corporate Governance Blueprint.

The Board submitted its improvement plan to Scottish Government in April 2019, and submitted a six-month progress report in November 2019.

2 BACKGROUND

The five key areas of the improvement plan are outlined as follows:

- Setting the Direction
- Holding to Account
- Assessing Risk
- Engaging Stakeholders
- Influencing Culture

3 ASSESSMENT

The improvement plan has been updated to indicate progress against each item (Appendix A) and the Board is asked to note the content of the updated plan.

In particular, the Board is asked to note progress in relation to the review of effective rostering within nursing as a component on focus on effective workforce utilisation. Internal audit took place in January 2020, the results of which were presented to the Audit Committee at its meeting on 23 January 2020 (Action 2). In addition, the Board is asked to note the continuing focus on recruitment of registered nurses within a challenging national landscape (Action 11).

In respect of Action 20, the Board is asked to note that the Scottish Parliament has passed legislation which gives the Scottish Public Services Ombudsman the role of Independent National Whistleblowing Officer (INWO). The legislation gives the Ombudsman new powers as the final stage in Whistleblowing complaints about how NHS services handle whistleblowing concerns, and to define Whistleblowing Complaints Principles and Standards. The Ombudsman, as INWO, has published the finalised National Whistleblowing Standards for NHS boards and other NHS providers. The INWO will be able to receive and handle whistleblowing concerns from July 2020.

A Whistleblowing Champion has been appointed to The State Hospital by Scottish Government, and commenced in this Non -Executive Director role on 1 February 2020.

4 RECOMMENDATION

The Board is asked to note progress in implementation of the improvement plan.

A further update will be brought to the next meeting of the Board in April 2020.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Corporate Governance Blueprint
Workforce Implications	None identified to date
Financial Implications	None identified to date
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board Standing Committees/Corporate Management Tem
Risk Assessment (Outline any significant risks and associated mitigation)	None identified to date
Assessment of Impact on Stakeholder Experience	Implementation will benefit stakeholder engagement through the workstreams indicated in the improvement plan
Equality Impact Assessment	Not formally assessed
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No impact identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND - IMPROVEMENT PLAN **Appendix A**

BLUEPRINT FUNCTION		ACTION	LEAD	ASSURANCE SYSTEM	TIMESCALE	PROGRESS
SETTING THE DIRECTION	1	Reconfirm the Board's strategic direction, and communicate this through the Strategy Map and development of strapline statement for corporate documents.	CEO	CMT	June 2019	**Completed:** Strapline finalised following hospital wide competition. Strategy Map reviewed as part of review of Corporate Objectives.
	2	Review of effective rostering system within nursing as component of focus on effective workforce utilization and safe staffing legislation.	Director of Nursing and AHPs	CMT	March 2020	**On Track**. Work is ongoing to ensure effective rostering is in place with the support of electronic systems. Currently testing SSTS eRostering module in one ward with a view to rolling this out wider. Restrictions on effective rostering remain due to fixed shift pattern; alternative, flexible shift pattern introduced for all new appointments to ward nursing posts. This has increased capacity and much more flexibility to support effective rostering. Internal Audit are undertaking work in January to review preparedness for safe staffing legislation. **Update:** RSM undertook audit 6th to 10th January 2020, results of which were presented to the January meeting of the Audit Committee. A range of actions linked to this

						point have been accepted and are being progressed.
	3	Development of more robust processes to compare planned and actual spend and to account for any variance.	Director of Finance & PM	CMT /Board	September 2019	**Completed:** Process in place- Planned and actual £ spend per budget line reviewed with each individual budget holder on a line-by-line basis from the 2019/20 mid-year 6-month reviews (30/9/19) – a summary of any significant or material variances is collated to be reported as appropriate.
HOLDING TO ACCOUNT	4	Ensure compliance with new national guidelines in management of Executive pay and performance through remuneration Committee approval for annual ESM pay and performance cycle.	Chair /Interim HR Director	Remuneration Committee	Ongoing	**On Track**
	5	Ensure implementation of attendance management policy through support from HR to line managers help identify and act upon patterns of absence. Continued implementation of the action plan developed through the Attendance Management Improvement Task Group (AMITG).	Interim HR Director	CMT	October 2019	**On Track.** Training for Line Managers and HR Managers implemented. Update presented on attendance management to each Board Meeting. AMITG paused to reflect action plan implemented and wider work plan.
	6	Implementation and compliance with Once for Scotland HR policies within TSH. Focus on policy awareness through completion of	Interim HR Director	Partnership Forum/CMT	December 2019	**On Track** – to align with roll out of the national guidance.

		metacompliance / staff bulletins/ staff training in Single Investigatory process.				
	7	Review performance framework and assurance information systems to support review of performance.	CEO	CMT	July 2019	**On Track -** Strategic Review of Performance underway with draft performance framework in development based on balanced scorecard approach of better health better care, better value and better workforce. Operational definitions for suggested KPI's being developed with associated data sources identified.
	8	Blueprint Improvement Plan to be placed on Board Workplan for review at each Board Meeting.	Chair	Board	June 2019	**Completed**
ASSESSING RISK	9	Further development of risk management with focus on risk register to ensure this is clearly defined with set of mitigating measures against each risk which also have a focus on improvement actions.	Director of Finance	Audit Committee / Board	December 2019	**On Track:** Underway through closer Risk Register monitoring and review process (managed by Risk Team Leader) and reporting to Risk Finance and Performance Group – All risk register items either now with action plan in place or underway. Board Workplan 2020 includes regular updates on Corporate Risk Register.

ENGAGING STAKEHOLDERS	10	Review and develop the Communications Strategy to include proactive engagement with aim of addressing dissonance between strategic aims of the hospital and public perception of these aims.	CEO	Board	March 2020	**Review of media strategy in progress:** with regular updates to the Board.
	11	Promotion of The State Hospital as an employer in the local area. Increase number of modern apprenticeships. Participate in local school careers events, local and university recruitment fairs	Interim HR Director	CMT	March 2020	**Ongoing** – engagement work commenced at university level to recruit new graduates to nursing posts. This was trialed in one University and plan is to roll out further for 2020 graduates. Further recruitment to take place early 2020 for registered nurses.
	12	Encourage carers / volunteers /staff / local population to attend public Board Meetings through additional promotion and links with local community.	Board Secretary	Board	September 2019	**On Track** – through promotion of external Board Meetings /Annual Review session in 2020.
	13	Hold two Board Meeting each year at external locations to promote role as national Board.	Board Secretary	Board	April 2020	**On Track** - Board Meeting 27 February in Lanark Memorial Hall, and can be evaluated to inform future planning.
	14	Annual Review - Public Meeting to be held outside of the hospital to help engage public engagement and attendance.	Board Secretary	Board	April 2020	Plan to be progressed as part of Annual Review planned expected summer 2020.
INFLUENCING CULTURE	15	Define culture in The State Hospital in terms of key strengths and	CEO	Board	December 2019	**Review in progress** – progressed in conjunction with response to Sturrock and Clinical Model

		weaknesses - take forward through development sessions				Review – Culture, Values & Behaviours, Leadership workstream led by CEO.
	16	Implement a Staff Recognition Scheme for long service as well as individual contribution to the organisation.	Interim HR Director	CMT	September 2019	**Completed**- first ceremony 24 October 2019.
	17	Embed a culture of quality across the organisation through initiatives such as TSH3030, Quality Forum and sharing our work more widely.	CEO	CMT	March 2020	**On Track** - QI Forum initiatives underway. TSH 3030 took place successfully in November 2019, with update to Board in December.
	18	Senior Management visibility through regular front line staff engagement meetings with CEO / Directors' Group - plan a calendar of events to ensure regular engagement.	CEO	CMT	July 2019	**On Track** - wider engagement across TSH – progressed in conjunction with response to Sturrock and Clinical Model Review.
	19	Senior Team / RMO presence at key events in hospital calendar e.g. patient learning awards/ sportsman dinner. Promote this through management structures.	CEO / Medical Director	CMT	September 2019	**On Track** -Coordination of central diary of events to help facilitate attendance.
	20	Link in with Scottish Government once appointment of the Independent National Whistleblowing Champion has been appointed.	CEO	Board	April 2020	**On Track** - appointment confirmed as Scottish Public Service Ombudsman at national level, and local appointment made to Board. National training event scheduled on 28 February.
	21	Plan a schedule of Non-Executive Director informal visits across TSH to help promote the values and behaviours of the organisation.	Chair	Board	August 2019	**On Track** - Schedule in place for patient and staff engagement

Board Report 20/14

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2020
Agenda Reference:	Item No: 23
Sponsoring Director:	Finance & Performance Director
Author(s):	Risk Management Team Leader
Title of Report:	Corporate Risk Register – Very High/High risks
Purpose of Report:	To update Board on Very High or High risks featuring on the Corporate Risk Register

1 SITUATION

This paper is prepared to provide oversight to the Board of the high and very high risks featuring on the Corporate Risk Register and to provide assurance that these are being addressed.

2 BACKGROUND

This is the first Board report on Very High or High Corporate Risks that are currently recorded on the Corporate Risk Register. The Corporate Risk Register was presented to the Audit Committee in January and is also a standing agenda item on the quarterly Risk, Finance and Performance Committee.

3 ASSESSMENT

There are no Very high risks recorded on the Corporate Risk Register currently.

The 7 following risks are graded as High:

MD30 Failure to prevent/mitigate obesity
*SD51 Physical or electronic security failure
*SD53 Serious security breaches (eg escape, intruder, serious contraband)
ND70 Failure to utilise our resources to optimise excellent patient care and experience
*ND71 Failure to assess and manage the risk of aggression and violence effectively
FD97 Unmanaged smart telephones' access to The State Hospitals information and systems.
HRD111 Deliberate leaks of information

*target risk met

CE = Chief Executive
MD = Medical Director
SD = Security Director
ND = Nursing Director
FD = Finance Director
HRD = Human Resource Director

These High risks are reviewed by risk owners (Directors) monthly and have action plans in place to assist reduction to their target level. All other risks fall into the review cycle detailed below:

Low risk	6 monthly
Medium risk	Quarterly
High risk	Monthly
Very High	Monthly

Risk distribution of other risks are as follows:

	Negligible	Minor	Moderate	Major	Extreme
Almost Certain					
Likely			ND70	MD30, HR111	
Possible			CE12, SD50, SD54, ND72, ND73, FD91, FD93, FD94, FD95,	ND71, FD97	
Unlikely			MD33, MD35, SD55, FD90, FD96	MD34, SD52, HR112	SD51, SD53
Rare			CE13	MD32	CE10, CE11

4 RECOMMENDATION

Board members are invited to note the Corporate Risk Register Very High/High Risk report, and to consider whether any amendment or addition should be made resulting from discussion at today's meeting.

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.	Risk, Finance & Performance Group/ Corporate Management Team
Risk Assessment (Outline any significant risks and associated mitigation)	As per paper
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.

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	RA	AP	Monitoring Frequency
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	31/03/20	Clinical Governance Committee	Y/Y	Y/Y	Monthly
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Extreme x Unlikely	Extreme x Unlikely	Security Director	Security Director	31/03/20	Audit Committee	Y/Y	Y/Y	Monthly
Corporate SD 53	Service/Business Disruption	Serious security breaches (eg escape, intruder, serious contraband)	Extreme x Unlikely	Extreme x Unlikely	Extreme x Unlikely	Security Director	Security Director	31/03/20	Audit Committee	Y/Y	Y/Y	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	31/03/20	SMT	Y/Y	Y/Y	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	31/03/20	SMT	Y/Y	Y/Y	Monthly
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Major x Possible	Major x Unlikely	Finance and Performance Director	Head of eHealth	31/03/20	Information Governance Group & SMT	Y/Y	Y/Y	Monthly
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Likely	Moderate x Unlikely	Interim HR Director	Interim HR Director	01/12/19	SMT	Y/Y	Y/N	Monthly

Actions from those not at target level

MD30 Failure to prevent/mitigate obesity

- Ongoing patient education and where appropriate restrictions/limits on additional food stuffs (snacks, takeaways, high energy food items and similar) being available out with meals in conjunction with 'Supporting Healthy choices' remit for those 'at high risk'.
- Planned hospital workshop in January 2020 to scope work and changes required.
- Review of cumulative effect of availability of food to patients and how this can be managed in a least restrictive manner to support patients physical health.

- Increased accessibility of physical activity opportunities for all patients daily – move to national physical activity targets (min 150 minutes vs. 90).
- Increased education and training for staff around physical health needs – identified key support staff (trained and assistant proposed) to follow on from health champion posts in 2020 across the site supporting physical health matters.
- Ongoing implementation and audit of health and Wellbeing plans for 100% patients updated monthly and discussed at CPA's.
- Initiation of 'counterweight plus' (VLCD plans) in 2020 to targeted patients.

ND70 Failure to utilise our resources to optimise excellent patient care and experience

- Recruitment to funded establishment
- Review of recruitment processes to streamline and minimise risks of gaps in workforce
- Review of roles and responsibilities regarding Nurse rostering and associated decision making
- Introduction of e-rostering platform
- Increase in staffing allocated to the nursing 'pool'
- Variation to shift pattern for new starts – 7.5 hour shift x 5 day
- Development of nursing element of workforce strategy
- Improved workforce information

FD97 Unmanaged smart telephones' access to The State Hospital information and systems.

- Monitoring of increased security aspects of new - awaiting evaluation

HRD111 – Deliberate leaks of information
No actions identified to reduce to target level – will be highlighted to risk owner.