THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 21 DECEMBER 2023
at 9.30 on MS Teams
A G E N D A

9.30pm			
1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 26 October 2023	For Approval	TSH(M)23/09
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 23/114
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
7.	**Patient Story:** **"Daytime Confinement or Room4U"** Introduced by the Director of Nursing and Operations		Presentation
8.	**Patient Advocacy Service: 12 Month Report** **I**ntroduced by the Director of Nursing and Operations		Presentation Paper No. 23/115
10.15am	**RISK AND RESILIENCE**		
9.	**Corporate Risk Register** Report by the Director of Security, Resilience and Estates	For Decision	Paper No. 23/116
10.	**Infection Prevention and Control Report** Report by the Director of Nursing and Operations	For Noting	Paper No. 23/117
11.	**Bed Capacity Report:** **The State Hospital and Forensic Network** Report by the Medical Director	For Noting	Paper No. 23/118
10.45am	**CLINICAL GOVERNANCE**		
12.	**Clinical Model – Update** Report by the Director of Nursing and Operations/Medical Director	For Noting	Paper No. 23/119
13.	**Quality Assurance and Quality Improvement** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 23/120

14.	**Clinical Governance Committee:** Approved Minutes of meeting held 10 August 2023	For Noting	CGC(M) 23/03
	Report of meeting held 9 November 2023		Paper No. 23/121
11.10am	**BREAK**		
11.25am	**STAFF GOVERNANCE**		
15.	**Staff Governance Report** Report by the Workforce Directorate	For Noting	Paper No. 23/122
16.	**Implementation Planning:** **Health and Care Staffing (Scotland) Act and e-Rostering** Report by the Director of Nursing and Operations	For Noting	Paper No. 23/123
17.	**Organisational Development Update, including iMatter survey 2022/23** Report by the Workforce Directorate	For Noting	Paper No. 23/124
18.	**Whistleblowing:** - **Quarter 2 Report** Report by the Workforce Directorate	For Noting	Paper No. 23/125
19.	**Staff Governance Committee:** Approved Minutes of meeting held 17 August 2023	For Noting	SGC(M) 23/03
	Report of meeting held 16 November 2023		Paper No. 23/126
12.10pm	**CORPORATE GOVERNANCE**		
20.	**Planning Update – Annual Delivery Plan 2024/25** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 23/127
21.	**Finance Report to 30 November 2023 (Month 8)** Report by the Director of Finance & eHealth	For Noting	Paper No. 23/128
22.	**Network Information Security** Report by the Director of Finance & eHealth	For Noting	Paper No. 23/129
23.	**Performance Report – Quarter 2** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 23/130
24.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 23/131
25.	**Board Workplan 2024** Report by the Head of Corporate Governance	For Decision	Paper No. 23/132
26.	**Any Other Business**		Verbal
27.	**Date of next meeting:** 9.30am on 22 February 2024		Verbal

28.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
29.	**Close of Session**		Verbal

Estimated end at 1pm

THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 23/09**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 26 October 2023.

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

Chair: Brian Moore

Present:

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

In attendance:

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

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone, and noted that there were no apologies for the meeting.

2 CONFLICTS OF INTEREST

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

3 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 24 August 2023 were noted to be an accurate record of the meeting subject to minor amendment only.

The Board:

1. Approved the minute of the meeting held on 24 August 2023.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board received the action list (Paper No. 23/65) outlining progress on outstanding actions, with the following updates being agreed. For Item 5, relating to the bed capacity reporting, it was noted that provision of more detailed information relating to patient waiting times could be person identifiable and would be routed more appropriately through the Clinical Governance Committee. For Item 7 relating to the forensic mental health legislative framework, this would be discussed further at the Board Development Session taking place on 7 November. For Item 10, relating to fencing within the Visitors Centre garden, this had been escalated with the relevant contractors for an installation date.

In terms of matters arising, it was noted that work had progressed to provide feedback on the patient story presented at the last meeting. This would ensure that staff understood the importance of careful messaging for patients in terms of their care journey across service; and for the patient who had told his story to get further support and feedback in this regard relevant for his own care.

The Board:

1. Noted the updated action list, with the updates provided on this as well as matters arising.

5 CHAIR'S REPORT

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

He advised that a Board Development Session took place on 7 September, with presentations on preparation for the implementation of Health & Care Staffing legislation in 2024 as well as the State Hospital (TSH) Anchors Strategy, and on the Whistleblowing standards. He had attended a corporate induction session on 20 September, which had provided an opportunity to meet new staff, to explain the role of the Board, and to hear invaluable feedback regarding new employees' experiences as they commenced careers within TSH. Non-Executive Directors would be involved in corporate inductions, going forward.

Mr Moore confirmed that he had attended the NHS Board Chairs away days, which had taken place on 14, and 15 September with a theme of sustainability in relation to climate, finance and workforce, and an action plan would follow. It was an opportunity for Chairs and key Scottish Government civil servants to discuss the issues and challenges, as well as possible solutions. He noted that the NHS Chairs' monthly meeting took place on 23 October, with topics for discussion including global citizenship, prisoner healthcare, and the new national and regional planning framework for NHS Boards across Scotland. The Cabinet Secretary for Health and Social Care joined the meeting, and there was further discussion of the implications of the recent Letby case in terms of patient safety. Mr Moore confirmed that TSH had submitted an assurance statement in this regard outlining the arrangements for clinical governance within the hospital.

Mr Moore also advised that Non–Executive Directors had attended an interesting session on cyber security on 24 October. He advised that he had been pleased to attend a Long Service Award presentation to a member of staff who was celebrating retirement after 45 years of service. He reflected that this had been a great opportunity to highlight the employee's commitment and achievement.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins provided an update to the Board on key national issues as well as local updates, since the date of the last Board meeting. In relation to NHS Boards Chief Executives monthly meetings, there had

been an update on the delivery mechanism for the introduction of the National Board for Delivery, to give central focus to regional and national planning. The meetings had also included review of Microsoft O365 licensing, an upgrade to the national radiology reporting system, as well as the Redress Scheme and the lower rate of surgical abortion within NHS Scotland compared to the rest of the UK. There had also been discussion around the provision of high secure care for women within the forensic estate within Scotland.

Mr Jenkins noted that he had enjoyed attending the Digital Inclusion workshop in TSH on 12 October, and that this innovative work would help to develop strategy going forward. He acknowledged Speak Up Week which had taken place in October promoting openness and transparency. Mr Jenkins confirmed that the Task and Finish Group focusing on sickness absence rates was making progress, and that an update would be provided at today's meeting. He advised that there was continued improvement being made towards eliminating daytime confinement for patients in the hospital, and that a visit had been received from the Mental Welfare Commission during this period. He also confirmed that the Security Project Oversight Board had met, and noted that the Board would receive an update on the status of the project at today's meeting. Mr Jenkins advised that a Multi-Agency Response exercise to test the hospital's contingency arrangements was held. He confirmed that he had also been pleased to take part in a corporate induction session, welcoming new employees to the organisation.

As part of his role as Chair of Healthcare in Custody Oversight Board he presented to NHS Board Chairs as well as SEND and to Directors of Public Health. An Away day would take place on 31 October with Mr Jenkins hosting the event for all 22 NHS Boards.

Mr Jenkins also referenced his role as Deputy Chair of the Sexual Assault Referral Centre (SARCS) Oversight Board, and his involvement in the successful appointment of a new Clinical Director MSN Neuro, and that he would be chairing a National Consultants meeting on the following day. Finally, Mr Jenkins confirmed that the TSH Annual Review would take place on 29 November, chaired by the Director of Mental Health.

Mr Currie said that the development of a new national board for central focus on regional and national planning strategy was interesting in terms of a consistent approach being taken and how this would impact existing territorial and special boards. Further, how this approach would dovetail with a National Care Service as well as the health and care staffing legislation being implemented in the coming year. In terms of resilience or another emergency situation like the recent pandemic, then it may be that similar pressures would be faced across the national health landscape with limited potential for shared resources. Mr Moore added that there may be implications for any proposed change in leadership of forensic mental health services, following the Barron review.

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

The Board:

1. Noted the update from the Chief Executive.

7 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 23/90) from the Director of Security, Resilience and Estates, which provided an overview of the Corporate Risk Register including movement on risk gradings and new risks.

Mr Walker summarised the paper, highlighting the proposed addition of Risk HRD113 in respect of the impact of delays within the Agenda for Change job evaluation process and the potential impact this may have on services. The full risk assessment was added to the paper, for the Board to consider. He also highlighted the improvement in Risk HRD112, relating to compliance with mandatory Level 2 Training in the Prevention and Management of Violence and Aggression, which had been reduced to low following the programme of training delivered. In relation to Risk ND71, relating to the failure to assess and manage the risk of aggression and violence effectively**,** Mr Walker noted the work underway to update this risk assessment with a focus on 'Serious' violent incidents and the risk to staff to provide a more

detailed assessment of the risk.

Mr McConnell asked whether further actions could be considered in relation to HRD113, and Ms McGovern confirmed that work was progressing well to progress this workstream, and reduce waiting times for completion. She added that work was underway to try to tie in with other smaller Boards to see whether there was further room for collaborative work.

Ms Fallon asked about the draft relating to the measurement of patient obesity, and what impact this may have. Professor Thomson confirmed that a full data set may not have been available for a variety of reasons including a complication rising in the patient's care which prevented the measurement being taken. Given the small numbers involved, any missing data would be impactful. Professor Thomson confirmed she would provide some further feedback in terms of how the data was collected and managed.

Action – Professor Thomson

There was agreement around the table that work was progressing well, meaning that the register provided a dynamic representation of risk and movement in each risk, and the background to the consideration of each. Mr Moore summed up for the Board noting the continuing work on how the Board considers risk appetite, with further consideration of this having taken place at the Board Development Session on 7 November. He confirmed the Board's agreement to the recommendations within the report including addition of Risk HRD113 relating to the job evaluation process, and that this would continue to be monitored for improvement.

<u>The Board:</u>

1. The Board reviewed the current Corporate Risk Register and approved it as an accurate statement of risk.
2. Agreed to the addition of Risk HRD113, and that this would continue to be monitored for improvement.

8 INFECTION PREVENTION AND CONTROL REPORT

The Board received a paper (Paper No. 23/91) from the Director of Nursing and Operations, which provided an overview of activity in infection prevention and control across the hospital in the period since the last Board meeting.

Ms McCaffrey summarised the content of the report, and asked the Board to note that although the hand hygiene audit was rated as amber, this was because it did not meet 100%, and that the standard maintained (at 99%) could be considered as being good. Ms McCaffrey intended to review this in the context of how this was recorded across NHS Boards, and to bring reporting at TSH in line with any comparative standard. In relation to the small number of Covid-19 cases which had occurred in the patient population, these had been managed effectively through the recently updated Standard Operating Procedure, and with consideration to least restrictive practice.

Mr Currie commented that he was in agreement with reconsidering the rating for the hand hygiene audits, as the standard achieved appeared to be excellent, and this did fit into an improving picture more generally. This included the management of Covid-19 cases in the patient population, in a balanced way – he noted that this had been discussed by patients recently at the Patient Partnership Group (PPG) and patients had shown their understanding and appreciation of the way in which incidences of Covid-19 infection were managed within the hospital.

Ms Radage asked about the rate of vaccination for staff, for seasonal flu and Covid-19, and Ms McCaffrey confirmed that the programme had been rolled out during October and that the uptake figures would be included in the next report to the Board in December. There had been focus on encouraging staff to come forward for vaccination, and the positive benefit of same. It was noted that staff may receive vaccination through their own board of residence, and so it was difficult to provide a full picture in this respect.

Action – Ms McCaffrey

The Board:

1. Noted the content of report.
2. Noted that uptake on the vaccination programme would be included in the next report.

9 BED CAPACITY REPORT

The Board received a paper (Paper No. 23/92) from the Medical Director, which detailed the actions taken to monitor the bed capacity within TSH as well as impacts from the wider Forensic Network. Professor Thomson presented the paper to the Board, and highlighted the change to reporting to show the movement of patients across services within TSH. There had been use of contingency beds within the Intellectual Disability (ID) service, meaning that additional resourcing had been allocated to support this.

Professor Thomson underlined that capacity across the forensic estate continued to be challenging. Board Members agreed that the information presented in report in terms of this positon was helpful, and should be included going forward.

Mr McConnell asked about the position within the Treatment and Recovery Service, which appeared to be at full capacity. Professor Thomson outlined how the process was bedding in for the flow of patients across services, and that this was dynamic with moves in and out of the service depending on the clinical status of each patient. Mr McConnell followed this up with a question on whether the model itself was contributing to this, and Professor Thomson provided assurance that there was no issue inherent in the model but the process was still bedding in across Service Leadership Teams, with a view to it becoming seamless. She emphasised that patient moves had to be considered based on the established clinical criteria.

Mr Moore summed up for the Board, noting the content of the paper and the continued pressures across the system.

The Board:

1. Noted the content of report.
2. Noted the continued pressures across the forensic estate

10 CLINICAL MODEL

The Board received a paper (Paper No. 23/70) from the Director of Nursing and Operations to provide an update on the work being taken forward by the Clinical Model Oversight Group (CMOG). Ms Clark joined the meeting and provided a summary of the key points for the Board, particularly the flow of patients across services within TSH, and the need for a central referral system. Ms Clark also highlighted the work progressing in relation to eliminating daytime confinement within the hospital, and the need to bring consistency of approach across services. In relation to this point, Ms McCaffrey added that the addition of data to RiO (electronic patient record) meant that the data could be used to help understanding of the key issues and drive improvement effectively.

Mr Currie noted the human element that may be at play in this regard, especially with differences found in approach, and asked if the data would help to demonstrate this. He added that effective communication with patients about any change in service delivery was important, to ensure that there was understanding on their part. Ms Clark advised that the senior charge nurse cohort were leading at a ward level, and taking oversight of any modified practice. This was then fed into the CMOG to allow regular consideration and review of practice across the whole site. Professor Thomson added her agreement that the addition of the relevant data to RiO was valuable and that the Clinical Quality team were then able to provide reporting on any variations, which helped define the issue and to support improvement.

Mr Moore noted the positive nature of the transition to the revised clinical model, and that this report helped to show the work continuing to support the bedding in of the new model. He added that in relation to daytime confinement, assurance had been received that this was being addressed, and that further detailed oversight of this was being taken through the Clinical Governance Committee.

The Board:

1. Noted the content of this update.

11 MEDICAL APPRAISAL AND REVLIDATION REPORT

The Board received a paper (Paper No. 23/71) from the Medical Director, representing annual reporting on Medical Appraisal and Revalidation as required by NHS Education for Scotland.

Professor Thomson summarised the report, which demonstrated the robust systems in place, and that medical appraisals and revalidations were up to date.

Mr Moore thanked Professor Thomson for this assurance, and the Board noted the content of reporting.

The Board:

1. Noted the content of this update.

12 MEDICAL EDUCATION REPORT

The Board received a paper (Paper No. 23/71) from the Medical Director, to provide an overview of undergraduate and postgraduate training within TSH for the period 1 August 2022 to 31 July 2023, in accordance with the General Medical Council (GMC) Quality Improvement Framework for Undergraduate and Postgraduate Medical Education.

Professor Thomson led the Board through the key highlights of the report and the training provided for each cohort, as well as the recovery in medical student training in the post-covid period. She asked the Board to note the Scotland Deanery visit which took place in April 2023, and the positive feedback this had drawn.

Mr Moore thanked Professor Thomson for this overview and commented on the very positive nature of the report. This was echoed by Mr McConnell, who also asked about whether there was further capacity for undergraduate training at TSH, and how formal undergraduate feedback was routed.

Professor Thomson advised that in terms of capacity, undergraduates training placements were provided across 24 weeks of the year currently, and that there may be some additional capacity possible, but only to a limited extent. She noted that undergraduate feedback is elicited through the universities presently, but if this was not available for TSH placements, then feedback could be sought locally. Ms Fallon was pleased to note the positive nature of the Scotland Deanery report, and the focus on Quality Improvement across the hospital. Ms Radage agreed that the report showed the strength of training that TSH gives, and asked for additional clarity around the lower comparative number of students from the University of Glasgow, compared to the University of Edinburgh. Professor Thomson advised that this related to the mental health training components within each university, and confirmed that additional students could be accommodated, if possible.

Mr Moore underlined that the report demonstrated ably the supportive learning culture in TSH, and asked if this reporting could be utilised further in the recruitment advertising to help promote TSH. Professor Thomson confirmed that the opportunities at TSH were well established and known to medical trainees across the country, but that wider advertising could also be considered.

Mr Moore confirmed that the Board were in agreement with the recommendations of the report, and

thanked all of those involved for the very high standards in evidence, as well as the positive feedback from training surveys, which had placed TSH within the top 2% of training sites within forensic psychiatry nationally.

The Board:

1. Noted the content of this update.

13 APPROVED MEDICAL PRACTITIONER STATUS

The Board received a paper (Paper No. 23/71) from the Medical Director, which confirmed the recruitment of two Consultant Forensic Psychiatrists, and asking the Board to consider the approval of their Approved Medical Practitioner status. Professor Thomson confirmed her recommendation that this should be the case, noting that an Approved Medical Practitioner (AMP) is a medical practitioner who had been approved under section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 as having special experience in the diagnosis and treatment of mental disorder.

Ms Fallon asked about the presentation of evidence to the Board in terms of each recommendation, and Professor Thomson confirmed that whilst this was not required legislatively, this could be added to future reporting. She noted that the Board could take assurance from the recommendations made, in her role as Medical Director, as these followed due process in terms of scrutiny. It was agreed that it would be helpful for future reporting in this area to annex evidence to this effect**.**

Action – Lindsay Thomson

The Board:

1. Noted the content of this update, and agreed the recommendations made.

14 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 23/97) which provided update reporting on progress made towards quality assurance and improvement activities since the date of the last Board meeting.

Ms Merson summarised the key elements of the report, and confirmed that work had begun to scope out the Quality Strategy, and this this would be brought back to the Board. She highlighted the clinical audit work reported within this period, and well as providing an update on the variance analysis tool. She asked the Board to note the progress outlined within the Clinical Quality flash report, as well as the activity underway through the Quality Forum, and Realistic Medicine. She also confirmed that the recruitment process was underway for a Project Manager within her team, which would help to support this area further.

Ms Fallon said that the report was positive overall, especially around the initiatives being taken forward by the Quality Forum. She also welcomed the updated evaluation matrix, which was helpful. She asked for further assurance on the three clinical audits relating to medication, and what the process was for these to be revisited. Ms Merson confirmed that these would be followed up, and it was agreed that further reporting should be routed through the Clinical Governance Committee to give an appropriate level of oversight.

Ms Radage asked if there had been any correlation found from the number of complaints received, patients incidents, and staff resourcing within the data. Ms Merson confirmed that there had been no trends found in this respect, and noted the detailed reporting through the Clinical Governance Committee in this regard.

Mr Moore commented on the uptake of shared decision-making training as an area where it would be good to see improvement, and also that the seclusion audit had shown that key documentation had been found to be in place as appropriate.

Finally it was noted that presentation of charts within the Clinical Quality flash report could be reviewed to give greater distinction to the information presented.

Action(s) – Ms Merson

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

The Board:

1. Noted the content the report and updates contained therein.
2. Requested further reporting to the Clinical Governance Committee relating to clinical audit follow up.
3. Requested minor amendment to presentation of charts within the report.

15 STAFF GOVERNANCE REPORT

The Board received a report from the Director of Workforce (Paper No. 23/98) to provide an update on all aspects of workforce performance across a range of key performance indicators (KPIs). Ms McGovern provided an overview of the key points of the report for the Board, focusing on the improvement seen to date on attendance management; as well as the positive progress on recruitment within the nursing cohort.

Mr McConnell asked a question on possible correlation between levels of sickness absence and the amount of overtime or excess hours that had been required over the same period. Ms McGovern noted that this was a multi-faceted picture with the amount of staffing required may vary depending on clinical activity. Ms McCaffrey added that during this period, there had been a need to support patients for external treatment, which meant that further resourcing had been required over time. Mr Jenkins commented further that a reduction in sickness absence to the target of 5% would impact positively on budget management, and that it was recognised that this positon required to improve.

Ms Fallon commented on the breadth of wellbeing activity shown, and asked a question on the timeline for the recruitment process, in terms of whether interview dates were set at the point of advertisement. Ms McGovern confirmed that recruiting managers were encouraged to do so, and that the Human Resources team were developing further guidance and training in this area.

In answer to a question from Ms Radage on departments within TSH which had not shown improvement in completion of PDPRs over a lengthy period, Ms McGovern advised that departmental managers were being provided with support. Mr Jenkins added that PDPR compliance was being reviewed as part of quarterly directorate performance reviews, as well as through both the Partnership Forum and the Corporate Management Team. This was a key area for improvement.

Mr Moore noted that this report covered a range of areas, and that the Board noted in particular the need to improve attendance management, and to manage downward the use of overtime and excess hours.

The Board:

1. Noted the content of the report

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

The Board received a report from the Director of Nursing and Operations (Paper No. 23/99) which outlined the progress made on the early implementation and testing of aspects of the Health and Care Staffing (Scotland) Act 2019 (the Act) within TSH as well as the adoption of e-rostering.

Ms McCaffrey confirmed that good progress was being made across each workstream, and that the key was now to re-consider how assurance was presented to the Board in this respect. She asked the Board to now that reporting to Scottish Government for Quarter 2 of this year, was now due for 3 November. There would be a further link meeting with the Chief Nursing Officer team on 8 December, available to the wider staff group within TSH. Mr Jenkins added that reporting was being reconsidered in terms of how best to present the key project milestones and to lend a more focused look forward to demonstrate readiness for April 2024.

Mr Moore noted that the possible challenge of the alignment within the delivery of forensic mental health care, and thanked Ms McCaffrey for the assurance provided to the Board.

The Board:

1. Noted the content of this update.

17 DIGITAL INCLUSION STRATEGY

The Board received a paper (Paper No. 23/100) from the Finance and eHealth Director, which provided an update to the Board to the work being progressed within TSH to ensure that all patients could be provided with appropriate opportunities with regard to digital technology and devices. Mr McNaught asked the Board to note the current position for patients, who had limited access, and the barriers to digital inclusion.

Mr McNaught outlined the engagement work conducted to date, which had led to a well-attended workshop on 12 October 2023 to work through the preferred options for digital services and the prioritisation of specific digital inclusion tools. This will form the basis for the next stage which would involve preparation of a blueprint, with associated roadmap, timeline and costings. This could then be brought back to the Board for decision on the way forward. It was anticipated that a business case would be need to be prepared seeking funding from Scottish Government.

Ms Fallon offered thanks to the project team, and wider staff groups for the work taken forward to date, and emphasised the need for patient engagement. Mr McNaught confirmed that this would be central and that engagement had been taken forward through the Patient Partnership Group. He noted that in doing so, there should be careful consideration making sure that patients understood both the possibilities and potential obstacles that may exist. There was agreement by Board Members, especially in terms of the financial landscape more generally, and the need to seek additional funding in this respect if possible.

Mr Jenkins also noted the national framework for digital inclusion across the forensic estate, and that this local strategy for TSH was being developed pending progression of national strategy. The Board discussed and agreed their desire for this local strategy to continue to be developed, given the importance for digital inclusion for patients, and not to be delayed whilst a national outcome was outstanding. It was agreed that Mr Jenkins should write formally to Scottish Government colleagues to confirm this position, and Mr Moore added that this should also be highlighted at the upcoming Annual Review on 29 November 2023. Professor Thomson added her agreement to this, especially to reach a consistent position across forensic services; and to ensure that patents were not at a disadvantage in this area.

Mr Moore summed up the Board discussion and underlined the importance of this workstream, and the need for this to be progressed. He offered thanks to the project team and asked Mr McNaught to relate

the Board's feedback on the impressive nature of the work completed to date.

The Board:

1. Noted the content of the report and were in agreement with the direction of travel outlined
2. Agreed that work should continue to be progressed within TSH, noting that a national position was awaited.
3. Agreed that Mr Jenkins should write formally to Scottish Government seeking an outcome to the Technology and Communications Report of 2018, updated in 2021.

18 PLANNING: ANCHOR STRATEGY AND ANNUAL DELIVERY PLAN 20223/24

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 23/101) to present the draft TSH Anchors Strategy 2023 – 2026 for approval prior to it being submitted to Scottish Government.

Ms Merson summarised the key elements of the strategy in terms of maximising local, progressive procurement of goods and services, as well as providing fair work opportunities, and in the use and/or disposal of land and assets for the benefit of the local community and economy. She also drew the Board's attention to the governance framework outlined within the strategy. She advised that national baseline metrics were awaited through which the implantation of the strategy would be measured in the future.

Following this, Mr Jenkins confirmed his view that the draft strategy met the brief as outlined by Scottish Government, within the limits of being a small national board in a rural community.

Mr Currie welcomed the strategy positively and referred to the potential of the impact that TSH could have on the local area, and also commented that it would be essential to define what "value for money" meant in the context of procurement as this could relate to a number of factors including costings and environmental impact. He noted the existing framework and guidelines for procurement within NHS Scotland and the need for clarity as to any potential conflict. Mr McConnell agreed with this point in relation to procurement, and confirmed his agreement that the draft strategy presented had been developed well in terms of the possible response from TSH in this area.

In answer to a query from Mr Moore about the position for contractor staff within the hospital, and how TSH could get assurance that those contractors adhered to fair work principles; assurance was given that this was through due process and the declarations made through the procurement process.

The Board also received a paper from the Head of Planning, Performance and Quality (Paper No. 23/102) relating to the TSH Annual Delivery Plan 2023/24 including the feedback received from Scottish Government in this respect. This feedback had indicated satisfaction that the plan did meet the set requirements and provided clarity and a shared understanding on what would be delivered by TSH during the current year. Ms Merson also confirmed that the Winter Preparedness Checklist had been completed and submitted in line with the requirements set out by Scottish Government.

The Board were content to note finalisation of the agreed plan and thanked Ms Merson for her work in this regard.

The Board:

1. Approved the Anchors Strategy 2023 – 26, and agreed that this should be submitted to Scottish Government.
2. Noted the finalisation and publication of the Annual Delivery Plan 20223/24.
3. Noted the submission of the Winter Preparedness Checklist.

19 FINANCE REPORT TO 30 SEPTEMBER 2023 (MONTH 8)

The Board received a paper (Paper No. 23/103) from the Finance and eHealth Director, which presented the financial position as at 30 September 2023.

Mr McNaught underlined the need to provide regular updates on the expected outturn for the year, to Scottish Government, and to indicate any projected underspend which could be subject to clawback to help address national pressures. The current projection was for breakeven to be achieved, subject to the adjustment pending for final Agenda for Change (AfC) funding from government. He also confirmed that in terms of capital, the forecast for the year was for full utilisation of the annual allocation.

Mr McConnell referred to the overall challenge to public finances and to the Audit General for Scotland which had been published on today's date which underlined these challenges. He asked about funding for required backlog maintenance work, and Mr McNaught confirmed that the work was already underway on each part of these meaning that existing agreed funding would not be reviewed. However, clarity was awaited on the potential for additional funding in this respect.

Mr Currie noted the potential for the impact of the Health and Care Staffing legislation for the 2024/25 year in terms of required staffing resources, as well as movement in terms of changes through AfC, and Mr Jenkins highlighted the impacts of a move to a 36 hour week and to the provision of protected time in particular. Mr Moore added to this discussion, in terms of the financial realities for all NHS Boards with a further 3% savings target for the coming year.

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

The Board:

1. Noted the content of the report.

20 NETWORK AND INFORMATION SYTEMS (NIS) REPORT

The Board received a paper (Paper No. 23/104) from the Finance and eHealth Director, to provide a detailed update on the work being progressed in this area. Mr McNaught summarised the main aspects, and confirmed that the electronic submission had been made by the due date of 16 October. Therefore, the outcomes was now awaited, and an indicative report may be issued in late November prior to the meeting arranged for 6 December which would confirm the final outcome. Mr McNaught also advised the Board that initial work had commenced for next year's NIS review.

Mr McNaught was asked to confirm the arrangements for the meeting on 6 December, for the Board, and the Board was content to note the overall position,

Action – Mr McNaught

The Board:

1. Noted the content of the report.
2. Requested confirmation in respect of the meeting with the Competent Authority on 6 December.

21 eHEALTH ANNUAL REPORT 2022/23

The Board received a paper (Paper No. 23/105) from the Finance and eHealth Director, to present the Annual Report for eHealth services. Mr Best joined the meeting in order to provide the Board with an overview of reporting.

Mr Best highlighted the key areas of activity progressed by each team within his department, particularly the integration of HEPMA and the electronic patient record system, and the growing input

from eHealth in key projects including the current security refresh. He also signalled the focus for the current year including patient digital inclusion and disaster recovery test plans, as well as the replacement of the wireless network and implementation of SharePoint through Outlook 365. Mr Best also outlined the challenge in terms of recruitment and retention so that the department could offer a full service across a wide range of complexity, technical knowledge and skills.

Mr McNaught added following a self-assessment on digital maturity within TSH, an audit had been carried out by Scottish Government and COSLA with very positive feedback on the management and use of data within TSH. The assessor had been impressed by the amount of data available to staff, as well as the practical way in which it could be used as part of business as usual practice. Mr Moore noted this as a major achievement, and Ms Radage echoed this. She asked about resourcing for the department in terms of staff, and if it would be possible to consider recruitment through apprenticeships. There was discussion on the availability of funding to support development in this way, especially relating to the infrastructure team.

Ms Fallon asked about the transfer to Near Me within TSH for video visiting, given the importance of this for patients, and that this should be included in future reporting. Mr Moore asked about the possible use of this for external patient outpatient appointments. Professor Thomson added her agreement for this for routine appointments, which did not require specialised testing, although the Health Centre could do a limited amount of testing on site. The Board asked for a further update in terms of the use of Near Me and/or Attend Anywhere in this way.

Action – Professor Thomson

Mr Moore offered the Board's thanks for the report which ably demonstrated the range of work the department was responsible for.

The Board:

1. Noted the content of the report.
2. Requested an update on use of virtual means for routine external patient appointments.

22 INFORMATION GOVERNANCE ANNUAL REPORT 2022/23

The Board received a paper (Paper No. 23/106) from the Finance and eHealth Director, to present the Annual Report for Information Governance across TSH. Mr Lawton joined the meeting to provide a summary for the Board.

Mr Lawton highlighted the change to the Data Protection Compliance Toolkit (DPCT) as well as the audit conducted by the UK Information Commissioner's Office which had led to a high level of assurance rating for TSH. He summarised the activity on Freedom of Information (FOI) requests and the improvement year on year seen through a self-assessment exercise. Further, he detailed the transformation of the Health Records Team into a wider ranging Record Management function.

Mr Moore noted the wide range of responsibilities shown here, and the overall good performance demonstrated. Mr Fallon asked about the "adequate" rating within the FOI self–assessment for publishing of information. Mr Lawton explained that this related to the website function in place at the time, which had limited search functions, and this had been resolved by the subsequent upgrade of the website. He also noted the limited access for TSH patients to make FOI requests and the need for improvement in that respect.

Mr Moore offered thanks to the team, for their work across the range of services involved.

The Board:

1. Noted the content of the report.

23 COMMUNICATIONS: ANNUAL REPORT 2022/23, INTRANET UPGRADE PROJECT /UDPATE REPORT

The Board received a paper (Paper No. 23/107) from the Head of Communications, which presented the Annual Report 2022/23 for Communications.

Ms McCarron asked the Board to note the key areas of progress made including the website upgrade as well as the expansion of the team in terms of resourcing. She also noted the increased use of social media for TSH as a key development. Mr Moore confirmed that the Board was content to note this update through annual reporting, particularly the role of staff bulletins for staff communications.

The Board received further papers from the Head of Communications relating to the upgrade to the intranet (Paper No. 23/108) as well as to re-branding (Paper No. 23/109). Ms McCarron confirmed that SharePoint Online was projected to be available in early 2025, and summarised the activity underway in preparation for this. In answer to a question from Ms Radage, it was confirmed that the current intranet site was no longer supported. In relation to rebranding for TSH, the Board noted that this continued to be progressed at a national level.

Professor Thomson provided positive feedback on the development of the communications team, and the increased level of support that was now available. Mr Moore also noted the publication of the TSH Annual Report for 2022/23 this month.

The Board:

1. Noted the content of reporting.

24 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report from the Director of Security, Resilience and Estates (Paper No. 23/110) detailing the update of the Perimeter Security and Enhanced Internal Security Systems re-fresh project. Mr Walker highlighted the key points, and the Board noted that a further update would be presented in a private session of the Board, given the security and commercial sensitivities.

The Board:

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

25 AUDIT AND RISK COMMITTEE

The Board received the approved minutes of the Audit and Risk Committee which had taken place on 22 June 2023, as well as a summary report relating to the key points of the meeting which had taken place on 28 September 2023 (Paper No. 23/111). Mr McConnell asked the Board to note the key aspects of this and that the full minute would be brought to the Board, once the Committee had approved it in due course.

26 ANY OTHER BUSINESS

Mr Moore noted that this was the last Board meeting attended by Ms McGovern in her capacity as Director of Workforce, before her transition to her new role. He thanked Ms McGovern formally for her contribution during her time at TSH, noting in particular the developments made in workforce reporting, the transition to a new Occupational Health service provider, as well as the improvements seen in both recruitment and retention of staff.

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

27 DATE AND TIME OF NEXT MEETING

The next public meeting would take place at 9.30am on Thursday 21 December 2023.

28 PROPOSAL TO MOVE TO PRIVATE SESSION

The Board then considered and approved a motion to exclude the public and press during consideration of the items listed as Part II of the Agenda in view of the confidential nature of the business to be transacted.

29 CLOSE OF MEETING

The meeting ended at 1.05pm

ADOPTED BY THE BOARD _____

CHAIR _____

DATE _____

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	Feb 23	Workforce Report	More detailed exploration of trends /patterns of sickness absence – add profile of length of service as well as service area. Add longitudinal data	L McGovern	October 23	**Update April 2023:** Reporting reviewed and presented under new format and including areas highlighted. Board reviewed changes in reporting and asked for further development of themes for sickness absence which would also be reviewed at Staff Governance Committee. **Update June 2023:** Reviewed by Board and further assurance reporting to be presented to Staff Governance Committee in August 23. **October 2023:** Reporting on agenda, and presentation of data reviewed. **CLOSED**
2	August 23	Corporate Risk Register	General request that monitoring reports are updated in details across all reporting	M Smith	October 23	**Update October 23:** Highlighted in board update to the CMT, following the Board. All sponsoring directors asked to ensure that report authors complete the form, and director to sign off. **CLOSED**
3	August 23	Corporate Risk Register	Include local risk register in reporting to align and tie together with CRR	D Walker	October 23	**Update October 23:** update is included in reporting on agenda. Update December 23: Risk approach discussed within Board Development Session on 7 November and actions agreed to come back to the Board **CLOSED**
4	August 23	Bed Capacity	Include the unit patient to be transferred to , as well as time waiting	L Thomson	October 23	**Update October 23:**This is in additional to previous request re adding time awaited to transfer – included in reporting on agenda December Update – Discussed and confirmed change in reporting **CLOSED**

5	August 23	Patient Story	Background data for Board on how the patient assessments were taken forward for placement within clinical model	L Thomson/ K McCaffrey	October 23	**Update October 23:** Two desktop exercises were held where RMOs and clinical teams were given definitions of each of the 4 services and asked to place each patients accordingly. Some anomalies were found during these exercises, for example a patient placed in transitions who had not been referred for transfer. The third exercise was used to place patients and reference back to clinical teams and to patients made to ensure this was done sensitively. **CLOSED**
6	August 23	Specified Persons	Re legislative aspects linked to restrictions – background reporting on forensic mental health framework	L Thomson	October 23	**Update October 23:** Verbal update will be provided at Board meeting Update December 23: Discussed at Board Development Session on 7 November and options reviewed. **CLOSED**
7	August 23	Specified Persons	Update to CGC re the telephone system and management of tel calls	D Walker	November	**Update October 23:** Added to November Agenda of Clinical Governance Committee – **CLOSED**
8	August 23	Supporting Healthy Choices	Add to CGC for reporting Update on Turas issues reported on	L Thomson/ M Smith/ S Whyte	TBC	**Update October 2023:** CGC Workplan to be updated and date for reporting to CGC to be confirmed. Miss Whyte confirmed that TSH staff have ongoing problems with access and that TURAS are aware of and are trying to resolve Below is text from the funding letter re the use of TURAS. *Boards must continue to record **all** referrals to weight management and type 2 diabetes prevention and remission services using the agreed standardised core dataset as stipulated by the 2023-24 Framework milestones in the implementation plan and gap analysis. Once fully integrated on to the Turas platform, boards must use this platform to continue to collect data and*

						provide reporting to PHS.SHCIP on to the CGG to meet the schedule set for the Committee. **CLOSED**
9	August 23	Central visiting / family centre	Update on fencing – when installed and gardens available	D Walker	December 23	**Update October 23:** Update on installation date to be provided at Board meeting. Discussed at Clinical Governance Committee on 9 November, and highlighted for confirmation of installation date. This has not been possible, and Director of Security. Resilience and Estates directly managing to seek solution.
10	August 23	QA/QI	Update on Clinical Quality Strategy, narrative within evaluation matrix on delays as well as target dates	M Merson	October 23	**Update October 23:** Update below is included in the QA/QI Paper on agenda. TSH will revise the Quality Strategy in 2023/24 with initial scoping taking place. In relation to the evaluation matrix a column has been added to the table on target completion dates and included text in the updates on current position so if there are any delays these are explained **CLOSED**
11	October 23	Corporate Risk Register	Re Obesity data – further update on reasons not being complete data set, and what is impact	L Thomson	December 23	**Update December 23:** Usually data not available due to patient being too unwell/newly admitted or off site. Reviewed with Clinical Quality re data set and change made so that set to patients who have consented and measurement taken. Clinical Quality then flag to dietician for any patient too unwell or refused measurement so that further engagement can be considered through the clinical team. Consider as action now closed.
12	October 23	Infection Prevention and Control	Include uptake rate for vaccination in December reporting	K McCafferty	December 23	**Update December 23:** Information included within reporting on agenda, consider closing action.

13	October 23	Approved Medical Practitioners	Board request for evidence to give assurance for AMP status	L Thomson	Immediate	To be included I any future AMP reports – added to reporting requirements so that will be the cas**e.** **CLOSED**
14	October 23	QA/QI Report	Clinical Audits re medication to be followed up for oversight through CGC	M Merson	Immediate	Clinical Quality asked to note need for follow up audits to be reported through Clinical Governance Committee**.** **CLOSED**
15	October 23	Health and Care Staffing	Review of reporting format, for performance/ milestones for assurance	K McCafferty	December 23	**Update December 23**: Reporting being reviewed, and changes made to report presented to today's meeting, and will continue to be refreshed in line with Board requirements.
16	October 23	Digital Inclusion	Re seeking outcome at national level on 2018 report and 2021 update	G Jenkins/ R McNaught	December 23	**Update December 23**: Highlighted in briefing pack to Mental Health Directorate for Annual Review on 29 November, and raised by CEO within session. Response now awaited from Scottish Government, with confirmation this will be by March 2024.
17	October 23	Anchor Strategy	To be submitted by 27 Oct to Scottish Government	M Merson	Immediate	**December 23:** Submission confirmed by due date **CLOSED**
18	October 23	NIS	Re arrangements for session on 6 Dec	R McNaught	Immediate	Confirmed that this is a teams session **CLOSED**
19	October 23	eHealth Annual Report	Re Attend Anywhere use in TSH	L Thomson	December 23	**Update December 23:** Confirmed through Health Centre that use of Attend Anywhere/ Near Me can be helpful within TSH including for external outpatient consultant appointments that do not require any physical intervention or specialist testing. This is most likely within health centre, through video-conferencing equipment is also being upgraded within ward areas. Consider closing action if no further info required.

Last updated – 15.12.23 M Smith

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	21 December 2023
Agenda Reference:	Item No: 8
Sponsoring Director:	Director of Nursing and AHPs
Author(s):	Patients' Advocacy Service Manager
Title of Report:	Patient Advocacy Service 12 Monthly Report – August 2022-July 2023
Purpose of Report:	For Noting

1. SITUATION

This report serves to provide assurance to The State Hospitals (TSH) Board the Patients' Advocacy Service (PAS) continues to meet the needs of State Hospital patients, as set out in the Service Level Agreement (SLA).

2. BACKGROUND

We will highlight progress made within the service including improvements, achievements, and future plans. We also set out any challenges faced and remedial action taken to overcome these. The following report highlights August 2022-July 2023.

3. ASSESSMENT

August 2022 – July 2023

- Achievements against the Key Performance Indicators (KPI) in the Service Level Agreement this year continue to be met to 83% with statistical reporting evidenced in section 4; The deficits relate in part to factors out with our control in relation to visiting patients within the 7 day timescale and the ward drop in. Patient narratives are in section 7 and accounts in section 12.
- Full and effective use is being made of the budget allocated by the Hospital for the service.
- 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.

- Robust arrangements are in place for the growth, professional development and support of all Advocates.
- Positive communication between PAS and The State Hospital continues to foster excellent working relationships beneficial to both organisations and patients.
- Continued increase in the amount of contacts and actions with patients in comparison to previous years.
- We continue to explore how PAS can promote itself as an operation wholly independent from The State Hospital, therefore ensuring we continue to provide independent advocacy to patients in line with SIAA guidance.

Section 9 of the main report identifies both organisational and service developments planned for the next reporting period.

- Continue to recruit Board Members.
- Update our Patient Board Rep recruitment and training package.
- Update our staff handbook to be current with legislative changes.
- Further expand our knowledge by maintaining current training and continuing to attend relevant courses and webinars.
- Continue to find ways to highlight our independence.
- Prepare for the upcoming tender process.
- Become more aware of positive ways of working such as with supported decision making.
- Responding to consultations and attend short life working groups as appropriate, to champion the voice of our patients in their unique position.
- Complete the annual questionnaire and take forward the views of patients on the PAS service.
- Further enhance our ward drop in service and how this can better support our patients.
- Address issues regarding patients in seclusion or in very restricted positions.
- Construct an admission booklet for new admissions to TSH detailing the role of advocacy and the support we can provide.
- Explore the options for having our own independent database.
- Continue to work towards independent email addresses.
- Finalise a protocol on Patients Boarding Out.
- Raise awareness of non-instructed advocacy for patients who lack capacity.

4. RECOMMENDATION

The State Hospital's Board for Scotland are asked to **note** this report.

PATIENTS' ADVOCACY SERVICE

12-Monthly Report

1st August 2022 – 31st July 2023

1 Introduction

The Patients' Advocacy Service (PAS) aims to provide an independent, highly skilled, responsible, and professionally run service within The State Hospital (TSH). Whilst observing the safety and security of the Hospital, the service works independently within it to promote patients as individuals, support 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 TSH. The report describes how the service provided by PAS has the ability to adapt to the ever-changing needs of the patient population especially with the ongoing issues surrounding Covid-19 and the staffing crisis.

1.1 Highlights of the Year

This report relates to August 2022 – July 2023, reflecting on another successful, albeit challenging year, during which we continued to provide an Independent Advocacy service to all patients. Work included this year is as follows.

- Recruitment of a new advocate, recruitment processes for an administrator and a co-opted member of our Board.
- Continued to support patients during a challenging period of accessing wards due in part to staffing issues.

- Continued to develop the knowledge and skills of the team by supporting them to attend training and webinars. All staff this period have undertaken accredited talking mats training.
- Continued to connect with external advocacy providers including those based in other high secure services in the UK.
- Continued to champion the patient voice by responding to important consultations and partaking in short life working groups relevant to the patient population including the involvement with the clinical model process and daytime confinement short life working groups.
- Increased actions and contacts with patients to meet demand for the service.
- Development of a protocol for continuing to offer patients with independent advocacy when boarding out in general hospitals.
- Continuing to work towards visual independence. This year we implemented our own lanyards.

On the 14th of November 2022 PAS held their 13th Annual General Meeting (AGM) where we delivered our Annual Report for 2021-2022. This was our first in person presentation since the beginning of the covid-19 pandemic which was well attended by TSH and external colleagues.

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 Key Performance Indicators highlighted in the service level agreement. The Person-Centred Improvement Steering Group (PCISG) receives monthly verbal updates by a representative from PAS and receives quarterly written reports highlighting the progress with the set KPI's. The service manager meets separately with the Person-Centred Improvement Lead (PCIL) monthly to provide update and receive support. Finally, this report, along with our annual report is circulated throughout TSH to various groups and all TSH staff are invited to attend our AGM.

Following discussion in 2021 TSH agreed to a 2 year extension to the service level agreement. This means we will move to tender in 2024.

2.1 Finance

The annual cost of the service to the Hospital in the financial year April 2022 - March 2023 was £149,369 which includes recurring funding of £20,000 initially received in April 2012 from the Scottish Government following the introduction of The Patients' Rights (Scotland) Act, 2011. The full financial report can be seen on page 36.

2.2 Committee Membership and Role

The Board of Directors comprises:

- Michael Timmons, Chair
- Heather Baillie, Treasurer
- Innis Scott, Secretary
- Ruth Buchanan
- Clare Daly

2.4 Board Meetings

The PAS Board of Directors held 5 Board Meetings during the year and an AGM. The AGM took place in person in Lanark Memorial Hall and was our first post covid-19. We held 3 online board meetings and 2 in person.

PAS remains committed to supporting our patient representative to meaningfully engage in our board meetings; the patients' voice is invaluable to the service and it is helpful for PAS Board members to hear directly from the patient representative, the issues being faced. Our current patient rep has been involved since January 2021 and actively engages in the Board meetings both by videoconferencing and in-person.

2.5 Workforce

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. Our team continued to provide a person-centred service to each patient. Securing and retaining skilled employees is challenging in such a unique environment.

As per our last report, one of our longest standing advocate tendered their resignation on July 2022 to train in mental health nursing following their time in PAS. Similar to many charities and NHS, recruitment has been a challenge for us. In January 2023, our newest advocate Emma Hatton joined the team 3 days per week (which was a reduction from the previous advocate working 4 days). Emma completed a robust induction, shadowing and mentoring programme.

We faced similar challenges recruiting for an Administrator following our Administrator moving on from PAS in December 2022. We were unable to recruit someone suitable to this role and after many conversations with our IT cloud provider, we identified a temporary solution. There was the opportunity to create our own database system which would finalise our independence from TSH systems, and streamline our data recording and administrative tasks. However, there were increased costs with this option. We discussed with TSH and after submitting cost savings, it was agreed any overages from cost savings in relation to the system versus an administrator post, these would be returned to TSH at the end of the financial year in 2024.Crucially, this option would support the team given the increased pressure of absorbing the admin role.

Finally, this year, we received a request from one of our advocates to reduce their working days from 5 per week to 4. Given the extenuating circumstances with this request, the PAS board felt it necessary to approve this reduction. In response, the board considered a number of options and chose for another staff member to increase from 4 days to 5 to cover the shortfall and absorb some of the pressure of patient contact.

As of July 2023 the PAS workforce is as follows:

- 1 x Full time manager 35 hours
- 2 x part-time Advocates 28 hours each
- 1 x part-time Advocate 20 hours

Whilst this formation does have a reduction of 1 day per week reduction in advocacy hours from the previous report and 3 days reduction of the admin role, the team have consistently worked hard and flexibly to ensure there has been no impact on patients and KPI's have been able to be met, service development has continued although at a slower pace.

Given the staffing pressures over this year we were unfortunately unable to resume our volunteer programme. It is vital to us to ensure we are best able to support those who graciously offer their time to the service. We recognize the value volunteers can add to our service and will continue to work to reach a place where we can adequately support volunteers.

2.6 Working Relationships

The PAS Manager maintains regular contact with hospital professionals including the PCIL, PCIT, Lead Nurses, Senior Charge Nurses and Complaints Officer. This ensures effective communication, collaboration and joint working whereby issues are dealt with promptly and locally. In addition, the PAS manager attends other relevant meetings throughout the Hospital and attends each PAS Board meeting and provides a report highlighting the work completed between meetings.

As per our last report the bi-monthly link meeting with a PAS board member, the chief executive and director of nursing has continued to share relevant updates and discuss any issues.

2.7 Training

Staff continue to complete and keep up to date with all mandatory training specified by TSH, including LearnPro modules and in person training. PAS welcomes the opportunity to engage in training and development offered by The State Hospital. This enhances knowledge and skills of our staff group, positively benefitting the patients. The PAS team

also engages in external training through the SIAA and other external bodies. This year PAS invested in Talking Mats training for all staff which provides staff with the skills to enhance communication with patients regardless of their communication needs.

Additional training completed this year includes:

- Human rights training x2 staff
- How to win contracts and service level agreements
- Trauma Skilled Practice

We actively encourage staff and volunteers to undertake training and continued professional development. All staff have a learning plan where they are able to highlight training needs. These plans are analysed on an annual basis.

2.8 Policies and Procedures

Policies for PAS remain integral to the service operating effectively for both staff and patients. We adhere to all TSH policies and PAS specific policies continue to be reviewed when necessary, ensuring they are GDPR and data protection compliant. We continue to increase the number of policies which have been equality impact assessed. Throughout the last year we have continued to work on our Staffing Handbook with our human resource service to ensure this continues to be updated in line with legislation.

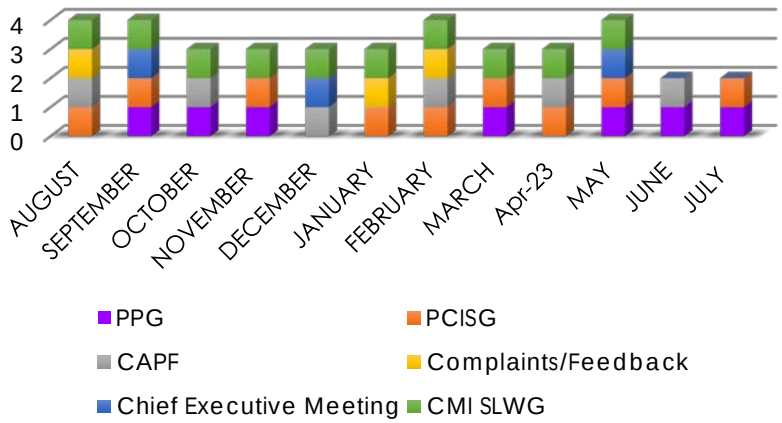
2.9 Participation / Integration

PAS staff participated in several State Hospital groups to facilitate and support integrated ways of working benefitting patient care including:

- Person Centered Improvement Steering Group
- Patient Partnership Group
- Child & Adult Protection Forum
- Complaints and Feedback
- Forensic Network Special Research Interest Group
- Digital Inclusion
- SLWG: Clinical Model Implementation
- Daytime Confinement

The graph below highlights the internal groups we attended.

Figure 1: Meetings Attended



We also attended external events including:

- SIAA Managers Support Group
- SIAA AGM
- SIAA Roundtable: SMHLR Independent Advocacy
- SIAA Roundtable: Mental Health Law Review Recommendations
- SIAA Conference
- Lived Experience Group – Scottish Government
- Health and Social Care Review
- Deprivation of Liberty
- National Care Service – Stakeholder Group
- Scottish Government Health, Social Care and Sport Committee
- Independent Advocacy: Promoting and Defending Human Rights
- Learning Disability, Autism and Neurodiversity Bill
- Forensic Network: Trans Guidance SLWG
- SofMH Learning and Development Strategy

PAS remains involved with the Scottish Independent Advocacy Alliance (SIAA) providing the distinctive perspective of patients within a high secure environment ensuring this is included in any developmental work. The events attended by PAS over the reporting period can be seen above.

Consultations both internal and external we have responded to over the reporting period include:

- Clinical Care Policy
- Seclusion Policy
- Patients Use of Telephone Policy
- CPA document review
- MHTS Service Users and Carers Policy
- Mental Health Act Code of Consultation
- Clinical Quality Improvement Framework

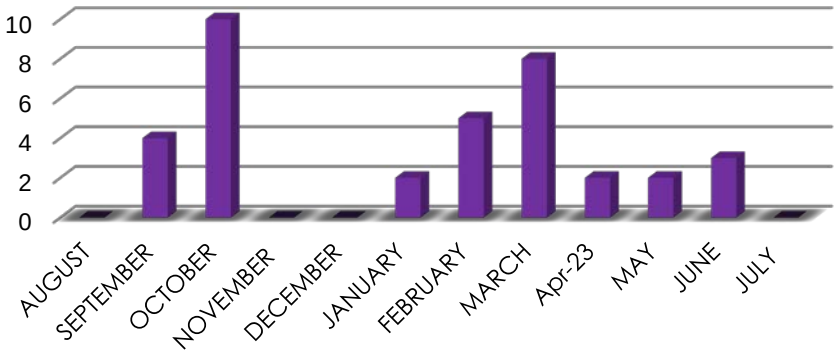
- SIAA Outcomes
- Scottish Mental Health Law Review
- Scottish Mental Health and Wellbeing Strategy

External working groups included:

- Mental Health Tribunal Service Users and Carers Group

We are involved in the induction process of new TSH staff, including students from various departments. The graph below shows on a monthly basis the inductions provided to new staff. These include student nurses, student occupational therapists, new social workers and health records staff.

Figure 2: Staff Inductions



3 Patient Questionnaire

The patient questionnaire is a requirement of our SLA. The PCIT distributed the easy read questionnaire to all patients and supported some to complete in November 2022. The PCIT collated the questionnaires and provided PAS with a report. 62 of 111 patients responded totaling a 56% response rate which is an increase from the previous questionnaire.

Actions Resulting from the Questionnaire

PAS are extremely grateful to both the patients who took the time to complete the questionnaire, as well as the input from patients and the PCIT in organising the questionnaire, distribution and collation.

The board and staff discussed the results and some of the key points include:

- Increasing Skye Centre appointments
- Male members of staff – making an effort to recruit male volunteers

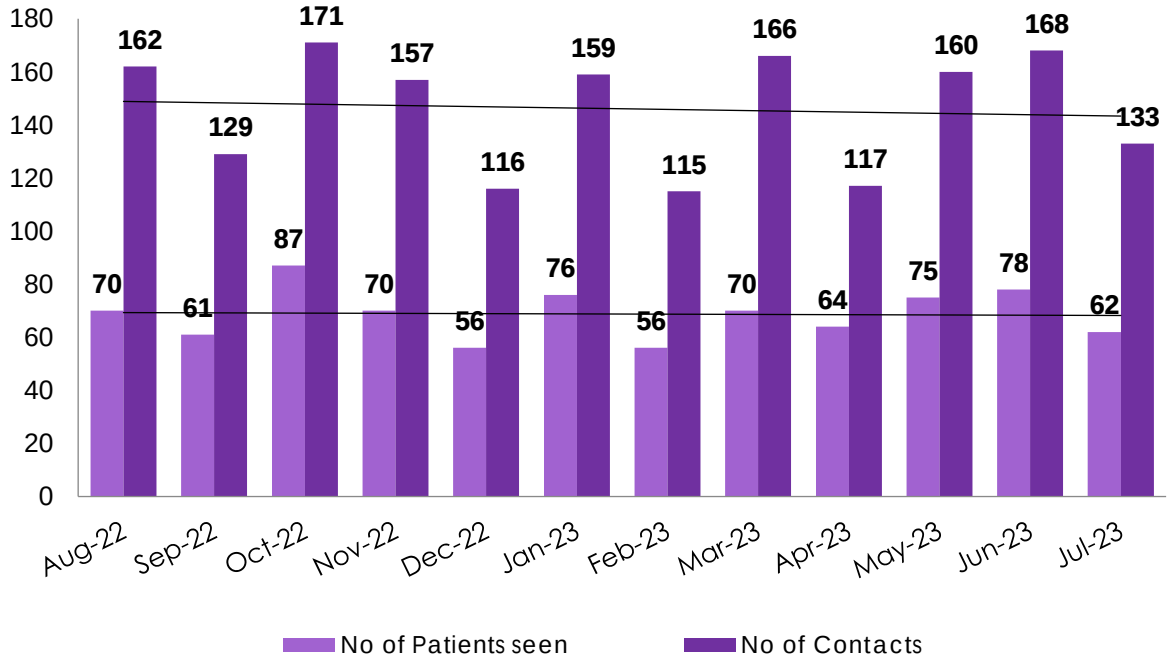
- Exploring options for patients choosing staff sitting in appointments when on level 3 observations

We attended the PPG to inform patients of the report and this was also disseminated through the Person Centred Improvement Steering Group. Additionally, a poster was created and placed in all wards to inform all patients of the outcomes and the actions we planned to take. A copy of this poster can be seen in Appendix 1.

4 Key Performance Indicators

4.1 Contact

Figure 3: Number of Patients Seen and Contacts



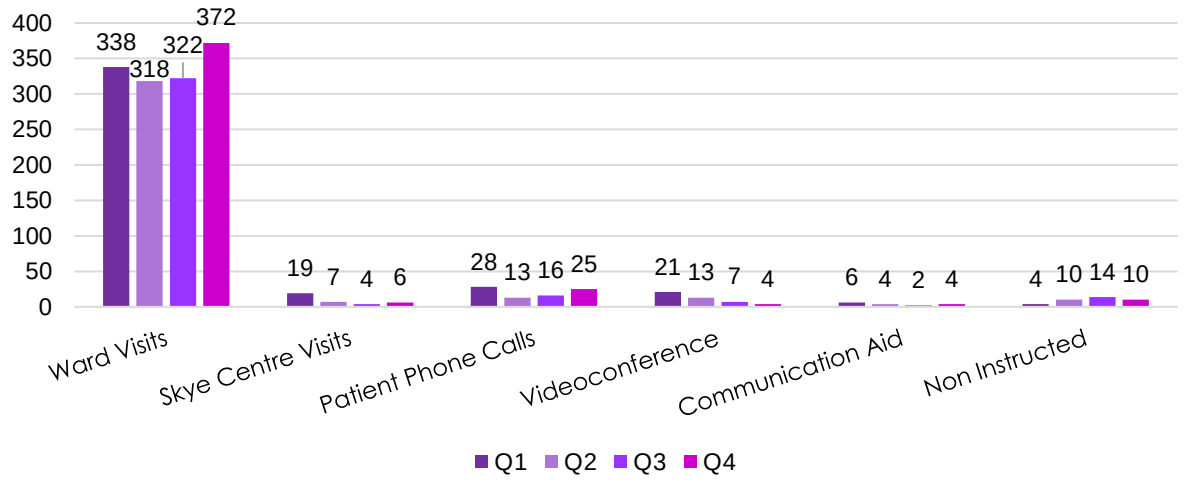
Overall we made 1753 contacts, an increase of 107 from the previous year, with 133 patients. All patients within TSH are seen by PAS a minimum of twice per year as we ensure each patient is approached prior to their case review, of which they have 2 per year. The average number of contacts per patient throughout the period was 13. These figures include 31 patients transferred to medium secure units, returned to prison, discharged to the court. Sadly, there were 2 deaths throughout this period. There were also 23 admissions.

As can be seen by the trend lines, both the number of contacts and the patients seen stayed static across the year. Despite the changes in our workforce this year, PAS has worked hard to ensure an equitable service continued to be provided to all patients. The

drops in specific months correlate to holidays where there are often multiple periods of annual leave correlating with school holidays although we continue to meet all requests for independent advocacy during these periods.

4.2 Communication by Quarter

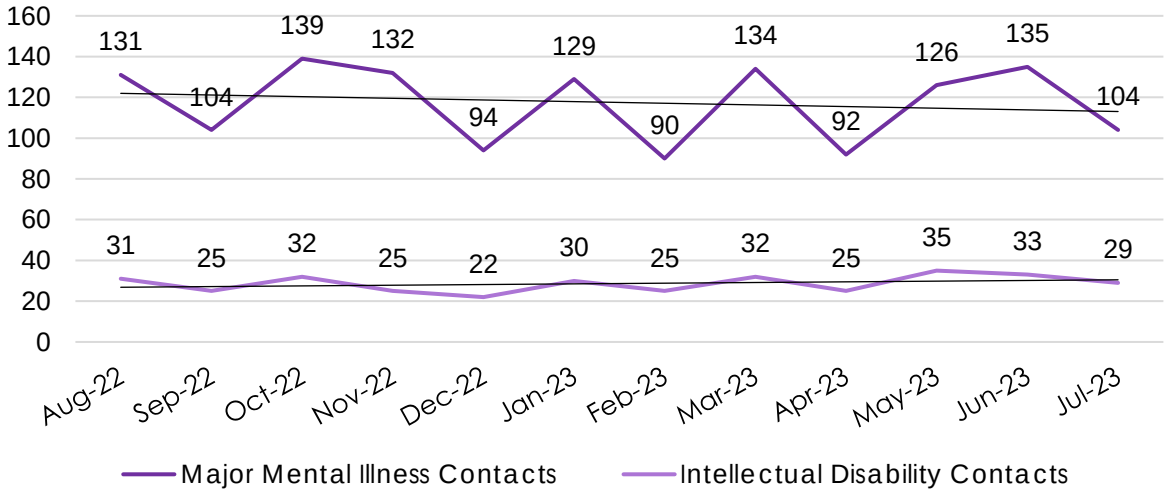
Figure 4: Communication by Quarter



The graph above shows how we communicated with patients by quarter. This highlights the diverse ways we interact with our patients. As shown, the majority of our contacts are ward based, however patient phone calls have remained fairly consistent across the year. Videoconferencing (VC) has decreased throughout the quarters, this is to some return to normality in in-person meetings for case reviews and solicitor meetings. One area to note is the increase in non-instructed advocacy. This is due to increased communication with clinical teams for those patients who lack capacity and the continued involvement of independent advocacy.

4.3 Major Mental Illness and Intellectual Disability Contacts

Figure 5: Intellectual Disability and Major Mental Illness Contacts Per Month

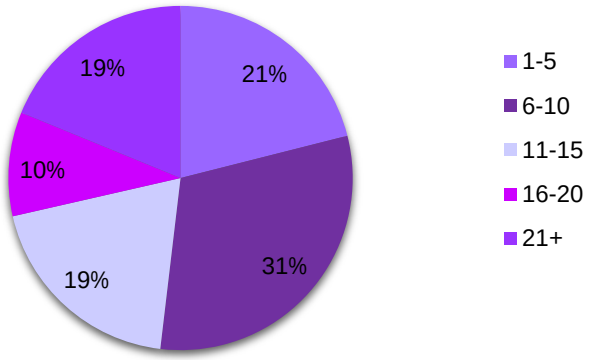


Within the service level agreement it notes reporting on the number of contacts specifically with patients identified as having an intellectual disability (ID) and the types of intervention provided. Shown in the graph above are the number of contacts per month for those with an intellectual disability and those with major mental illness (MMI).

Throughout the reporting period a variety of issues were discussed with individuals. A lot of the work related to legal work such as supporting a patient to engage the services of a solicitor, facilitating contact with a solicitor or attending solicitor meetings. In addition there were discussions surrounding CPA's, tribunals and parole boards. Alongside the legal element, there were conversations regarding a patients' treatment, complaints, staff and discussing options. 1 patient has a weekly meeting for relationship building and engagement. Additionally, there was support for the patients during the clinical model moves including providing active listening. These contacts were evenly spread across the patient population.

4.4 Contacts per Patient

Figure 6: % of Contacts per Patient



All categories for this graph have increased from the previous report aside from those seen 1-5 times which reduced from 27% to 21%. We continue to monitor patient contacts to ensure these are reflective of the service we provide. Some patients require more support than others, this is particularly true of our intellectual disability patient group and new admissions to the Hospital.

Throughout this period we have continued to host a weekly drop in to the ID ward partly due to increased contacts. Additionally, we have ensured to visit new admissions on a weekly basis until their first case review which is around 12 weeks post admission. This is to offer increased support at a challenging time. We have found this reporting period, patients have required more from the service with more complex challenges which has led to increased support. In addition, patients required a lot of support in relation to the clinical model changes which again has increased the amount of contact we have had with patients.

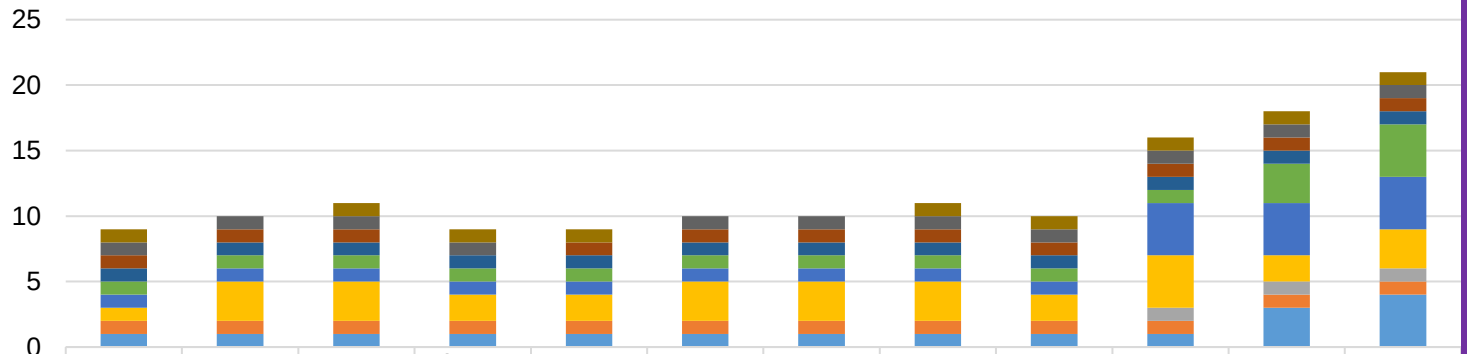
4.5 Ward Drop In

The service level agreement requires PAS to provide a monthly drop-in to each ward. The following graph reflects this target was not fully met during August 2022-July 2023. This is partly due TSH staffing difficulties over the past year where it has been challenging to get on the wards at times.

Since March 2023 there have been no missed drop in's on any ward. We have introduced a monitoring system at our team meetings to ensure this is actioned on a monthly basis.

As shown, Iona 2 and 3; Arran 1 and Lewis 1 all have a weekly drop in. Some months this is not completed each week due to the named advocate being on leave however individual requests for independent advocacy are honoured. We have some additional action points to follow up on now the clinical model has officially been stood up which will be highlighted in the next report.

Figure 7: Ward Drop In



	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	Apr-23	MAY	JUNE	JULY
Mull 2	1	0	1	1	1	0	0	1	1	1	1	1
Mull 1	1	1	1	1	0	1	1	1	1	1	1	1
Lewis 3	1	1	1	0	1	1	1	1	1	1	1	1
Lewis 2	1	1	1	1	1	1	1	1	1	1	1	1
Lewis 1	1	1	1	1	1	1	1	1	1	1	3	4
Iona 3	1	1	1	1	1	1	1	1	1	4	4	4
Iona 2	1	3	3	2	2	3	3	3	2	4	2	3
Arran 3									0	1	1	1
Arran 2	1	1	1	1	1	1	1	1	1	1	1	1
Arran 1	1	1	1	1	1	1	1	1	1	1	3	4

4.6 3 Year Comparison (2020-2021, 2021-2022, 2022-2023)

Figure 8: 3-Year Comparison

	No of Contacts	Ward Visits	Skye Centre Visits	Patient Phone Calls	Issues	Actions
2020-2021	1204	1204	0	0	1941	2388
2021-2022	1652	1174	71	157	2917	3165
2022-2023	1753	1350	36	99	3079	4112

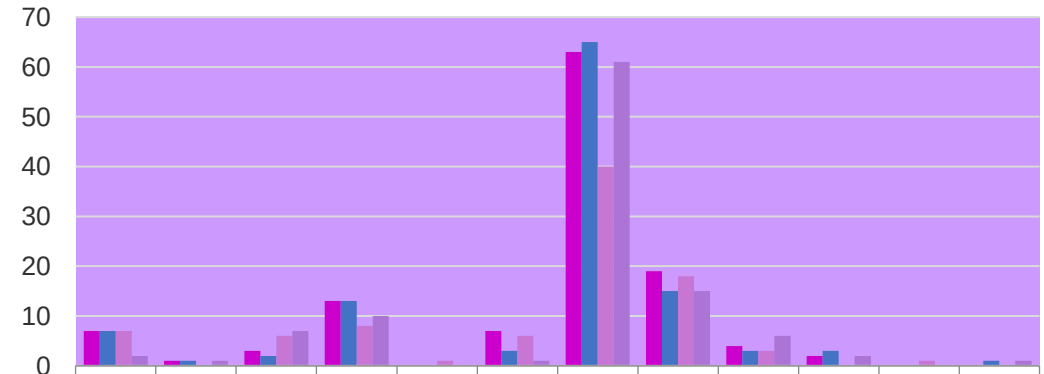
The figures in the above graph shows a steady increase over the past 3 reporting periods for the number of contacts which have increased considerably since 2020 as have the number of issues and resulting actions.

We began recording the number of phone calls specifically with patients so we could identify how much contact we had with patients as well as internal and external organisations to provide more in depth data. This began in October 2021 and is specifically for phone calls where advocacy support has been provided. As shown however, majority of our contact remains on ward.

We have noted an increase in the amount of CPA's, tribunals and parole boards which patients request support, with very few declining this service (See figure 13 for more information). One of the other notable increases is the discussion with staff outside of a telephone call or email which offers quick resolve to issues a patient may be facing.

4.7 Formal Referral Routes

Figure 9: Referral Type by Quarter



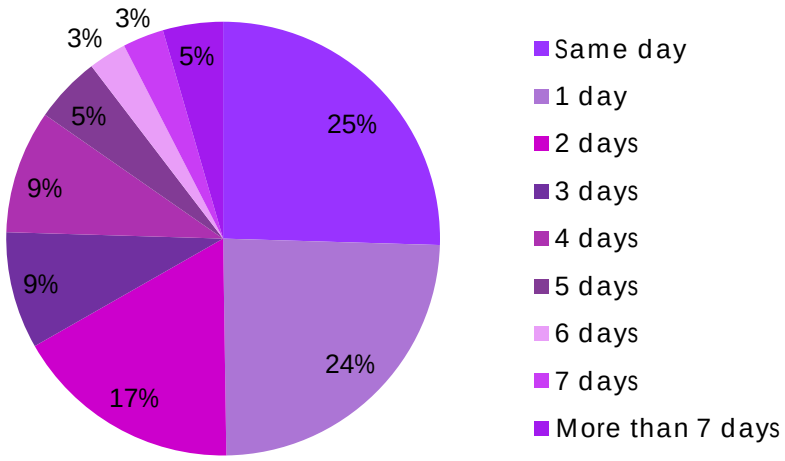
	Adm	MHOT	NSE	NST	NSV	SA	ST	SV	SWE	SWT	RMOT	RMOE
Q1	7	1	3	13	0	7	63	19	4	2	0	0
Q2	7	1	2	13	0	3	65	15	3	3	0	1
Q3	7	0	6	8	1	6	40	18	3	0	1	0
Q4	2	1	7	10	0	1	61	15	6	2	0	1

Abbreviations in Appendix 2

The above statistics relate to formal requests to see an Advocate by quarter. 73% of referrals came directly from patients, a drop of 6% from the previous report. Hospital staff continue to be vital for us to provide support to patients, with a further 20% of referrals coming from nursing staff, social work and RMO telephone calls and emails, an increase of 1%. There has been a marked increase in the volume of referrals coming from social work colleagues highlighting the positive working relationship we have.

4.8 Patient Referral Timescales

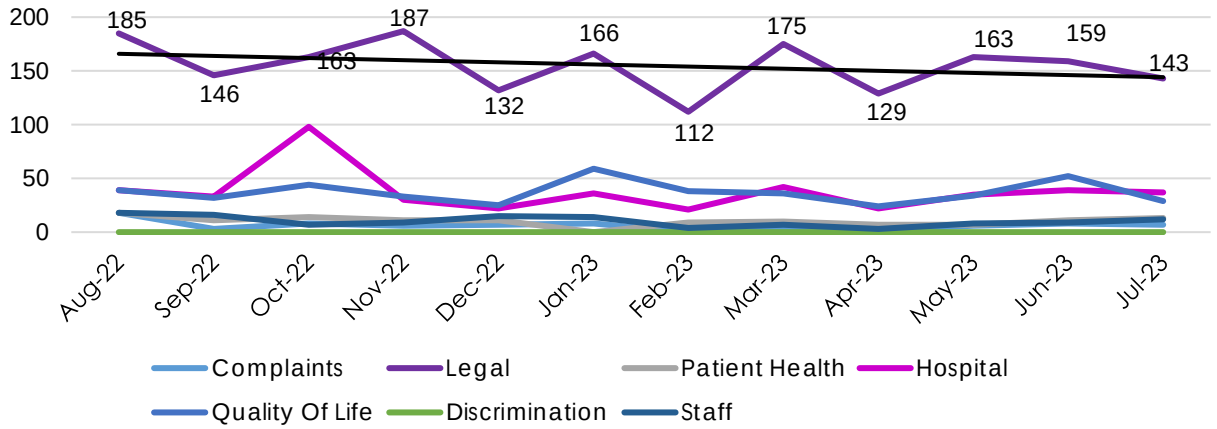
Figure 10: Annual Referral Timescale



This graph relates to how quickly PAS responded to requests to see an advocate. As shown, 25% were responded to on the same day with a further 17% seen within 2 days. This highlights 37% of patients were responded to within a 2 working day period. This is a significant drop from last year's report which was 67%. This is partly due to the staffing challenges we have faced this year in addition to the difficulties in accessing wards at times. Furthermore, patients have continued to have increased access to activity which also impacts on being able to see them within a quicker timeframe. 5% of patients were seen out with the 7 day period, an increase of 3% from the previous report. This related to new admissions who nursing staff deemed it too risky to visit or patients in isolation who were unable to be seen therefore out with the control of PAS. We engaged with nursing staff to keep updated of how a patient was and whether they were able to be visited. All patients were offered another advocate to visit them. It also encompasses those patients who requested advocacy support but wished to wait until their designated advocate was back on site from annual leave or isolation.

4.9 Issues

Figure 11: Issues



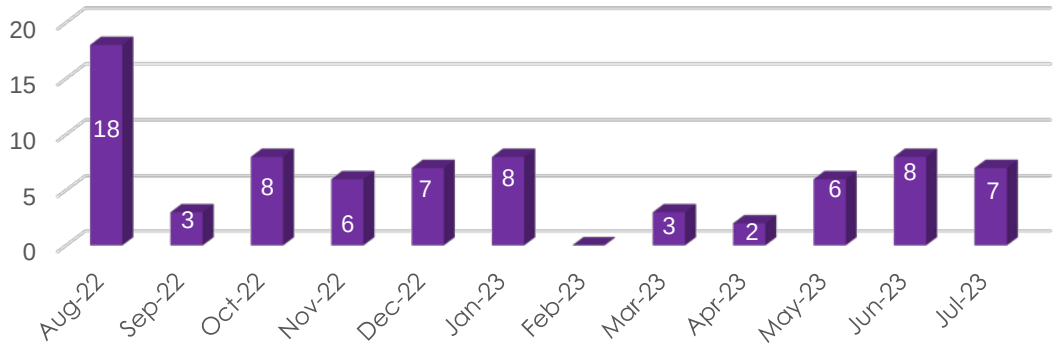
"I never used to use advocacy but now I do you can help me with lots of different things"

Patient

The service dealt with 3079 issues, a slight increase from 2917 in the previous reporting period; of highlight Legal issues remain a majority contributor with 1860 issues (60% of the total, mirroring the previous report). Hospital issues, which cover hospital-based issues including policies and procedures; ward or hub moves and changes to a patient's clinical team account for a further 13%, a 4% increase from the last report. Lastly, quality of life issues relating to food, family, and grounds access etc. account for 12%, a decrease of 2% from the last report.

4.10 Complaints and Outcomes

Figure 12: Number of Complaints Advocacy Assisted with



PAS recorded 49 complaints submitted which is a slight decrease from 55 in the previous reporting period. These complaints related to a variety of factors however, the spike in

August 2022 related to a change in facility time, placements and issues surrounding grounds access. Ward closures were also prominent over the period. 6 complaints were retracted by patients either due to fear of retribution, no faith in the system or wishing to let the issue go. 8 were resolved locally prior to formal complaint and there were 53 discussions of a potential complaint recorded. These discussions encompass informing patients of their right to submit a complaint, discussions about the process but which do not get to the stage of a complaint being submitted.

"Can you get the outcome of the complaint for me, I trust you."

Patient

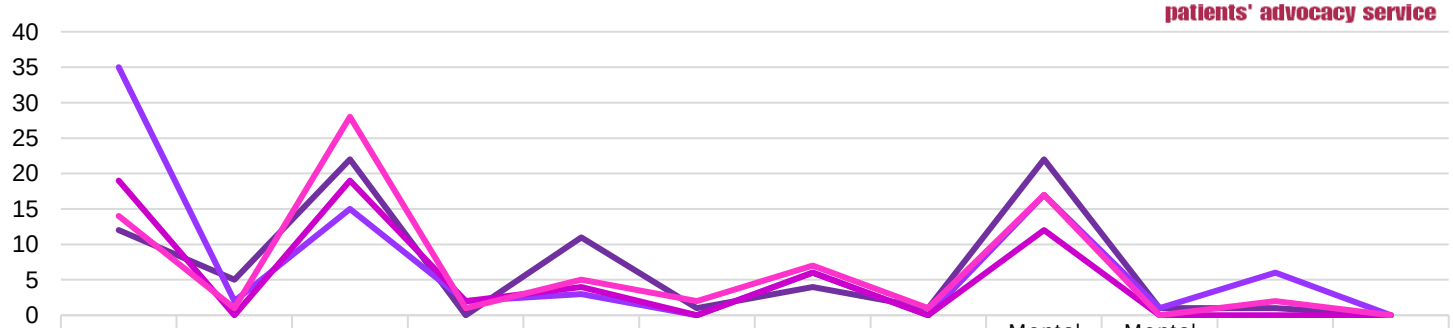
4.10.1 Complaint Outcomes

Action	*Patient Outcome*	*Hospital Outcome*	*Total*
Discussion about a complaint	Patient able to express dissatisfaction and discuss their options in line with TSH Policy.	Locally resolved by complaint not being submitted. Patients' rights met.	53
Formal Complaint submitted	Patients' dissatisfaction expressed in line with TSH policy.	Patients' right to make a complaint upheld.	49

4.11 Legal Activity and Outcomes

Activity classified as legal is associated with support and attendance at formal meetings with patients, such as Care Programme Approach meetings (CPA), Adult Support & Protection Investigation (ASPI), Mental Health Tribunals, Parole Boards and Solicitor meetings with the patient; all of which require to support prior, during and following the meeting. As can be seen from the following tables, there has been a marked increase in the number of meetings we have supported, particularly with solicitors and other staff.

Figure 13: Legal Meetings



	Annual CPA's Attended	Annual CPA's Declined	Intermediate CPA's Attended	Intermediate CPA's Declined	Discharge CPA's Attended	Discharge CPA's Declined	Admission CPA's Attended	Admission CPA's Declined	Mental Health Tribunals Attended	Mental Health Tribunals Declined	Parole Boards Attended	Parole Boards Declined
Q1	12	5	22	0	11	1	4	1	22	1	1	0
Q2	35	2	15	2	3	0	6	0	17	1	6	0
Q3	19	0	19	2	4	0	6	0	12	0	0	0
Q4	14	1	28	1	5	2	7	1	17	0	2	0

As noted above, we attended the vast majority of legal meetings throughout the reporting period. Of the 307 meetings PAS supported patients' either by attending with them or on their behalf. PAS was present at 93.5%, an increase of 9.5%. Those who declined gave reasons such as them not feeling as if there was any need to attend as they knew where they were at in their progress and feeling like they were sufficiently able to advocate for themselves.

4.11.1 Care Programme Approach Outcomes

The following table highlights the patient and hospital outcomes relating to care programme approach (CPA) meetings with further insight in to the volume of work included pre and post CPA.

Action	***Patient Outcome***	***Hospital Outcome***	***Total***
Pre-discussion to Admission CPA	Patient supported to understand the process of a CPA, what is involved, who will be in attendance, support to formulate questions and informed of their options regarding attendance.	Patients' rights to independent support upheld. Patients fully informed of the procedure of a CPA saving staff the time of discussing this information.	31
Attendance at admission CPA	Patients fully aware of what is being discussed at the CPA by attending in person or by having advocacy representation on their behalf.	Patient involvement in the CPA process ensuring patient centred care and accessing their rights to independent support in line with the Mental Health Act.	23
Reflective Discussion separate to admission CPA	Supported to fully understand contents of the CPA, the	Ensuring patient understanding of the CPA, reaffirming of actions to be	9

	actions to be taken and plans for the next 6 months.	taken saving staff time disseminating this information.	
Declined advocacy support at admission CPA	Having the choice to decline advocacy support following discussion of the admission CPA.	Patients right to independent support upheld and autonomy in decision making.	2
Discussion prior to Annual or Intermediate CPA	Patient supported to prepare for a CPA by discussing the format, formulating questions, writing a statement and deciding on their attendance.	Patient centred care ensuring patient involvement in CPA process.	265
Attendance at Annual or Intermediate CPA	Patient and/or advocacy attendance at the CPA. Ensuring the patient voice is heard and questions answered.	Patient involvement in the CPA process ensuring patient centred care and accessing their rights to independent support in line with the Mental Health Act.	80 Annual 84 Intermediate
Reflective Discussion separate to the Annual or Intermediate CPA	Supported to fully understand the content of the CPA. If not in attendance, ensuring they are aware of discussions and actions to be taken.	Ensuring patient understanding of the CPA, reaffirming of actions to be taken saving staff time disseminating this information.	54
Declined advocacy support at Annual or Intermediate CPA	Patient approached and discussed the CPA process ensuring their right to independent support. Making the choice to decline advocacy support at the meeting.	Patient rights to independent support upheld and autonomy in decision making.	8 Annual 5 Intermediate
Pre-Discussion to Transfer/Discharge CPA	Patient supported to prepare for a CPA by discussing the format, formulating questions, writing a statement and deciding on their attendance.	Patient centred care ensuring patient involvement in CPA process.	22
Attendance at Transfer/Discharge CPA	Patient and/or advocacy attendance at the CPA. Ensuring the patient voice is heard and questions answered.	Patient involvement in the CPA process ensuring patient centred care and accessing their rights to independent support in line with the Mental Health Act.	23
Reflective Discussion separate to Transfer/Discharge CPA	Understanding the content of the CPA and plans for their transfer.	Ensuring patient understanding of the CPA, reaffirming of actions to be taken saving staff time of disseminating this information.	6
Declined Advocacy Attendance at Transfer/Discharge CPA	Patient able to self-advocate and make an autonomous choice to decline support.	Patients right to independent support upheld and autonomy in decision making.	3

4.11.2 Mental Health Tribunal Outcomes

The following table shows the outcomes relating to Mental Health Tribunals alongside the pre and post discussions which take place to ensure the patient understands their rights and potential outcomes.

Action	*Patient Outcome*	*Hospital Outcome*	*Total*
Pre-discussion to Mental Health Tribunal	Patients provided with verbal and written information ensuring they understand their legal rights and the process of the Mental Health Tribunal. Supported to actively write a statement if they wish.	Patients informed and supported with their legal rights i.e., their right to a solicitor and support from Advocacy in line with the Mental Health Act.	185
Attendance at Mental Health Tribunal	Patients supported to attend the mental health tribunal or have their voice heard through advocacy attendance in their absence.	Patients' legal rights to independent support met. Patient involvement in their care.	68
Reflective discussion after the Mental Health Tribunal	Patients supported to understand the outcomes of a tribunal and their legal rights following.	Patient supported to understand their rights and the outcomes saving staff time sharing this information.	15
Declined advocacy support at a Mental Health Tribunal	Able to make an autonomous decision and attend with their solicitor or had no challenges and declined all attendance.	Patient supported to understand their rights and make a choice.	2

4.11.3 Other Legal Outcomes

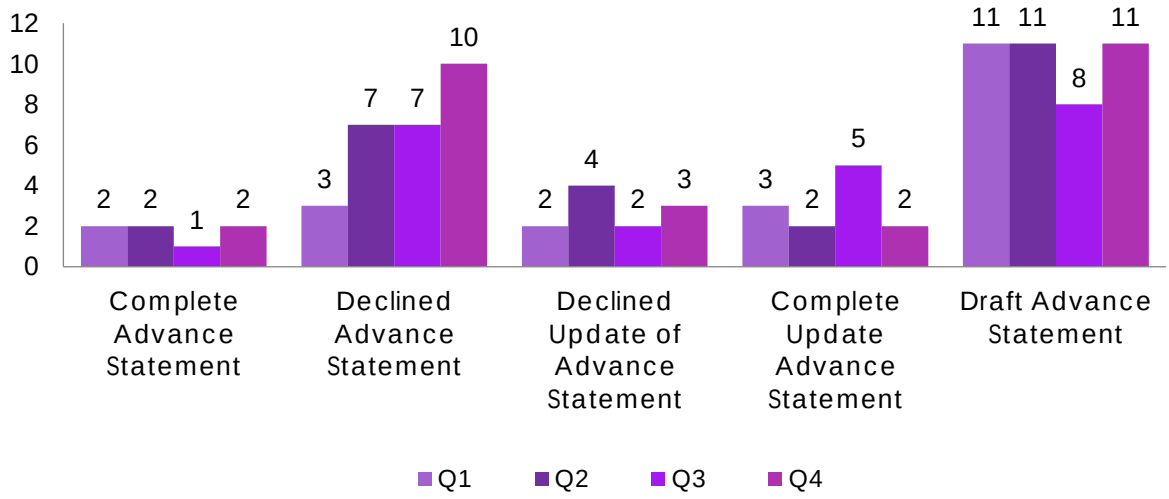
This final table highlights the outcomes relating to other legal matter such as Adult Support and Protection (ASP), Parole Boards and attending meetings with solicitors.

Action	*Patient Outcome*	*Hospital Outcome*	*Total*
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 as per the Mental Health Act.	23
Supported during a meeting	Patient supported by Advocacy to attend meeting and express their views.	Patients supported as per their right to have Advocacy support as per the Mental Health Act.	47 – Staff, Independent Dr's, MHO's etc. 28 - Solicitors
Parole Board	Patients provided information regarding their legal rights and the process of the Parole Board Hearing.	Patients informed and supported with their legal rights i.e., their right to a solicitor and support from Advocacy.	30 Pre-Discussions

	Ongoing discussion with patients to ascertain levels of understanding and support accordingly. Statement written and submitted in advance if desired.		9 Reflective Discussions 9 Attended 0 Declined
Adult Support and Protection	ASP referral made when patient feels or is deemed at risk. Advocacy support to attend the meeting.	Hospital fulfilling legal obligation to support patients through ASP process.	24 Discussions 9 Attended 0 Declined

4.12 Advance Statements

Figure 14: Advance Statements



The graph above shows our activity relating to advance statements each month throughout the reporting period. Over all we supported 7 patients who did not have an advance statement to write one, updated a further 12 to be more up to date with a patients' wishes and had 184 discussions about what an advance statement is and its purpose. All categories have had increases from the previous reporting period, particularly the discussions highlighting the commitment to discussing the benefits of an advance statement. Many reasons for declining are offered however, most frequently patients feel that if they can be overridden they are not worth completing. Similarly, for those returning to prison, as they do not require to be adhered to, especially for those on lengthier sentences, people feel there is no point.

4.12.1 Advance Statement Outcomes

The table below shows the outcomes for both the patient and hospital of this input from PAS.

Action	Patient Outcome	Hospital Outcome	Total
Advance Statement Completed	Patient's wishes expressed regarding future care and treatment giving a guarantee the clinical team will take these into account.	Fulfilling legal obligation, providing knowledge of Advance Statements and support to complete these. Advance Statements are person centred, considering patient's wishes. Accurately recording and storing Advance Statements with medical records.	7 New 12 Updated 184 Discussions

5 Progress to Actions of the Last Report

Action	Outcome
Organisational:	
We aim to recruit further Board Members and an additional Patient representative to ensure a variety of expertise and experiences.	Ongoing. The advert remains live on Volunteer Scotland where we respond to requests. 1 ne co-opted member was introduced to the service. We plan to recruit an additional patient representative.
Updating patient rep recruitment and training materials.	Not achieved due to organizational pressures.
Volunteers, we aim to recruit new members to meet the conditions as set out in the SLA.	Due to organizational pressures, we have been unable to dedicate the time and support required to induct volunteers to the service.
Further expand our knowledge by maintaining current training and continuing to attend relevant courses and webinars.	Achieved, all staff completed talking mats training and have either completed or are enrolled on human rights training.
Organise the AGM with diversity in speakers.	We hosted the AGM for the first time in person, speakers will be explored for future events.

Service:	
Continue to explore options to highlight the work of PAS in a wider scope.	Achieved, website is constructed and live. Reports are continually updated in response to feedback. We have enhanced input with the SIAA sharing good practice and learning.
Continue to connect with other advocacy services and share best practice.	Achieved, we have quarterly meetings with leads from high secure services, bi-monthly meetings with the SIAA managers and monthly meetings with local advocacy services.
Remain committed to responding to consultations as appropriate, to champion the voice of our patients in their unique position.	Achieved, we responded to 5 national and 3 internal consultations.
Complete the annual questionnaire and take forward the views of patients on the PAS service.	Achieved, the patient questionnaire was completed. The poster can be seen in appendix 1.
To continue to support The State Hospital in regards to changes in the Clinical Model, ensuring patients' voices are prioritised.	Achieved, we attended the short life working group and supported patients during the transition.
Review our ward drop in service and how this can better support our patients.	Partially complete, we have improved our attendance and will implement further changes when the clinical model is implemented.
Continue to stregthen our relationships with both internal and external groups.	Achieved, better networking with other advocacy services, SIAA and internal colleagues such as consultant psychiatrists and social work leading to increased referrals and discussions.
Address issues regarding patients in seclusion or very restricted positions.	Paused, set as a priority action for next reporting period.

Continue to join short life working groups to champion the patient voice.	Actioned, attended clinical model- and joined Trans guidance SLWG through Forensic Network.
Further identify ways for patients to share ongoing feedback on the PAS service.	Partially achieved, patients asked for feedback when leaving TSH. Look to improve this in the next reporting period.
Construct a PAS admission booklet for new admissions to TSH.	Partially achieved, in draft.
Await the Scottish Government reponse to the outcome of the Independent Forensic Mental Health Review with a view to adapating to new ways of delivering Indepent Advocacy within TSH.	Response published, look to identify whether adaptions are required to PAS.

6 Areas of Good Practice

"It's really good to have you there to listen and feel like you're not judged. When you speak to the nurses or any part of the clinical team it's different"

Patient

We continue to maintain good practice and meet requirements of the Service Level Agreement by:

- Review of Policies and Procedures
- Monthly support sessions with all staff
- Ongoing staff growth, professional development and training
- Approachable, unbiased, and visible service
- Positive and professional relationships with stakeholders and other professionals relevant to patients and independent advocacy
- A variety of expertise within PAS team providing knowledge and experience in a unique setting
- Flexibility to adapt and meet the needs of TSH and patient group as required
- Annual feedback on the service from patients with patient involvement on the development of the Patient Questionnaire
- Development of projects which benefit the patient group positively, for example Boarding Out Protocol currently in draft.

7 Patient Stories

7.1 Repairing Relationships

Therapeutic relationships are vital for relational security in secure settings and this notion has been widely researched, particularly for nursing staff. Whilst there is little research on independent advocacy, PAS has the fortunate position of working with patients for a number of years at times. One thing apparent to us, is the better the relationship we have with patients, the more of a positive impact and enhancement to rights it can have.

Whilst it is important for all members of the clinical team to ensure relationships are repaired, this is of vital importance to independent advocacy given the rights of a patient under the mental health act.

We had a patient who was not getting the answers they were looking for in relation to an appeal of their order. They did not like to hear the potential outcomes, however it was important they were aware of these. This caused the patient to feel the advocate was not on their side and not hearing their wishes. In such a scenario, it is imperative for the advocate to know when to pause the conversation and return to the patient when the situation has diffused.

In this scenario it is important for the advocate to ensure the patient does not experience re-traumatisation by not feeling listened to or supported, as we are aware many of our patients have had challenging childhoods. The advocate will arrange to go back and visit with the patient to ensure they are aware we are hearing them and the information we are giving them is to ensure they can make an informed choice. By returning to the patient we are making them aware their rights are important to us, they are being heard and we are willing to action those rights. By PAS taking responsibility for returning to the patient rather than waiting for them to contact us, we can quickly and effectively repair the relationship by using alternative means of communicating the options. By the advocate being pro-active, this models to the patient a positive relationship, re-engages them to ensure future issues relating to their rights are respected and actioned. It can also be beneficial for enhancing the relationship with the patient, by building trust the advocate is going to come back to them, even when the communication has not been, from the patients' perspective, productive.

"Thank you so much for coming back down to see me"

Patient

7.2 Contact with Patients' on Observation Levels

In TSH patients are placed on various levels of observation dependent of their risk, which is identified by TSH staff. We are guided by them and whether a patient is able to be visited. When patients are on the highest form of observation levels, this can be challenging, as our interactions with patients can only take place with nursing staff in the room. This is of course in conflict with our independent status but is necessary for everyone's safety. We always give the patient the option to speak to us on the phone or to wait and discuss any issues with us in private when there is no longer a requirement for staff to be in the room. This can be challenging when patients are on higher levels of observation for a long period of time however, it is vital these patients continue to be offered independent advocacy to address any issues and receive information about their rights. Independent advocacy can offer support to contact solicitors, attend case reviews and ensure their views are represented in the event the patient is unable to attend on their own. Additionally, being placed under such restriction, independent advocacy support is necessary for patients to be able to exercise their rights. Although there is a challenge in supporting a patient to feel comfortable and open enough to discuss the issues they may be facing, ensuring consistent communication and building trust at this time is necessary to ensure the patient feels they have the opportunity to express their opinion on their care and treatment.

These scenarios are challenging for all individuals involved, for independent advocacy remaining visually independent to the patient, the staff being present but not within the conversation and the patient being comfortable and feeling supported. It also highlights the necessity for all staff in TSH, as well as patients being aware of the role of independent advocacy and ensuring positive working relationships are forged.

"Thanks very much for coming and checking in"

Patient

7.3 Grounds Access

Patients view grounds access as the opportunity to have more freedom, evidence of their progress and a step closer to getting out of The State Hospital. Once patients have been approved for grounds access, the wait to have this implemented and the ability to get out on the grounds unescorted is a challenge. PAS supported patients to make a complaint regarding the length of time it was taking, following approval, to get their grounds access in place. Some of the challenges related to forms going missing in the post, delays in forms being signed and generally the slow progression of the stages. Patients felt frustrated they now had the opportunity to get out on the grounds but due to the procedures were unable to. During challenges with staffing deficits causing wards to be closed or on modified working, patients were unable to get out of the ward for some space, whereas they would have been had their application progressed in a timely manner. Patients who submitted a complaint were fully upheld. In addition, this issue was highlighted by PAS at the PCISG as a challenge. TSH were aware of the problem and were already in the process of moving to a digital system in order to negate some of the difficulties with missing forms which they hoped to be able to be brought in sooner than anticipated to support the reduction of future challenges.

Having PAS available to support patients to express their feelings and frustrations ensured TSH were aware of the specific challenges these patients faced and were able to resolve the matter. In addition, being part of a stakeholder group we were able to raise the issue in an escalated manner which had we not been in attendance may not have been the case. This highlights the value of independent advocacy being able to both raise challenge on behalf of individual patients in addition to highlighting similar issues for more than one patient in an elevated forum to support change to processes.

9 Feedback


"Thanks for always being there" - Verbal
"A wee card to say thank you for your support" – Patient Card
"Thanks for all your help, you're a really nice lassie" – Verbal
"Thank you for helping me get such a good lawyer" – Verbal
"You always excel in what you do for me" - Verbal
"[Advocate] has been great, she's done so much for me" – Verbal
"Thanks very much for chasing up my hospital appointment, it's come through now" - Verbal
"Thanks for explaining that, it ticked a lot of boxes in my head" – Verbal
"Thanks for taking the time out to come along and support the patient" – Parole Convenor
"Thank you for all your help. You've really made a big difference in my stay here. Keep up the great work." – Verbal
"Thank you so much for seeing me with the interpreter before the CPA" – Verbal
"I can't thank you all enough for all the work you do" - Verbal
"You just always cheer me up when you come to see me" – Verbal
"I would like to thank my advocacy worker who is always there to help and support me" - Verbal
"I just wanted to phone and thank you for everything you have done as I wouldn't have got out without it" – Ex-Patient
"You'll have a good laugh, they're a great team" - Verbal
"Thanks for sorting the VC out for court. It made a big difference and was greatly appreciated" – Verbal
"I'm going to write a letter to the chief executive to let him know how useful advocacy is" – Ex-Patient
"I'm really thankful you're involved in this. I'm glad I know where things are at now [with my children]" – Verbal
"You've been great through the complaint process I couldn't have done this without you" – Verbal
"Appreciate everything advocacy does for me. I like you are independent/different from the staff - you are always there for me." - Verbal

patients' advocacy service

"The Skye Centre drop-in on shop days was beneficial although feel you are all on the ward more. Feel it is good you are able to come along to our meetings with us so as to take notes. This is helpful as we do not take everything in with what's been said and done. Like the new lanyards feel these stand out and helps us to see you are different to the other staff". - Verbal

"Thank you for explaining the CPA process, I understand how it works now and don't need to speak to anyone else about it." – Verbal

"Thank you for coming to my CPA, it was good to have you there as a support." – Verbal

"It's important to have advocacy to be able to get us information." – Verbal

"You're very good at your job." - Verbal

"It's a big weight off you can sort that list of stuff." - Verbal

"I think it's important you come to the [solicitor] meeting with me so you can talk for me." – Verbal

"Thank you for dealing with my drivers license, I feel better knowing it's been sent and you have all the details." – Verbal

"I really appreciate [advocate] and everything she's done for me." – Verbal

"[Advocate] has been so good at helping me with all the stuff to do with [child]." – Verbal

"you won't go wrong learning from [advocate], she is really good. - Verbal

"It's good you guys are in here as we don't have anyone like you in prison." – Verbal

"You're the best advocate I've ever had, you're really on the ball." – Verbal

"She's a really nice girl, I'd highly recommend talking to advocacy". – Verbal to peer

"Advocacy do a great job even though there is only 4 of you. You are always friendly on the grounds to patients. You always take the initiative when patients have issues and don't always look for the easy way out - you always give us options. I think it would be beneficial for patients who are on level 3s to be able to have a private conversation with you maybe it could be done via the VC. Things that could improve the service - having the Skye Centre drop in so there is somewhere to speak to you away from ward staff. Have a link up between other advocacy in medium secure. Have a male advocate. – Patient leaving TSH

"Thank you for all your help. You have made all this [bereavement] a lot easier."– Verbal

"I got my money thanks for doing that for me" – Verbal

10 Future Areas of Work and Service Development

10.1 Organisational

PAS remains committed to providing the highest quality independent advocacy service to TSH patients. We continue to develop the service to meet the needs of the changeable patient group and the changing environment we work in. As an organisation we aim to develop in the following areas:

- Continue to recruit Board Members.
- Update our Patient Board Rep recruitment and training package.
- Update our staff handbook to be current with legislative changes.
- Further expand our knowledge by maintaining current training and continuing to attend relevant courses and webinars.
- Continue to find ways to highlight our independence.
- Prepare for the upcoming tender process.

10.2 Service

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

- Become more aware of positive ways of working such as with supported decision making.
- Responding to consultations and attend short life working groups as appropriate, to champion the voice of our patients in their unique position.
- Complete the annual questionnaire and take forward the views of patients on the PAS service.
- Further enhance our ward drop in service and how this can better support our patients.
- Address issues regarding patients in seclusion or in very restricted positions.
- Construct an admission booklet for new admissions to TSH detailing the role of advocacy and the support we can provide.
- Explore the options for having our own independent database.
- Continue to work towards independent email addresses.
- Finalise a protocol on Patients Boarding Out.
- Raise awareness of non-instructed advocacy for patients who lack capacity.

"You're a wonderful organisation"

Carer

11 Ethnicity Group Contacts for all Patients, 1st August 2022 – 31 July 2023

This table demonstrates PAS provides support to patients from a variety of ethnic backgrounds equally and continually monitors this.

Ethnic Group	PAS Code	No. of Patients	Percentage	No. of Contacts	Percentage
White Scottish	1A	84	63%	1164	66%
White Other	1B	7	5.3%	104	6%
White Irish	1C	*	1.5%	21	1.2%
White English	1D	*	1.5%	18	1.2%
Other Ethnic Background	1E	*	2.3%	47	3%
White British	2A	22	16.5%	293	17%
Asian, Asian Scottish, Asian British	3B	*	0.8%	7	0.2%
African, African Scottish, African British	4B	*	1.5%	29	1.2%
Other Ethnic Groups, Chinese	3E	*	0.8%	13	0.7%
Unknown	U	9	6.8%	61	3.5%
	Total	133	100%	1758	100%

If the number of patients are below 5 a * is used to protect identity.

Thanks for helping me with all those issues, I would struggle because English is not my first language

12 Financial Report

Income and Expenditure Report

For the period from 1 April 2022 to 31 March 2023

	£
Gross Income	120,378
Gross Expenditure	136,089
Incoming Resources	
Government Funding	120,370
Bank Interest	8
	120,378
Cost of Charitable Activities	
Employment Costs	125,873
Establishment Costs	1,679
Print, Post, Stationery	65
Subscriptions and donations	379
Training	986
Computer Costs	915
Trustees/Meeting Expenses	355
Sundries	476
Advertising	1286
	132,014
Governance Costs	
Accountancy Fees	2,700
Professional Fees	1,375
	4,075
Total Resources Expended as per Account	**136,089**
Cash & Bank Accounts	**51,187**
Liabilities payable in one Year	4,210
Net Current Assets	**46,977**

13 Next Review Date

The Patients' Advocacy Service Annual Report will be available to The State Hospital Board from August 2024.

14 Reference List

Equalities Act (2010), [Online], Available at https://www.legislation.gov.uk/ukpga/2010/15/contents

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

The Patients Rights (Scotland) Act (2011), [Online], Available at https://www2.gov.scot/Topics/Health/Policy/Patients-Rights

The Mental Health (Care and Treatment)(Scotland) Act (2003), [Online], Available at http://www.legislation.gov.uk/asp/2003/13/contents

15 Appendix 1

16 Appendix 2

Abbreviation	Full Name
Adm	Admission
MHOT	Mental Health Officer Telephone
NSE	Nursing Staff Email
NST	Nursing Staff Telephone
NSV	Nursing Staff Verbal
SA	Self-Answer machine
ST	Self-Telephone
SV	Self-Verbal
SWE	Social Work Email
SWT	Social Work Telephone
RMOT	Registered Medical Officer Telephone
RMOE	Registered Medical Officer Email

Paper No. 23/116

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	December 2023
Agenda Reference:	Item No: 9
Sponsoring Director:	Director of Security, Estates and Resilience
Author(s):	Risk Manager
Title of Report:	Corporate Risk Register Update
Purpose of Report:	For Decision

1 SITUATION

A corporate risk is a potential or actual event that:

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

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

2 BACKGROUND

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

3 ASSESSMENT

3.1 Current Corporate Risk Register - See appendix 1.

3.2 Out of Date Risks

All risks are in date.

3.3 Update on Proposed Risks for inclusion on Corporate Risk Register
No new risks are proposed for the CRR

3.4 Corporate Risk Register Updates
No relevant updates to current risks

3.5 High and Very High Risk – Monthly Update
The State Hospital currently has **3** 'High' graded risks:

Director of Nursing: ND71 - **Failure to assess and manage the risk of aggression and violence effectively**

Risk is at target level and continues to be managed effectively with existing procedures and training. Violence and aggression incidents monitored by Risk & Resilience Team through Clinical Governance Group.

Monthly Update: Behavioural / Violent incidents have increased slightly moving in to Q3, this measure takes into account all behavioural incidents including verbal aggression.

Of the violent incidents linked to the category there is a recorded rise in incidents that have resulted in the use of physical intervention. In September 23 TSH recorded a peak of 26 physical intervention incidents, this decreased to 10 in October and has increased to 14 in November. 2 patients are responsible for the majority of these incidents. 1 incident resulted in injuries that met the RIDDOR criteria which affected two members of staff. Further investigation into the RIDDOR incident is underway and the current risk assessment relating to activity has been reviewed. Latest figures have been shared with the Patient Safety Group and work is underway to disseminate the information to the wards

PMVA Level 2 Figures continue to remain at target level.

Work is underway to update risk assessment with a refreshed focus on 'Serious' violent incidents and the risk to staff. The final draft of risk assessment has been completed and will be shared with Patient Safety Group for comment prior to going to CMT in January 24 for final approval.

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

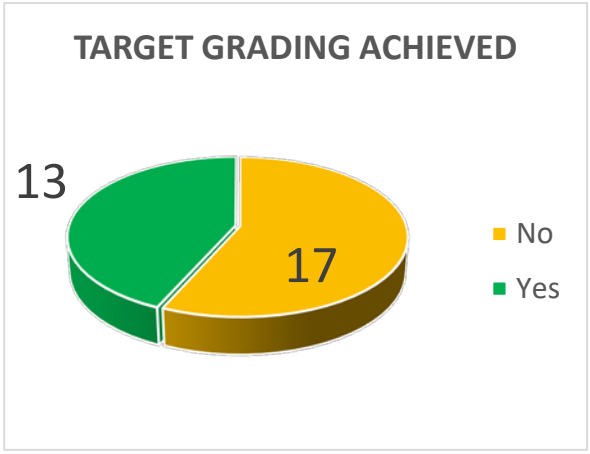
Monthly Update: Overweight and obesity in Nov '23 was 85.5%, an increase from 80.7% in September missing data accounts for 4.9% of patient population. There are multiple approaches in place across the organisation to address this issue, these include the following:

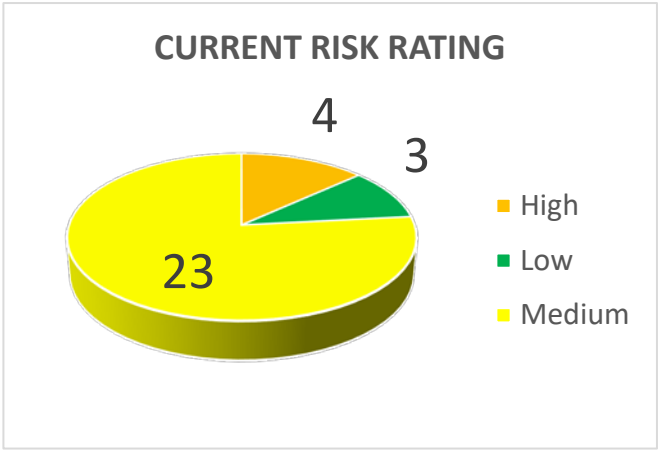
- Weight management group, Healthy Living Group should run again early 2024, Slim & Trim (will be re named) and health psychology along with dietetics will look at different way of delivering this (discussions in progress).
- Continued offer of pharmacological adjunct therapies where appropriate such as metformin, orlistat and pathways wrote for GLP1 agonists (diabetes management medication) when nationally available to use.
- From a Physical activity perspective, quicker routes to sports and Skye centre assessment with minimum 2 sports placements for new admissions when able.
- Benefits of Skye Centre Activity staff and remit for supporting patients activities and walks.
- Hub areas open now offering more activity to patients off ward, support from Occupational Therapists and clinical staff support but staffing challenges still remain.
- Increased remit of health psychologist work with hard to reach patients.
- Weight management pathway update to incorporate diet management framework needs and will be updated again with changes and practice needs following implementing clinical model.

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

Monthly Update: E-Rostering continues to be implemented across hospital, Project Manager has been appointed to bring project to close.
A proactive recruitment plan has successfully reduced the staffing deficit and adverts are currently live to recruit to the remaining 5.2wte posts.
Proactive work surrounding absence management has also seen a reduction and return of staff to work. This work again has had a positive impact on staffing.
Risk register and risk assessment also completed. Numbers of incidents are reducing overall, full closure incidents have decreased significantly.

3.6 Risk Distribution





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

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

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

Review Periods:

Low risk	6 monthly
Medium risk	Quarterly
High risk	Monthly
Very High	Monthly (or more frequent if required)

3.7 CRR Development

The Risk management team are continuing to review and refresh the risk management process and a proposal on a new approach was presented and discussed with the Board Members at the Board Development session on 7 November. Board Members were content with the approach being taken and Risk Management will now make a formal approach to CMT and the Board to ratify the way forward. This will be presented to CMT in early January paving the way for a review to take place of the current Corporate Risk Register and ensure the risks are aligned to the Corporate Objectives.

4 RECOMMENDATION

The Board are asked review the current Corporate Risk Register as an accurate statement of risk.

MONITORING FORM

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

Paper No. 23/116

High Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	27/12/23	Clinical Governance Committee	Monthly	-
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Moderate x Possible	Moderate x Likely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	27/12/23	Clinical Governance Committee	Monthly	-
Corporate ND 71	Health & Safety	Failure to assess and manage the risk of aggression and violence effectively	Major x Possible	Major x Possible	Major x Possible	Director of Nursing & AHP	Director of Nursing & AHP	27/12/23	Clinical Governance Committee	Monthly	-

Medium Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	28/02/24	Corporate Governance Group	Quarterly	-
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Head of Risk and Resilience	28/02/24	Clinical Governance Committee	Quarterly	-
Corporate CE 12	Strategic	Failure to utilise appropriate systems to learn from prior events internally and externally	Major x Possible	Moderate x Possible	Moderate x Unlikely	Chief Executive	Head of Risk and Resilience	28/02/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate CE 14	ALL	The risk that Coronavirus (Covid-19) could affect The State Hospitals primary aim to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff.	Major x Almost Certain	Minor x Likely	Minor x Possible	Chief Executive	Senior Nurse for Infection Control/ Risk Manager	28/02/24	Corporate Governance Group	Quarterly	-
Corporate CE15	Reputation	Impact of Covid-19 Inquiry	Extreme x Likely	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	28/02/24	Covid Inquiry SLWG	Monthly	-

Corporate MD 32	Medical	Absconsion of Patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Associate Medical Director	09/12/23	Clinical Governance Committee	Quarterly	-
Corporate MD 33	Medical	Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Medical Director	Associate Medical Director	09/12/23	Clinical Governance Committee	Quarterly	-
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Unlikely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	09/12/23	Clinical Governance Committee	Quarterly	-
Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Major x Rare	Major x Rare	Security Director	Security Director	27/01/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	27/01/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Unlikely	Moderate x Rare	Security Director	Security Director	27/01/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 53	Service/Business Disruption	Serious security breaches (eg escape, intruder, serious contraband)	Extreme x Unlikely	Extreme x Rare	Extreme x Rare	Security Director	Security Director	27/01/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 54	Service/Business Disruption	Implementing Sustainable Development in Response to the Global Climate Emergency	Major x Likely	Major x Unlikely	Moderate x Rare	Security Director	Head of Estates and Facilities	27/01/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	27/01/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	27/02/24	Clinical Governance Committee	Quarterly	-
Corporate FD 90	Financial	Failure to implement a sustainable long term model	Moderate x Likely	Moderate x Unlikely	Moderate x Rare	Finance & Performance Director	Finance & Performance Director	28/02/24	Finance and Performance Group	Quarterly	-
Corporate FD 91	Service/Business Disruption	IT system failure	Moderate x Likely	Moderate x Possible	Moderate x Possible	Finance & Performance Director	Head of eHealth	28/02/24	Finance and Performance Group	Quarterly	-

Corporate FD 96	Service/Business Disruption	Cyber Security	Moderate x Likely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth	28/02/24	Information Governance Committee	Quarterly	-
Corporate FD 98	Reputation	Failure to comply with Data Protection Arrangements	Moderate x Likely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth/ Info Gov Officer	28/02/24	Information Governance Committee	Quarterly	-
Corporate FD 99	Reputation	Compliance with NIS Audit	Major x Likely	Moderate x Possible	Moderate x Rare	Finance and Performance Director	Head of eHealth	28/02/24	Information Governance Committee	Quarterly	-
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Unlikely	Minor x Rare	HR Director	HR Director	16/01/24	HR and Wellbeing Group	Quarterly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Moderate x Possible	Moderate x Unlikely	HR Director	HR Director	16/01/24	HR and Wellbeing Group	Quarterly	-
Corporate HRD 113	Service/Business Interruption	Job Evaluation and impact on services in TSH	Major x Possible	Moderate x Possible	Negligible x Unlikely	HR Director	HR Director	16/01/24	HR and Wellbeing Group	Quarterly	NEW!

Low Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate CE 13	Strategic	Inadequate compliance with Chief Executive Letters and other statutory requirements	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Chief Executive	Board Secretary	27/01/24	Corporate Governance Group	6 monthly	-
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	27/01/24	Security, Risk and Resilience Oversight Group	6 monthly	-
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	06/04/24	Information Governance Committee	6 Monthly	-
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Possible	Moderate x Rare	Moderate x Rare	HR Director	Training & Professional Development Manager	16/01/24	Clinical Governance Group	6 Monthly	↓

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	21 December 2023
Agenda Reference:	Item No: 10
Sponsoring Director:	Director of Nursing, AHP & Operations
Author(s):	Senior Nurse for Infection Control
Title of Report:	Infection Prevention and Control Summary Report
Purpose of Report:	For Noting

1. SITUATION

This report is presented to the Board to provide an update regarding any key areas of concern/ progress in relation to Infection Prevention and Control (IPC) activity.

2. BACKGROUND

The Infection Control reporting structure consists of the Infection Prevention and Control Group (IPCG), as the operational group. This reports into the Infection Control Committee, as the governance group. This group also reports through to the Clinical Governance Group, which provides assurance reporting to the Clinical Governance Committee.

3. ASSESSMENT

Patient Tests (Infection Control)	From 1 September to 30 November 2023 • 16 Covid tests undertaken on symptomatic patients • 12 patients who were symptomatic returned a positive result.
Total number of positive patients to current date	175 positive Covid19 cases from March 2020 to November 2023
Vaccinations	Patient Vaccination ran from 1 November to 14 November 2023. 44 (43%) uptake of Covid Booster (decrease from 60 (58%) in 2022. 46 (45%) uptake of Flu vaccine (decrease from 56 (54%) in 2022. There were 3 staff clinics facilitated during October, with drop in clinic facilitated at a wellbeing event.

	<u>Public Health Alerts</u> There have been 3 Public Health Alerts published within the reporting period 1. **2023/30** UK cluster of Shiga toxin-producing *E. coli* O26:H11 with HUS 2. **2023/27** Detection of single human case of influenza A(H1N2)v in England 3. **2023/26** Further increase of respiratory syncytial virus (RSV) in Scotland 4. **<u>Patient Safety Alert</u>** There has been 1 patient safety alert released 07.12.2023, pertaining to Burkholderia cencocepacia and contaminated eye products. There is no action required from the State Hospital.

National Guidance

No national guidance has been published during the reporting period.

4. RECOMMENDATION

The Board is asked to note the report

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP / Corporate Objectives	Appraising the Board of IC activity
Workforce Implications	None identified through reporting.
Financial Implications	None identified through reporting.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Infection Control Committee
Risk Assessment (Outline any significant risks and associated mitigation)	Key areas of risk to be defined in report and presented by Sponsoring Director.
Assessment of Impact on Stakeholder Experience	None identified.
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 applicable.
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:	21 December 2023
Agenda Reference:	Item No: 11
Sponsoring Director:	Medical Director
Author(s):	PA to Medical Director
Title of Report:	Bed Capacity within The State Hospital and Forensic Network
Purpose of Report	For Noting

1 SITUATION

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

2 BACKGROUND

a) TSH

The following table outlines the high level position from the 1 October 2023 until 30 November 2023.

Table 1

	Admissions & Acute	Treatment & Recovery	Transitions	ID	Total
Bed complement	24	48	24	24 (includes 12 contingency beds)	120 (+ 20 additional unstaffed beds)
Beds in use	20	48	20	12 + 3 surge	103
Admissions	5 (external) 0 (internal)	0 (external) 2 (internal)	0 (external) 2 (internal)	1 (external) 0 (internal)	6 (external) (internal)
Discharges/Transfers	1 (external) 2 (internal)	2 (external) 2 (internal)	3 (external) 0 (internal)	1 (external) 0 (internal)	7 (external) (internal)

Bed occupancy as at 30/11/2023	83.3%	100%	83.3%	62.5% (all beds) 125% (ID beds)	85.8% (available beds) 73.6% (all beds)

Please note that in total there were 103 patients as of 30 November 2023, within this number 15 patients are under the care of the Intellectual Disability Service (the service is currently 3 patients in excess of their 12 patient allocation).

18 patients have been identified for transfer from TSH and 3 have been fully accepted for transfer. Of these 3, none have been waiting longer than 8 months. Two patients have won excess security appeals. Full details are available but not included for reasons of patient confidentiality.

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

b) TSH Contingency Plan

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

c) Forensic Network Capacity

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

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3 ASSESSMENT

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

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

4 RECOMMENDATION

The Board is asked to note the report.

MONITORING FORM

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

Paper No. 23/119

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	21 December 2023
Agenda Reference:	Item No: 12
Sponsoring Director:	Medical Director / Director of Nursing and Operations
Author(s):	Professional Nurse Advisor
Title of Report:	Clinical Model Oversight Group – Update Report
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

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

3 ASSESSMENT

There have been two CMOG meetings since the last Board update provided in October 2023. Areas of work that have been discussed and progressed in this time include:

1. The development of a standardised agenda for use at each of the service leadership team meetings. This has now been finalised and agreed by CMOG members and will be in use from January 2024.
2. The development a referral form within the patient's electronic record to monitor and track progress through each of the clinical services.
3. Development of standardised reporting template to be used by each of the clinical services for reporting to both CMOG and the Activity Oversight Group (AOG). The development of one reporting template will prevent duplication of effort whilst improving the sharing of information across both forums.

In addition to the above the group continues to support each of the services in "settling in" to the new service structures and working through any teething issues/concerns that arise – either site wide or local to each service area. Over the coming months the group will continue to monitor patient progress/flow through each of the services and consider revisions to the clinical service guidance documents based on learning to date. The group will also review key performance indicator (KPI) data to date to ensure each service is functioning as it should.

CMOG members have scheduled protected time in February 2024 to meet collectively as group to reflect on overall progress with transition to the revised model so far and consider any next supportive steps as necessary. In the meantime, the group continues to function effectively and there are no specific issues that require escalation to either CMT or the Board at this juncture.

4 RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP / Corporate Objectives	CMOG reporting supports one of the hospitals core objective of "better care" – ensuring patients are receiving the right care, in the right place at the right time.
Workforce Implications	Workforce implications monitored through Workforce Governance Structure.
Financial Implications	N/A
Route to Board Which groups were involved in contributing to the paper and recommendations.	Clinical Governance Organisational Management Team Workforce Governance
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	21 December 2023
Agenda Reference:	Item No: 13
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Performance Clinical Quality Facilitators
Title of Report:	Quality Assurance and Quality Improvement
Purpose of Report:	For Noting

1. SITUATION

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

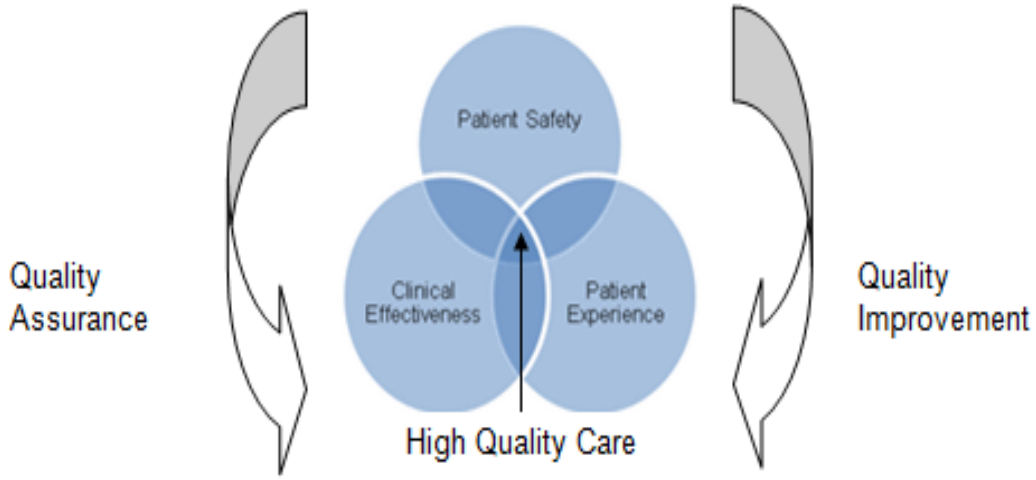
2. BACKGROUND

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

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

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

3.



ASSESSMENT

The paper outlines key areas of activity in relation to:

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

4. RECOMMENDATION

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

MONITORING FORM

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

QUALITY ASSURANCE AND IMPROVEMENT IN TSH DECEMBER 2023

ASSURANCE OF QUALITY

Clinical Audit

The Clinical Quality Department carries out a range of planned audits. Over the course of a year there are usually 25 – 28 audits carried out. These aim to provide feedback and assurance to a range of stakeholders that clinical policies are being adhered to. All clinical audit reports contain recommendations to ensure continuous quality improvement and action plans are discussed at the commissioning group. It has been agreed, that going forward the QA/QI report will report on audits that have been through the Commissioning Group to allow improvement plans to be included.

There have been three audits presented at Commissioning Groups. All these audits were presented at the Medicines Committee.

- Medication Trolley Audit
- Medicine Fridge Audit
- Clozapine Audit

The results of each audit were reviewed by the Medicines Committee in November 2023, and improvement plans developed. Full reporting will be routed through the Clinical Governance Committee for detailed oversight.

Variance Analysis Tool (VAT) – Flash Reports

The first quarterly flash report since the move to the new clinical model was published and sent round teams:

HOSPITAL WIDE VARIANCE ANALYSIS FLASH REPORT

Date: July-September 2023

Overview and areas of good practice

This report refers to all annual and intermediate reviews held across the hospital in quarter July-Sept 23.

The quarterly VAT report is split as follows:

Sept 23	Annual	Intermediate	Total	VAT completion
Admission	3	4	7	97%
Arran T & R	7	6	13	97%
Lewis T & R	6	6	12	97%
ID	1	5	6	99.8%
Transition	6	3	9	93%

Overall VAT form completion continues to be good at 96%

- Completion of the Medical VAT interventions in the ID service was 100%
- Provision of the Social Work and Skye Activity Centre reports were 100%
  Compared to last quarter (Apr-June 23):
- Provision of the Dieteticis Report increased from 93% to 96%.
- Provision of the Pharmacy Report increased from 67% to 92% and attendance increased from 41% to 60%
- Provision of the Psychology report increased from 73% to 83% and attendance increased from 52% to 66%
- Provision of the Security report increased from 80% to 83%

Areas of concern

- Completion of the Medical VAT interventions were below 90% in all services with the exception of the ID service.
- Dietetic attendance decreased from 67% to 61%
- Consultant attendance decreased from 100% to 83%
- Key Worker/Associate Worker attendance decreased from 64% to 51%
- Security attendance decreased from 62% to 38%
- Provision of the Occupational Therapy report decreased from 83% to 77%
- Social Work attendance decreased from 79% to 68%
- This period is a key annual leave period and looking at the same period last year Psychology and Occupational Therapy have increased attendance figures this year. Medical, KW/AW, Social Work, Pharmacy, Security and Dietetics are all showing a decrease in attendance compared with the same period last year.

Any challenges with the systems that are being addressed

Ongoing VAT review looking into obtaining assurance data direct from RiO. Meetings will be held in the coming months with individual professions to identify how VAT interventions will be pulled from RiO.

When discussed at the Clinical Governance Group it was noted that it had taken some time for dates of CPAs to flow through into the various disciplines and nursing work to a 12 week rota so it was difficult to move staff onto other shifts to enable them to attend the CPA's for their patients. This should be rectified in the next quarter. It was also noted that this time period covered school holidays and we always see a decrease in attendance.

QUALITY IMPROVEMENT

QI Forum

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

QI Capacity Building

QI Essential Training has been delivered twice in 2023, the first training was delivered over 2 days in June/ August and a further 2 day session delivered in Oct/Dec to TSH staff. Projects are progressing with a project feedback session planned in the Q4.

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

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

QI Case Study – Progress Notes for ID Patients

The Case Study detailed in **Appendix 1** is a QI project, from the QI Essentials Training in June. Its focus was to review the percentage of patients within the ID Service receiving a keyworker 1 to 1 each week. The paper details the QI methodology used and highlights how each of the wards in the ID service were performing during the project timeline. Although the project period has ended, analysis of data has continued on a weekly basis and communication with Senior Charge Nurses in Iona 2 and Iona 3 is ongoing to support them with further improvements where necessary.

Realistic Medicine

Realistic Medicine (RM) is the Chief Medical Officer (CMO) strategy for sustaining and improving the NHS in Scotland. It is the CMO's vision that, by 2025, all healthcare professionals in Scotland will demonstrate their professionalism through the approaches of RM. In December 2022, Scottish Government published "Delivering Value Based Health and Care" (VBH+C), setting out the vision for VBH+C and reinforcing the RM approach as the vehicle through which VBH+C would be realised.

The six key themes of RM are:

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

The Realistic Medicine Action Plan has been updated for Q3 with progress across the projects noted. Priorities for the remainder of the year include a focus on increasing the uptake of the Shared Decision Making (SDM) module on Turas and supporting approaches to incorporate the BRAN (Benefits, Risks, Alternatives and do Nothing) questions within the high secure forensic setting. A QI project is ongoing in 1 hub to embed BRAN questions as part of the monthly care plan update. Following this project, further roll out and spread will be considered.

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

Evidence for Quality

National and local evidence based guidelines and standards

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

Over a 12-month period, an average of 200 evidenced based guidance documents issued from a variety of recognised bodies and reviewed for relevancy by the Clinical Quality Facilitator. During the period 1 October 2023 to 30 November 2023, 25 guidance documents have been reviewed. There were 21

documents which were considered to be either not relevant to TSH or were overridden by Scottish guidance and 3 documents which were recorded for information and awareness purposes. The remaining SIGN guideline, in relation to Dementia, will require a completed matrix.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
Mental Welfare Commission (MWC)	2	2	0
SIGN	1	0	1
Healthcare Improvement Scotland (HIS)	1	1	0
National Institute for Health & Care Excellence (NICE)	21	0	0

There are currently 5 additional evaluation matrices, which have been outstanding for a prolonged period and await review by their allocated Steering Group. The progress of the first two evaluations from HIS and the MWC was temporarily paused due to TSH adapting to the COVID-19 pandemic however as per Gold Command, action on matrix completion began again at the start of July 2020. The responsibility to review these matrices changed ownership from the PMVA Review Group to the Patient Safety Group, which recommenced meetings in September 2020. Work is progressing with both, with an anticipated completion date of 2024.

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

The evaluation matrix for SIGN guideline Care of Deteriorating Patients" is on the agenda for the Physical Health Steering Group meeting in December for final sign off. Whilst SIGN's national guideline for stroke was been delayed due to prioritizing of numerous guideline reviews by the practice nurse and GP. Review of this document has been completed and pending feedback from Psychology, an adapted evaluation matrix will be compiled for review and completion by a wider multi disciplinary team. It should be noted that there are approximately 530 recommendations within this document which required to be reviewed given that only a few may be relevant to TSH.

Table 3: Evaluation Matrix Summary

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
HIS	From Observation to Intervention: A proactive, responsive & personalised care & treatment framework for acutely unwell people in mental health care	Patient Safety	Evaluation matrix completed with 28 outstanding recommendations Patient Safety meeting took place mid-September. Policy continues to undergo extensive review with projected implementation date of early 2024. Will be able to complete evaluation matrix when final version of policy is agreed.	Jan 2019	Feb 2024
MWC	The use of seclusion	Patient Safety	Work ongoing. Release of updated Seclusion Policy currently on hold due to ongoing work with Clinical Care Policy with seclusion tier 1 and 2 being incorporated. Both policies to be launched together. Finalising of evaluation matrix pending awaiting any possible	Oct 2019	Feb 2024

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
			changes linked to Clinical Care Policy.		
NICE	Multiple sclerosis in adults: Management UPDATED	PHSG	Previously reviewed in Oct 2014 when recorded for information purposes only. Given that TSH had no patients with an MS diagnosis PHSG agreed that should this change, the guideline would be used. Current 2022 situation was same however there is now 1 possible diagnosis pending with patient on waiting list for further investigation. Completion of matrix placed on hold until outcome of referral.	June 2022	2024 Awaiting outcome from specialist referral (March 2023)
SIGN	Care of deteriorating patients	PHSG	Evaluation matrix tabled for PHSG for final sign off.	June 2023	Dec 2023
SIGN	National Clinical Guideline for Stroke	PHSG	CQ and Practice Nurse meeting to review content as it contains over 530 recommendations which will not all be relevant to TSH. Meetings held and identifying of relevant recommendations nearing completion. Currently awaiting feedback from Psychology. Once received, review meeting will be arrange involving all disciplines for final completion.	April 2023	Jan 2024

Appendix 1

Keyworker 1-1 Progress Notes

Louise Lindsay, Clinical Quality Facilitator

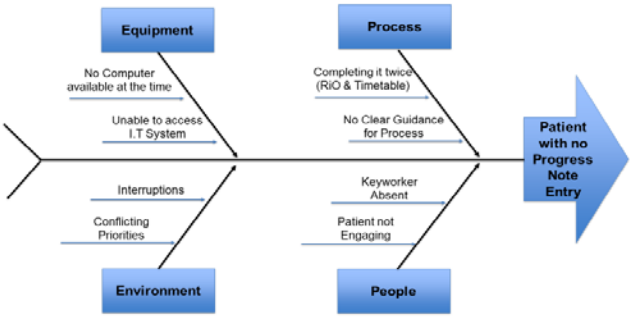
Project overview

Some patients within the ID service were not consistently receiving weekly keyworker 1-1's. As this is a vital part of the patient's care, I began to monitor this and communicated the findings to the Iona Senior Charge nurses on a weekly basis.

Project Aim: By the 31st of August 2023, 100% of ID service patients will have a keyworker 1 to 1 progress note entered into rio every week.

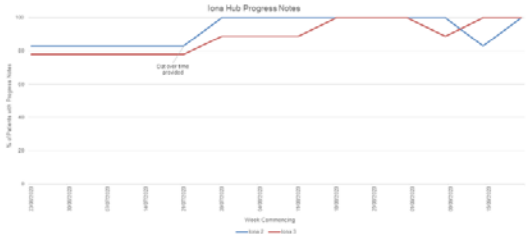
Method:

To begin with, I thought about my aim statement and what I wanted to achieve. I then created a fishbone diagram to look at the different factors for why a patient might not have a 1-1 recorded in the system. We are very fortunate that we have an extensive reporting structure within our electronic patient system and this supported me in carrying out my analysis. I pulled the reports to see which of the ID patients had received the keyworker 1-1 each week. I then created a document which I shared with the senior charge nurses for Iona 2 and Iona 3 to show how many of their patients had progress notes entered during that week.



Results

Once the reporting structure changed from only week to week data to including the data over time, I noticed there was an improvement in the percentage of patients receiving Keyworker 1-1's across the service. This was supporting the Senior Charge Nurses to see the data for their ward clearly. It was a small but effective change.



Conclusions

When we reached the 31st of August target, it was clear there was an improvement across the service for the percentage of patient's receiving a keyworker 1-1. I did continue to pull the data after this date and initially there was a continuation of the high standard however, there has been a dip in the % of Iona 3 patients receiving keyworker 1-1's and work is ongoing with Senior Charge Nurses in the service to make a further improvement and try another Test of Change.

Process Changes

Each of the wards were consistently sitting at around 80% of their patients receiving a keyworker 1- 1 and in order for an improvement to be seen, I had to change my reporting from week to week to providing the data over time. This would ensure clarity for how many patients were receiving their 1-1 weekly on both wards and if we were seeing an improvement.

Learning points, achievements, next steps

My personal learning points from this experience, have been to keep your project small and as simple as possible. Introducing a small change can have a big impact but even if things are going well, continue to monitor as the change may not continue to show sustained improvement. This is when another test of change should be carried out to see what the impact is.

Contact: Louise Lindsay
Email address: Louiselindsay3@nhs.scot

Scottish Improvement Foundation Skills Programme (SIFS)

THE STATE HOSPITALS BOARD FOR SCOTLAND **CGC (M) 23/03**

Clinical Governance Committee

Draft Minutes of the meeting of the Clinical Governance Committee held on Thursday 10 August 2023.

This meeting was conducted virtually by way of MS Teams, and commenced at 09.45am.

Chair:	
Non-Executive Director	Cathy Fallon
Present:	
Non-Executive Director	Stuart Currie
Vice Board Chair	David McConnell
In attendance:	
Chief Executive	Gary Jenkins
Board Chair	Brian Moore
Head of Corporate Governance	Margaret Smith
Head of Planning and Performance	Monica Merson
Consultant Forensic Psychiatrist	Dr Khuram Khan
Director of eHealth and Finance	Robin McNaught
Risk Manager	Stewart Dick [Item 6 & 13]
Lead Professional Nurse Advisor	Josie Clark [Item 7, 8 & 12]
Consultant Forensic Clinical Psychologist	Dr Louise Kennedy [Item 9]
Head of Psychology	Dr Elizabeth Flynn [Item 10]
Lead Occupational Therapist	Monique Crothall [Item 11]
Acting Medical Director	Dr Duncan Alcock [Item 14]
Senior Charge Nurse, Skye Centre	Alexandra McLean [Item 15]
Personal Assistant to CEO / Chair	Lindsay Kirk [Minutes]

1 APOLOGIES AND INTRODUCTORY REMARKS

Ms Fallon welcomed everyone to the meeting, and apologies were noted from Ms Shalinay Raghavan, Non-Executive Director, Professor Lindsay Thomson, Ms Karen McCaffrey, Ms Lindsey MacGregor and Ms Jacqueline Garrity were unable to attend the meeting.

2 CONFLICTS OF INTEREST

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

3 TO APPROVE THE MINUTES / ACTON NOTE OF PREVIOUS MEETING HELD ON 11 MAY 2023

The Minutes of the previous meeting held on 11 May 2023 were noted to be an accurate record of the meeting.

The Committee:

1. Approved the minute of the meeting held on 11 May 2023.

4 MATTERS ARISING

There were no urgent matters which arose for discussion.

5 PROGRESS ON ACTION NOTES

The Committee received the action list and noted progress on the action points from the last meeting.

The Chair asked for an update on reporting regarding pattern of assaults, and it was confirmed that this would come to the next meeting.

Ms Fallon also asked for an update on the recording of patient calls and also progress with carers clinics. In respect of the telephone system, Mr Jenkins advised that work was progressing on options presently. One proposed option would be to install a new recording system however cost was indicated to be in the range of £25k. If this was the preferred option, additional capital funding would be required. An update would be provided at the next Clinical Governance Committee.

Mr Jenkins also advised that there are ongoing issues regarding a leak in the PLC room in the Skye Centre. The contractor were investigating the source of the leak. A plan was being created and would be provided at the next Clinical Governance Committee.

Mr Jenkins advised that he was in talks with Mr Kenny Andress, Head of Estates and Facilities, regarding the delivery and installation of fencing. This would be added to the rolling action list and followed up.

Ms Merson provided advice on carer engagement, including carer clinics. This was being reviewed through the Mental Health Practice Steering Group for the coming year, and reporting would return through that route.

Action(s): Secretariat to request reporting as discussed

The Committee:

1. Noted the updated action list, and the progress being made in this regard.

6 CORPORATE RISK REGISTER – CLINICAL RISKS

Members received and noted the Corporate Risk Register clinical update which was presented by Mr Stewart Dick, Risk Manager, noting that all risks were up to date. He provided specific updates on the main points from the report which included ND71 – Failure to assess and manage the risk of aggression and violence effectively and ND70 - Failure to utilise our resources to optimise excellent patient care and experience, MD30 – Failure to prevent / mitigate obesity.

In relation to the Prevention and Management of Violence and Aggression (PMVA) Mr Dick noted that the risk had moved from a rating of low to medium. Mr Jenkins advised that PMVA training had paused for some time during COVID. When training was re-started, there had been a need to do so in bulk to ensure all relevant staff were trained. This had resulted in large number of training expiring at the same time. The training would be spread out to avoid recurrence in 12-18 months. Mr Dick assured committee there was an action plan in pace to get this training completed in September with a view to reduce the risk level by then.

The Committee:

1. Noted the reviewed current clinical Corporate Risk Register
2. Accepted it as an accurate record.
3. Agreed that no additional information was required for future reporting.

7 CLINICAL MODEL PROGRESS UPDATE

Members received and noted the Clinical Model Progress update which was presented by Ms Josie Clark, Lead Professional Nurse Advisor. Ms Clark provided an overview of reporting, which included detail on the clinical guidance. The Clinical Model Oversight Group had its first meeting on 21 May 2023 and have had four meetings since. The meetings had moved from fortnightly to monthly. Ms Clark advised that the Service Leadership teams were settling in well and that a monthly flash report will be presented to the Organisational Management Team (OMT). Ms Merson added that the clinical guidance had been approved and became live on 24 July, with each new service in full operation.

Dr Alcock noted that presently there was some differentiation in approaches across services, allowing reflection through which to consider quality improvement in delivery.

Mr McConnell praised the comprehensive report and advised that it would be good to provide to new members of staff as it contains very high level of detail. Mr McConnell suggested that it would be beneficial to include the key areas of differing approaches across services. Mr Currie advised that this report is a good starting point giving a base point, and in the future it would be helpful to receive reporting on what had not been anticipated with change, and what could be learned through this.

Mr Jenkins commented that reporting would be rebased around the new model, covering key metrics to ensure reporting was aligned for assurance. Ms Merson noted that Variance Analysis tools would be split into the new sub-specialties going forward.

Ms Fallon noted that it would be helpful for reporting to be reframed in this way for the committee. She also commented that it had been helpful to see the inclusion sections on wellbeing and independent advocacy. She also thought that the positive ethos of the clinical model could be seen within the clinical guidance document.

Action: J Clark

The Committee:

1. Noted reporting.
2. Outlined and agreed adjustments to be made for reporting in the future.

8 STAFFING REPORT: CLINICAL IMPACTS & INTERNAL AUDIT REPORT

Members received and noted the report and the summary presented by Ms Clark.

Ms Clark noted the increased use of the Supplementary Staffing Register in nursing, as well as the strong focus on eradicating daytime confinement. A short life working group led this work through the Director of Nursing and Operations and the Medical Director. Practice around modified working had been re-defined and agreed through the Corporate Management Team (CMT). Work was ongoing with eHealth to ensure accurate recording of relevant data which could now be updated on RIO (the electronic patient information system). She also outlined the focus on delivering patient activity within the context of pressures on staffing, with a daily resource huddle to review any challenges and allocate resources to allow more activities to take place each day. Finally, she advised that interviews had taken place for registered nurses, and ten new offers had been made within the last week reducing the number of vacancies going forward.

Mr Currie noted that terminology should be carefully defined in relation to the legislation and staffing levels; even with a full complement of staff there remained the potential of incidents occurring. Mr Currie commented that it was really encouraging to see the increase in staff numbers which demonstrated the unique appeal the hospital had. It would be positive to continue fill vacancies, with the continued use of overtime and the supplementary staffing register helping to

demonstrate baseline staffing needs. In response, Ms Clark advised that recently some nursing colleagues had returned to TSH after having worked elsewhere which had been very positive. Mr McConnell noted the past agreement to vary the skills mix between registered and non-registered nursing, and that it was positive to see this recent increase in recruitment in registered nurses. Mr Jenkins advised that The State Hospital pre-emptively took a decision to over recruit Band 3 as there was a challenge recruiting Band 5 nurses, with the hope to equalise it over a 12 month period. This has been successful with a number of Band 5 nurses being recruited. He offered the view that proactive recruitment was required as a pre-emptive strategy.

A point of clarity was raised regarding the reasons for the drop in resource incidents which were usually around 900 but had dropped to 550.

Action: J Clark

Mr Currie also raised the question as to whether there had been changes seen following the pandemic, and how this may affect approaches. Mr Jenkins agreed that this could be impactive alongside recruitment challenges and the pressures being experienced on attendance management. All of these factors were being actively reviewed to help inform the way forward to get to an improved position.

Ms Fallon noted that the internal audit report had been shared with the committee, and Mr Jenkins confirmed that this had been considered in detail by the Audit and Risk Committee. The auditors were asked to undertake a review to understand where we are in regards to eRostering, Workforce planning etc. The report gave an accurate reflection of a snapshot in time and the processes in place. Mr Jenkins advised that this report was brought to the Clinical Governance Committee for transparency however the actions outlined would be monitored through the Audit and Risk Committee.

Ms Fallon summed up the discussion and non-executive board members had previously considered what role they could play in induction of new staff.

The Committee:

1. Noted the report.
2. Outlined further requirements required in reporting for the next meeting.

9 MENTAL HEALTH PRACTICE STEERING GROUP REPORT

Dr Louise Kennedy, Consultant Forensic Clinical Psychologist joined the meeting and presented the Mental Health Practice Steering group report to the members. The key areas discussed were quality assurance and improvement work. There was a review of CPA process and how it linked to the Clinical Outcomes. A draft CPA document was being created to make it more meaningful and useful, this will link in with the electronic patient records. She outlined the key points in this respect. She also noted that the Trauma and Informed Care training was progressing and will continue to be monitored.

Dr Kennedy advised that Grounds Access Policy was under review and is out for consultation until 30 August 2023. It is hoped that an electronic requests system can be implemented and patients can request these themselves. The aim was to have this finalised by next year.

Mr Jenkins asked for some clarification around use of Advanced Statements, and Dr Kennedy advised that from a clinical point of view these were optional within a high secure setting. Patients often believed that this would be something for the future. There was work ongoing to help the patients understand how this may be beneficial for them. Dr Alcock echoed this point, with patients being encouraged to consider this for the future.

Mr Moore queried if there is timeline in place regarding the implementation of the new CPA process. Dr Kennedy advised that it was currently being shared with stakeholders, Heads of

Departments, Patient Centre Improvement Team and Clinical Quality for feedback. All feedback to be back within two months. A draft will then go to the Patient Partnership Group.

The Chair thanked Dr Kennedy for this report and asked about appointment of a trauma champion, and it was agreed that this should be considered.

Action: L Kennedy

The Committee:

1. Noted the report.

10 PSYCHOLOGICAL THERAPIES – SIX MONTHLY UPDATE

Dr Liz Flynn, Head of Psychology joined the meeting to present update reporting on the Psychological Therapy Service, which highlighted data regarding core activities of the Psychology department, key performance indicator and quality assurance and improvement activity.

Dr Flynn advised that although there have been recruitment issues, they will have one new staff member start with the team later this year. They are currently interviewing for the vacant Consultant Post. The service is currently considering a restructure to allow for the introduction of a Band 8b member of staff. Looking at the figures of sessions completed over the last six months and the annual figure, the State Hospital was doing well in providing both individual and group sessions. During the summer months, group sessions were reduced and these were staggered into autumn. There were plans to have a group specifically for the transition service. In relation to this the service would need to consider what portion of the workforce require training.

Dr Flynn advised that the target for patient engaging with Psychological services was 85%, and was currently at 80% with reasons for this detailed in the report. The department was doing well in referral to treatment time target and there were ongoing discussions with colleagues on how to record data better to provide accurate reporting on those patients waiting on referral.

Mr McConnell thanked Dr Flynn for her report. Mr McConnell raised concern regarding high turnover of Assistant Psychologists. He also asked regarding the Clinical Psychologist, what kind of level of challenge is there, and if there a current work around in place. Mr McConnell also asked for more information on the Link nurses and where we currently sit with this. Dr Flynn advised that the high turnover of Assistant Psychologists is expected as these are usually temporary posts to allow for training/experience. There would be interviews on 10th and 11th August and Dr Flynn did not expect any issues in recruiting for these posts. Dr Flynn advised that the recruitment on the Band 8a is a concern as there is a national shortage of qualified individuals to take up this role. There was however a potential to create a seconded promoted post within the team to gain training and experience. Link Nurse is a development opportunity which will help to upskill nurses and the hope is that the nurse will pass on their experience and knowledge to other colleague.

Mr Moore praised report and commented that it was positive to see the Health Psychologist post being filled. Mr Moore advised it would be beneficial to get an update in future regarding the impact this role has had in terms of benefit to patients. Dr Khan advised that this is part of Supporting Healthy Choices workstream.

Ms Fallon asked that a verbal update was provided at the next meeting in relation to any impacts that service issues may have on patient risk assessments. This should be added to the rolling action list.

Action: Update Action List - Secretariat

The Committee:

1. Noted the report.

2. Asked for update on impacts on risk assessments

11 REHABILITATION THERAPIES SERVICES REPORT

Ms Monique Crothall, Lead Occupational Therapist joined the meeting to present the Rehabilitation Therapies Service report from October 2022 to June 2023.

Ms Crothall advised that there a number of assessment tools used to allow a more robust standardised assessment of functional skills, however the training regarding The Model of Human Occupation Screening tool was no longer available therefore new staff cannot be trained in the use of this assessment at this time. The department would need to consider the assessment tools going forward. Ms Crothall also advised that due to staffing pressures the number of Assessment of Motor Process Skills and Interest Checklists had reduced.

She provided an overview of the efforts within the service to review the services and pathways offered to patients and to realign services. Ms Crothall also outlined the key areas for development over the next year.

Mr Moore thanked Ms Crothall for her report and advised that in relation to the open hub sessions and group work, it was useful to get feedback from both staff and patients and would be keen to get information on how they benefit from this work in future report. It was agreed that this would be beneficial for future reporting.

Mr Currie noted assurance through this reporting, and noted the innovative ways of working employed. He asked for further feedback on how to demonstrate the difference made when a vacant post was filled, and how this could be shown in terms of patient care.

Mr McConnell asked how do the team deal with any changes or challenges due to staff shortages. Ms Crothall advised that a Morning Resource meeting took place every day which provided Service Leads with details of all staffing issues and events or activates taking place. This allowed Service Leads to coordinate resources across the site and ensure effective staff distribution.

The Chair echoed the Board and thanked Ms Crothall for the report, in particular the section on About Me Passport and the team development session. Going forward it would be useful to have a presentation on good principles in rehabilitation, and patient digital inclusion.

Action – L McGregor

<u>The Committee:</u>

1. Noted the report.
2. Outlined further reporting requirements/updates

12 PATIENT SAFETY PROGRAMME REPORT

Members received and noted the Patient Safety Programme report from July 2022 – June 2023, which was presented by Ms Josie Clark, Lead Professional Nurse. Ms Clark discussed the key priorities that were in place for 2022/2023 and provided the committee with an update from the report regarding each priority. Ms Clark advised the committee of the key priorities for 2023/2024.

Mr Moore offered the view that it would be helpful not to pause further in relation to the Quality and Safety visits.

Action: J Clark

The Chair thanked Ms Clark for her report and looking forward to seeing the staff safety survey

results and details on the Quality Assurance visits.

Ms Fallon asked if points of clarity could be updated within reporting in terms of reporting periods.

The Committee:

1. Noted the report.
2. Noted that Quality and Safety Visits would re-commence as soon as possible

13 DUTY OF CANDOUR ANNUAL REPORT

Members received and noted the Duty of Candour Annual report which was presented by Mr Dick, Risk Manager. Mr Dick advised that there were no incidents that required the Duty of Candour procedure to be enacted. The eLearning Training module uptake continued to increase and remained high with 97.2%

Ms Fallon praised the report and confirmed it as a good learning opportunity.

The Committee:

1. Noted reporting.

14 INCIDENT REPORTING AND PATIENT RESTRICTIONS

Members received and noted the report on Incidents and Patient Restrictions within the first quarter 2023/24. The report was presented by Mr Dick and it showed the type and the amount of incidents received through the incident reporting system (Datix). Further, it updated all the restrictions applied to patients during period 1 April to 30 June 2023.

Mr Dick provided a summary of the key points in reporting. He advised that incidents were down significantly from 1250 in the previous quarter to 818 in Q1. There had been an increase in RIDDORs with three in Q1. One took place during PMVA training, one patient restraint and one assault. Mr Jenkins has asked for more analysis on the reasons for this. Self Harm incidents had decreased from 31 to 19 and Mr Dick advised that this is mainly from one patient. There was one serious incident which requires CAT2 review. This was due 11 August however the team have asked for a four week extension due to staffing issues.

Mr Currie asked if there was a trend or any areas of concern, adding that it may be worth looking at same 12 month period of previous year and see if there are any similar events and record on report that this is an event that happens at the same time each year. Mr Dick to review this for future reports.

Action: S Dick

Mr Jenkins confirmed that in relation to RIDDORs, analysis had shown no specific trends. He advised that there was an incident where keys were reported as missing, but this had not been the case. Further inspection and a manual count showed all keys were located and it was found that there was an issue with the software, with work being progressed on this presently to ensure accuracy.

Dr Alcock praised staff in relation to the clinical model and patient moves, with downward trend in incidents being remarkable. This was a testament to good practice in being able to maintain the security and safety of the overall hospital during these moves.

Mr Moore asked for assurance that there were no issues or concerns regarding prohibited substances. Mr Dick advised that no additional issues have been found. Mr Jenkins reassured the committee that there are random deep searches at reception and if required additional resources can be brought in if there are any suspected substance misuse within the organisation. There was

nothing to indicate any substance misuse within the organisation at present.

Ms Fallon raised concerning issues regarding prohibited items being brought into the hospital by staff and clinical waste reoccurring. Mr Dick advised that any incident of prohibited items was recorded in Datix and Security staff inform line managers. Clinical waste was a recurring issue and the Infection Control team were working with wards to identify the problem areas. There would be more analysis on this which would provide more information on the type of incidents, percentage, what is being brought in etc. This would be added to the action list for follow up.

Action: S Dick

The Committee:

1. Noted the report
2. Asked for further reporting as outlined
3. Added an update on clinical waste incidents to the action list

15 LEARNING FROM FEEDBACK REPORT

Members received and noted the Learning from Feedback Quarterly Report which provided the Committee with an overview of activity related to feedback for the first quarter of the financial year 2023/24. Ms Alex MacLean, Lead Occupational Therapist joined the meeting and provided members with a brief summary of the report and highlighted the following areas in terms of feedback shared relating to concerns and a number of themes identified;

- Challenge in accommodating child visits.
- Access to the garden, in relation to the floppy top.
- Spending limit in charity shop has been lifted.

Ms MacLean advised that 20 children have now been approved for visits however, for every child visit, four adult visits cannot go ahead. There was a challenge to get the balance right however, to date no visit had been refused. The report may need to be amended to make it clear that if the requested date is not available an alternative has been found.

Ms MacLean advised that one solution would be to increase visitation sessions from one to two at the weekend. In relation to access to the garden, this was due to the delay in the floppy top fencing being delivered. This was ordered on 13th July and as soon as it has been installed patient and carers can access the garden.

Ms Fallon welcomed the update and was delighted that the £5 limit in the Charity Shop had been lifted.

The Committee:

1. Noted the Learning from Feedback Report

16 LEARNING FROM COMPLAINTS

Members received and noted the Learning from Complaints report presented by Ms Margaret Smith, Head of Corporate Governance and Board Secretary.

The report provided an overview of complaints, concerns and enquiries for the first quarter of the financial year 2023/24. The report also detailed the complaints received, the stages at which they were handled, as well as complaints closed within this period. Ms Smith provided a high level account of the content of the report and provided assurance on key areas.

She advised that there have been a number of developments within the Complaints Department, as well as in the delivery of the service. This included increased face to face contact with patients, especially in the Skye Centre Atrium and patients were responding well to this. A new direct telephone service was up and running which allow patients to make contact directly. Posters with details on how patients can complain were being created and distributed around wards. Finally the next stage would be to take forward a changed rota system for front line investigators.

Mr Currie welcomed the report and commended staff for their efforts in this area. He noted the openness of the process and was of the view that it was more effective to ensure effective resolution of complaints even if this did mean that the target response times could not always be met. This would help patients and carers to feel reassured that their concerns had been listened to and taken on board.

Mr McConnell noted that reporting would be changed to align with the services within the clinical model and asked how this would affect the way data was presented, as it would be important to maintain a clear picture through clinical stages. Ms Smith noted that this would need to be done carefully, to align to the new service areas but also to continue to reflect the national key performance indicators, and this may be complicated as it was mid-year.

Mr Jenkins advised that he followed up with a patient who raised concerns, however, had since left TSH. In a safe and open space he advised that he was very happy with the complaints process, how complaints are addressed, and its transparency.

Ms Fallon asked Ms Smith for clarity regarding complaint from MSP that was not in report. Ms Smith advised that this complaint came in at the very end of Q1 and was currently being investigated. It would be reported on at the next Clinical Governance Committee meeting.

Ms Fallon asked Ms Clark to confirm the restrictions on the number of items within a patient room. Ms Clark confirmed that there were some restrictions regarding clothing and items like DVDs because of safety and security however the numbers were always open for discussion with individual patients.

Ms Fallon commended Ms Smith and her team on their comprehensive report and thanked them for the extensive work by the department.

The Committee:

1. Noted the Learning from Complaints Report

17 DISCUSSIONS ITEM; 'DAYTIME CONFINEMENTS AND CHANGES TO PRACTICE AND STAFFING'

Mr Jenkins provided an overview of the Daytime Confinement. Mr Jenkins reiterated that the common and number one aim of all staff is to eradicate Daytime Confinement in The State Hospital. This remains a considerable challenge however there is working ongoing to achieve this.

The Committee agreed to defer this item to the next Clinical Governance Committee meeting noting that it was expected that considerable progress would have been made in this areas, and that Professor Thomson and Ms McCaffrey would be in attendance.

The Committee:

1. Agreed to carry forward to the next meeting.

18 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

Ms Fallon suggested an area of good practice from today's meeting is the All About Me passports.

In terms of items for concern, it was noted that an update had been requested in respect of recurrence of clinical waste.

Ms Fallon raised the issue of staff incidents at security reception due to prohibited items. Mr Jenkins advised that the committee could be provided with an analysis of the type of items being found as these were everyday items (personal mobile, umbrella) found rather than anything more concerning. An analysis in this respect may bring assurance for the committee.

Action: S Dick

The Committee:

1. Agreed with the addition to the Areas of Good Practice
2. Agreed to review the Areas of Concern noted above at next meeting with view to add to Areas of Concern document if required.

19 COMMITTEE WORKPLAN

Ms Fallon questioned why the Staffing Report being reported under May, August and November. Ms Smith noted that this should now be amended.

Action: Secretariat

Members raised no other issues regarding the Committee Workplan.

20 ANY ISSUES ARISING TO BE SHARED AMONGST GOVERNANCE COMMITTEES

It was noted that an issue had been raised that could be shared with the Staff Governance Committee, around vacancy management and how to demonstrate the benefit of filling vacancies towards baseline made to service delivery.

Action: Secretariat

21 ANY OTHER BUSINESS

Members raised no other items of other business.

22 DATE OF THE NEXT MEETING

The next meeting would be held on Thursday 9 November 2023 at 0945 hours via Microsoft Teams.

The meeting concluded at 12.38 hours.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	21 December 2023
Agenda Reference:	Item No: 14
Title of Report:	Clinical Governance Committee – Highlight Report
Purpose of Report:	For Noting

This report provides the Board with an update on the key points arising from the Clinical Governance Committee meeting that took place on 9 November 2023.

1	Corporate Risk Register	The Committee reviewed the clinical risks within the Corproate Risk Register, and confirmed these to be an accurate statement of risk.
2	Clinical Model Oversight Group	The developments in service delivery across the Service Leadership Teams was noted, especially patient flow through the services within the hospital and a centralised referral process based on clinical indicators.
3	Patient restrictions/incident reporting Q 2 report	The Committee received quarterly reporting on the types and numbers of incidents, including RIDDOR reporting and serious adverse events, and patient restrictions during this period. The increase in patient incidents in this quarter was noted, and confirmed that there had been no identifiable trend. It was noted that a serious adverse event review was being undertaken in relation to administration of medicines, and that clinical waste incidents had increased.
4	Patient Movement	The Committee received reporting for the first six months of the financial year, across a range of metrics for patient movement including admissions, transfers to other services, and appeals against excessive security. It was confirmed that the patient's board of residence is responsible for provision of care once the patient is ready to be discharged from the State Hospital.
5	Physical Health Steering Group	The PHSG Chair provided a report to the Committee on the core activities completed within the previous 12 months. The work being done on physical health improvement was recognised. The Committee noted the work being done to support virtual clinic outpatient appointments when possible, rather than the patient having to attend another hospital site in person.
6	Adult and Child Protection	Reporting from the Social Work Mental Health Manager on activity across previous 12 months. The Committee saw positive management of access for family contact which was consistently monitored. The service was being managed proactively. It was

		noted that there were no child protection referrals or near misses within this period; and it was agreed it should be noted within reporting should there be nil incidence.
7	CPA/MAPPA	Good performance on CPA for 100% on all patient transfers over a five year period. The inter agency work being carried out across the hospital was commended.
8	Patient Telephone System	The Committee reviewed progress on upgrade to system, and costs involved. This would increase capability to manage and record calls.
9	Learning from feedback Q2 report	Reporting on key themes for this quarter including management of carer visits to the hospital, including extended visit times with meaningful activities. There was also feedback about lack of access to the garden area during visiting and also access to telephone calls from ward areas. Patient feedback from the Patient Partnership Group was noted relating to witnessing restraints; and it was confirmed that nurse practice development would take forward support to give reassurance to patients. PPG lead passed on thanks from patients to Non- Executive Director for their regular attendance at PPG meetings.
10	Learning from complaints Q2 report	Reporting for this quarter included metrics on national KPIs, as well as the continued development of complaints service delivery within TSH. This included adding complaints reporting to the metrics reviewed within quarterly performance meetings led by the CEO. Within this quarter, the most common issue was staff attitude and behavior but detailed investigations had confirmed that the concerns raised were not upheld.
10	Daytime confinement	The Committee reviewed daytime confinement practice as a detailed discussion item, based on reporting demonstrating improvement since the date of the last meeting. The core solutions would be to continue to recruit to nursing roles to establishment, as well as reducing sickness absence levels. The goal was to reach nil daytime confinement by January 2024, and for it to be a never event. The need for clear communications with patients was emphasised as being essential.
11	Areas of good practice/concerns	The committee noted development of the family centre visiting, improvement on patient and carer engagement in CPAs, and also increased visibility of complaints officer and direct telephone access to service.

RECOMMENDATION

The Board is asked to note this update, and that the full meeting minute will be presented, once approved by the Committee.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP / Corporate Objectives	As part of corporate governance arrangements, to ensure committee business is reported timeously to the Board.
Workforce Implications	None
Financial Implications	None
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board requested, pending approval of formal minutes
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	None
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	21 December 2023
Agenda Reference:	Item No: 15
Sponsoring Director:	Interim Workforce Director
Author(s):	Interim Workforce Director
Title of Report:	Workforce Report
Purpose of Report:	For Noting

1. SITUATION

This report provides an update on workforce performance.

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

2. BACKGROUND

The Workforce Directorate consist of HR, Learning & Organisational Development and Occupational Health Services. The Teams work closely together to support Managers and Staff within TSH on a number of key areas and this report details the background and update for each Department.

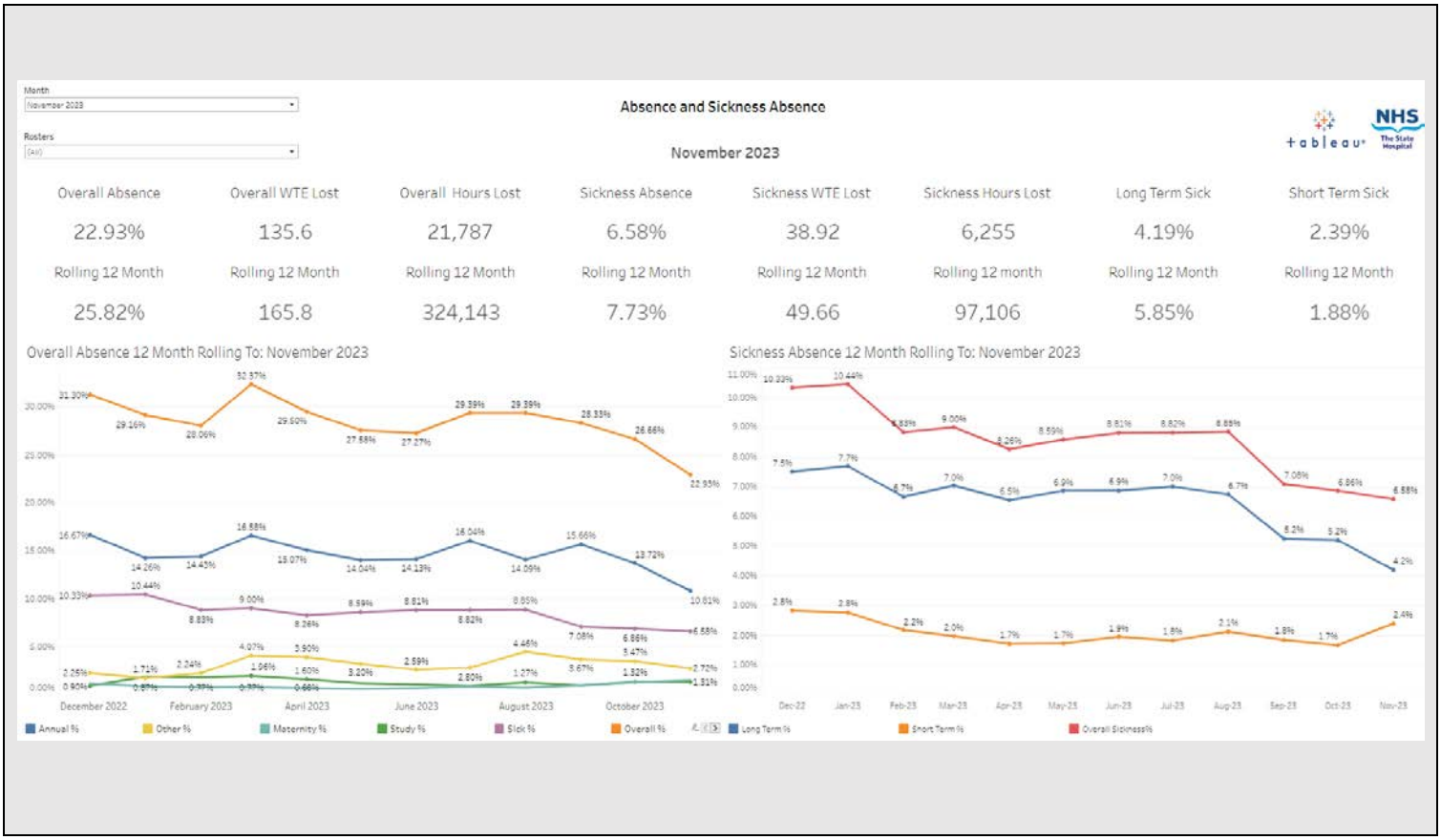
It was agreed by the Board that the reports should be amalgamated into one regular update.

3. ASSESSMENT

Attendance Management

Maximizing healthy attendance at work is a priority for the organisation. Since April 2023, the absence rate remained relatively static around 8% until September where it reduced to 7.08% and this continued to reduce in October to 6.83% and November to 6.58%. This is outlined in graph 1 below.

Graph 1 – Board sickness absence until November 2023



There are a number of contributing factors for this:

- The implementation of the new Occupational Health contract has taken time to imbed since its instatement in April 2023.
- Dedicated support to managers and employees from HR, staff side & Occupational Health collectively.
- The Chief Executive Officer discussed with each Director and team as part of their performance review meeting of the key areas of challenge within their portfolio.
- Attendance training takes place for all managers and staff side representatives within the hospital. 35 managers have attended to date and the most recent session took place on 1st December 2023. The topics covered in the training include application of the Attendance Policy, absence reporting, holding meaningful, quality absence meetings, return to work discussions, occupational health referrals and employee assistance.

A Task and Finish Group was established and initially chaired by the Workforce Director, following their departure, the membership was reviewed and streamlined and is now chaired by the Deputy Chief Executive from the end of October 2023. The Task and Finish group meets fortnightly to assess, progress and drive actions that can be taken to obviate and address absence challenges.

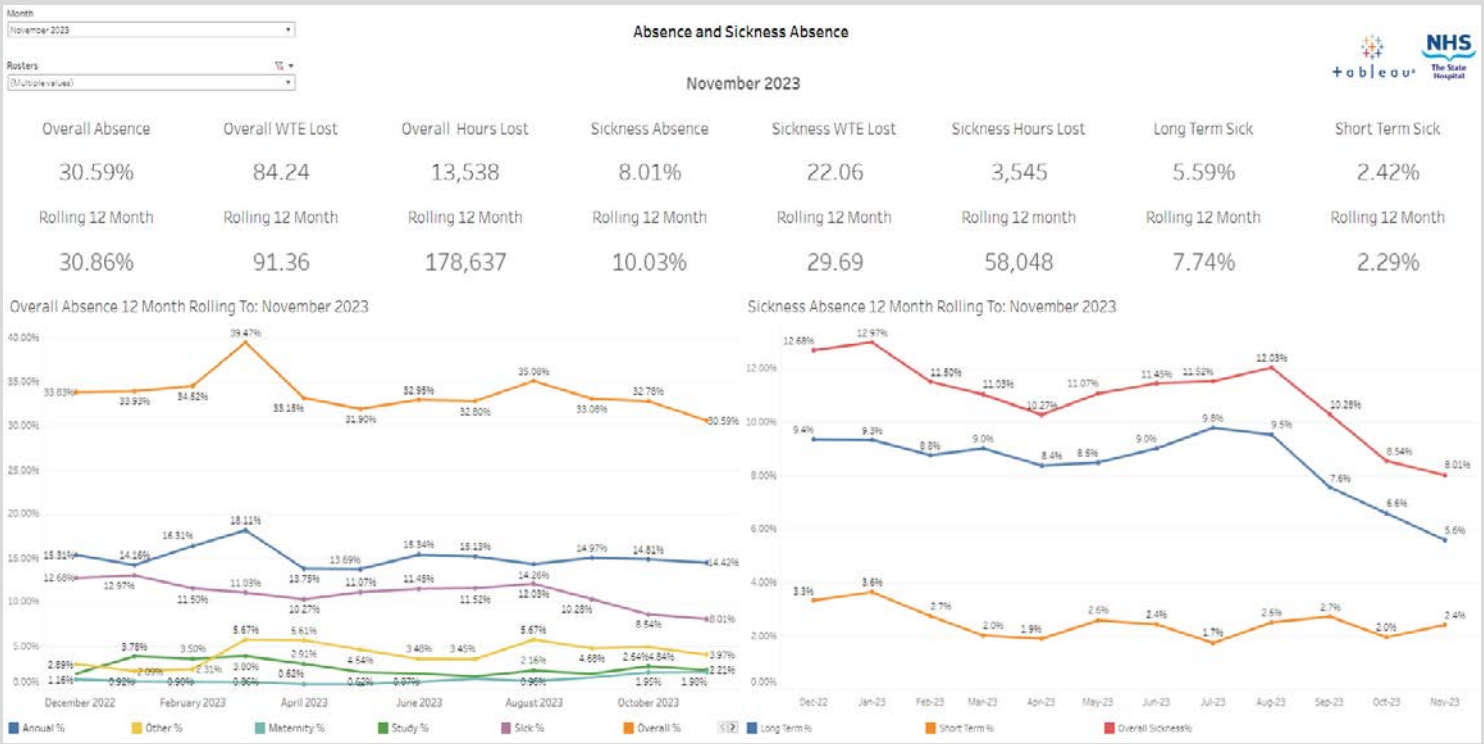
Analytical data was developed to retrospectively assess trends over a 60 month period and the Head of OD & Learning met with each manager to discuss the historic trends and offer.

There is no singular solution that will bring the organisation to within its 5% target in the immediate term. Each individual employee faces their own set of absence circumstances, therefore it is imperative the organisation supports staff with their return to work journey and proactively assists them to sustain their attendance.

However, it can be seen from the pattern above that early progress indicates the organisation overall is moving in the correct direction.

There does however remain specific areas of challenge. These remain consistently high, but the Board should be assured that a target approach is actively being taken. For example, the graph below shows that whilst Ward Nursing is one of these areas, the actual rolling absence trend performance is still lower than it has been over the last 12-month period:

Graph 2 – Wards / Hubs sickness absence until November 2023



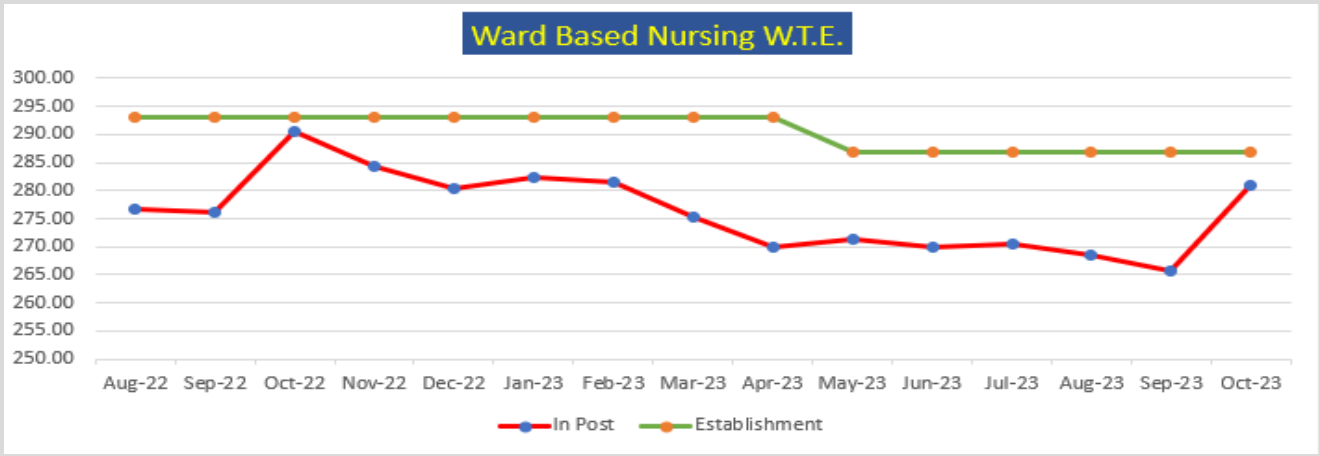
Recruitment – Nursing

Over the course of 2023, recruitment activity for registered nurses has been driven by the recruitment & retention strategy, raising the profile of The State Hospital as an employer of choice for nurses within NHS Scotland. This has been a multi-disciplinary effort supported by various departments across the organisation including social media campaigns, attendance at recruitment fayres and provision of marketing materials for distribution at key recruitment junctures.

Inductions for new appointments are phased throughout the year. This can depend on the date of registration for newly qualified practitioners who are offered the opportunity to commence as HCSWs in the first instance and can complete their induction and training during this time, prior to commencing as a registered nurse.

In addition to the external recruitment, HCSWs have been supported to undertake their degree through the Open University, while working for the State Hospital.

The graph below demonstrates the outcome of this significant recruitment activity in terms of the current vacancy rate compared to the funded wte. This has been recognised in the resourcing meeting which for w/c 13th November there were -78 shifts over the week to be covered, compared to over 200 shifts requiring covered weekly in the Summer.



Through the Nursing Directorate Workforce Governance Group (NDWGG), quality and compliance with local inductions and establishment of personal development plans will be an area of focus to ensure that the on-boarding process is a positive experience.

It is a commitment in the Board's Workforce Plan and Recruitment & Retention Strategy to recruit to registered nurse positions on an ongoing basis and noting Corporate Management Team's agreement to 'over recruit' to registered positions, an updated analysis of the workforce profile (including age and gender) will be considered and presented to the NDWGG for consideration of next steps. This will include consideration of 'male focused' advertisements and / or consideration of HCSW adverts (which have historically been attractive roles within the Board) with a view to encouraging applications from those who wish to pursue a career in nursing through the Open University route.

Job Evaluation

Job evaluation activity has been high throughout 2023 with some long standing 'legacy' roles which needed addressed. This created a risk posed to operational services (through being unable to recruit or effect organisational change) where job descriptions cannot be evaluated, in accordance with the National Job Evaluation Policy, in a reasonable time. The target timeline is 14 weeks and the average timeline for outcomes given in 2023 was 15.25 weeks, however, to demonstrate 'worst case' one post took 78 weeks and one took 48 weeks (both significant change to existing post holders).

However, significant work has been undertaken in recent months to consider areas for improvement and risk mitigation to ensure that the national process is effected as efficiently as possible locally.

To reflect the progress made:

- All posts given an outcome in November, were achieved within the 14 week timeframe.
- There are 3 posts waiting to be evaluated (from 15 posts in August). Of the 3, 2 require Quality Checking only (dates are scheduled) and one is a review (paperwork awaited but included in these figures for transparency).

Further work is planned to provide training materials for managers when they require it in relation to writing and maintaining quality job descriptions to ensure that on receipt they can be progressed as soon as possible. Additionally, the job evaluation leads will undertake a succession planning exercise to ensure that trained practitioners continue to be available to support the process.

Equality Networks opportunity for Staff from Minority Groups

Gillian Russell, Director, Health Workforce, Leadership & Service Reform Directorate (Scottish Government), 13th July 2020 highlighted the need for staff networks to be established and whilst the initial focus will be to engage BAME staff there was a recognition that Boards should *'…establish a network of champions, including at senior and executive team levels on race, disability and LBGTQ with the involvement of staff networks, trade unions and professional organisations'.*

Due to the size of TSH Board and therefore the ability for a staff network to serve its desired intentions, links were made with NHS Lanarkshire to enable TSH staff from minority groups to join staff networks, should they wish to.

The Equality Lead from NHS Lanarkshire Hina Sheikh attended the HR & Wellbeing meeting in July to present information about the staff networks, which was well received and it was agreed that communications would be issued to TSH staff inviting them to join the appropriate network. This included the opportunity for staff from the ethnic minority community (EMEN) to attend a Q&A session with the First Minister.

The communication is below.

Going forward, the HR department, with support from Communications, will provide regular reminders about the opportunity to join the networks through the staff bulletin, and this has been included in the E&D section of the 'in person' induction. Relationships are developing with the E&D team within NHS Lanarkshire to ensure that areas of good practice or concern which are identified within the networks are shared with TSH HR team, as appropriate, to ensure TSH staff on the networks receive parity of experience where possible.

NHS Employee Networks

To help provide support to our employees we offer a number of different networks, to aid mutual support, provide a collective voice and ensure appropriate representation and inclusion. This service is currently based within NHS Lanarkshire but is open to our employees here at the state hospital. Peer support can be vital, having the opportunity to chat to someone else around issues they are currently facing or even share positive experiences.

Our current employee networks include:

EMEN: Ethnic minority employee network

LGBT+: Lesbian, Gay, Bisexual, Transgender Plus

DAWEN: Disability and Wellbeing Employee Network

EMEN: Ethnic minority employee network

EMEN was formed in February 2021, holds quarterly meetings and publishes quarterly newsletters. EMEN has a 3-year action plan, held a staff survey and a Q&A with Rt Honourable FM Humza.

Future meetings for EMEN 14th September 2023, 14th December 2023 and 14th March 2024

LGBT+: Lesbian, Gay, Bisexual, Transgender Plus

Group was formed in February 2022 in NHS Lanarkshire. It is currently in the process of agreeing an action plan. LGBT+ aims to provide a supportive network, increase the opportunities to feedback challenges faced at work to help create an inclusive work place.

Future meetings, 7th November 2023 and 6th Feburary 2024

DAWEN: Disability and Wellbeing Employee Network

This is the most recently formed group within NHS Lanarkshire in October 2022. It is currently in the process of agreeing an action plan. DAWEN also aims to provide a supportive network, increase the opportunities to feedback challenges faced at work to help create an inclusive work place.

Future meetings 13th November 2023 and 6th May 2024

Staff care and Wellbeing

Everyone faces challenges and pressures in order to help our employees a staff care a wellbeing service has been set up. This is to help build resilience and enhance wellbeing

through provision of regular wellbeing focused classes and events. This can be through Group support or individual support

Organisational Development & Learning Update

PDPR Compliance

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

As at 30 November 2023:

- The total number of current (i.e. live) reviews was 542 (88.3%) – an increase of 3.2% from 30 September 2023.
- A total of 63 staff (10.2%) have an overdue review – a decrease of 3% from September 2023
- A further 9 staff (1.5%) have not yet had a review meeting – a decrease of 0.2% from September 2023. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.
- There were 7 departments below the State Hospital's 80% minimum compliance threshold (a decrease of 1 from the last update in September).
- Compliance with PDPR is being actively managed through the Board's Corporate Management Team

Statutory & Mandatory Training Compliance Update

A key requirement within the Staff Governance Standards is to ensure that all staff are appropriately trained. This includes having systems and processes in place to support and monitor compliance with statutory and mandatory training requirements. Compliance levels for statutory and mandatory training at 30 September 2023 are noted below – with high levels of compliance for both statutory and mandatory training being effectively maintained.

Statutory Training	Mandatory Training
93.9% compliance	***85.8% compliance***

Corporate Induction Refresh

A review and refresh of the corporate induction programme has been undertaken to ensure that all new employees complete a robust induction process, and are provided with relevant training, information and support when they commence in post. A new 'Core Induction' online learning module has been introduced and delivery of a corporate 'face-to-face' induction workshop has also been re-established - with the first event taking place in September 2023. In addition, a new Welcome Handbook has been produced and is issued alongside the employment contract to all new staff. Initial feedback has been positive and a continuous improvement approach will be taken to ensure that helpful and relevant information is included in the materials we well as the in person event.

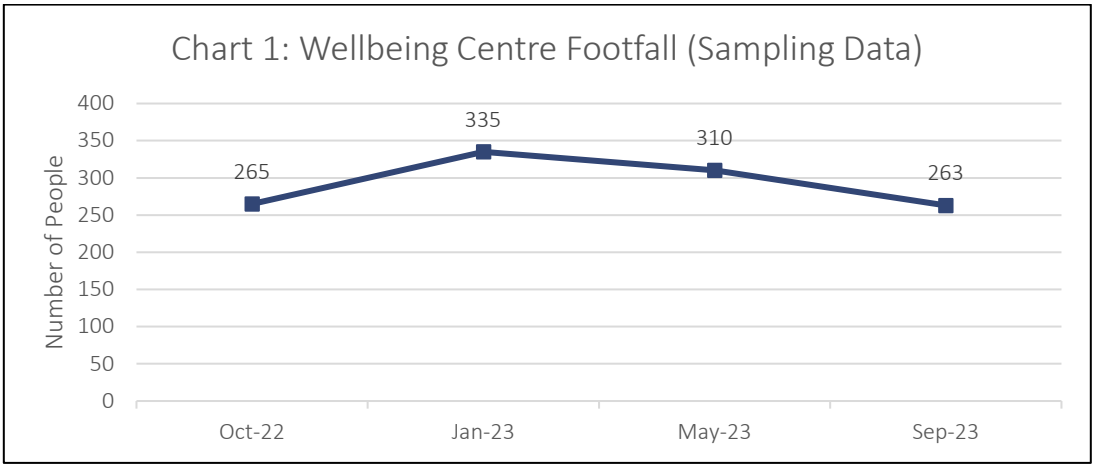
Coaching Provision

Work is being progressed by the OD Manager to re-energise local coaching provision and cultivate a coaching culture. This includes development of a coaching guide, and delivery of 'Coaching Skills for Managers' training. The coaching guide sets out the processes of the organisational offer, how it is delivered, what people can expect in their coaching journey and ways this is monitored and evaluated. The Coaching Skills for Managers training commenced in October 2023 and has been attended by 14 managers to-date.

Wellbeing

The Wellbeing Centre continues to be available for all staff to access 24/7, as and when required (including before, during or after shift). There is dedicated support available within the Centre Monday–Friday, 9am-5pm, and a broad range of wellbeing activities were delivered during September and October 2023.

Data on use of the Wellbeing Centre is obtained through sampling, with footfall monitored and recorded (during standard office hours) for one month within each quarter. A total of 263 people were recorded as accessing the Wellbeing Centre in September 2023, with comparative data provided for information in Chart 1 below.



The Staff Care Specialist service provision remains in place via a SLA with NHS Lanarkshire (NHSL). Two Staff Care Specialists (Graeme Bell and Patricia Johnston) each provide support for one day per week. This is on a temporary basis until December 2023, and a new Staff Care Specialist is scheduled to take up post in January 2024, having recently been recruited by NHSL.

A new Peer Support Network was also officially launched on 18 September 2023. Evidence underscores the crucial role of peer support in fostering mental well-being. Having access to support and attentive listening enhances resilience and overall well-being, and providing a supportive space enables processing of experiences, reinstating control, and boosting confidence in handling challenges. A framework to support monitoring, evaluation and sustainability of the Peer Support Network has also been developed.

In addition to the above, plans are currently being put in place to undertake an evaluation of the Staff and Volunteer Wellbeing Strategy.

Staff Engagement & Recognition

A 'Long Service Award' presentation ceremony took place on 7 December 2023, with 50 staff eligible to receive an award (including 2 staff for 45 years service, 5 staff for 40 years service, 11 staff for 30 years service, and 32 staff for 20 years service). This was well attended and hosted by the Board Chair, providing an excellent opportunity to hear from employees about the reasons they have worked with The State Hospital for a number of years.

4. RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP / Corporate Objectives	Links to the Staff Governance Standard 3 Year Workforce Plan, Recruitment & Retention Strategy and Mandatory / Statutory Policy
Workforce Implications	Failure to achieve relevant targets will impact ability to efficiently resource organization, ensure sustainable workforce for present and future.
Financial Implications	Failure to achieve 5% sickness absence target results in additional spend to ensure continued safe staffing levels. Failure to recruit and rtain staff results in additional staffing costs. Potential legal claims where staff are not appropriately trained to undertake their roles.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Corporate Management Team, Staff Governance Committee, Workforce Governance Group, Partnership Forum, HR and Wellbeing Group
Risk Assessment (Outline any significant risks and associated mitigation)	Fully outlined and considered in the report
Assessment of Impact on Stakeholder Experience	Failure to achieve the set targets will impact on stakeholder experience
Equality Impact Assessment	Not required for this report as monitoring summary report.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	
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:	21 December 2023
Agenda Reference:	Item No: 16
Sponsoring Director:	Director of Nursing and Operations / Director of Workforce
Author(s):	Director of Nursing and Operations / Senior Nurse Workforce Planning
Title of Report:	Implementation for Health and Care Staffing Act/ eRostering Update
Purpose of Report:	For Noting

1 SITUATION

The Health and Care (Staffing) (Scotland) Bill was passed by parliament on 2 May 2019 and received Royal Assent on the June 6, 2019 and will be enacted in April 2024. 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.

All territorial Health Boards and those National Health Boards delivering patient facing clinical services are covered by the legislation, which is underpinned by guiding principles and duties. They will report on compliance with the act from April 2025.

The State Hospital are Early Implementers to test out Chapters 5 and 8b of the legislation. Chapter 5 relates to “real time staffing” and risk escalation and Chapter 8b refers to “duty to ensure appropriate staffing”.

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

2 BACKGROUND

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

The Health Care staffing/eRostering Compliance group uses a quality improvement approach as part of the preparation for the forthcoming Health and Care Staffing Legislation. The group report into the Workforce Governance Group, Corporate Management Team (CMT) the Staff Governance Committee and the Board.

The group identified three tests of change, which commenced in June 2023.

These are as follows:

1. Implementation of the eRostering System within the clinical rosters
2. Implementation of the Mental Health and Learning Disabilities Real Time Staffing Template.
3. Implementation of the self-assessment template within Iona Hub clinical team.

3 ASSESSMENT

Health and Care Staffing Act

The State Hospital's newly revised Quarter 2 report was submitted to the Scottish Government (SG) in November 2023. The new template is the version that boards will be asked to report with going forward, we are therefore also testing the template to ensure fit for purpose. We are awaiting response from SG regarding our Q2 report however; continue to get very positive verbal feedback from both Healthcare Improvements Scotland (HIS) and SG. This feedback provides reassurance we are working positively towards our preparedness for enactment in April 2024.

Progress to date

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

- HCSA Compliance Group formed which includes an oversight of the implementation of eRostering. The first meeting was on 11 December 2023 and terms of reference have been developed and agreed.
- Development of a Project Plan to be agreed at meeting on 11 December 2023 (Appendix 1)
- Q2 Self-Assessment has been submitted to SG and we await feedback.
- Multidisciplinary engagement sessions have taken place with Iona & Mull Clinical Teams.
- Joint training with HIS and workforce lead with be delivered in January for the real time staffing resource (RTSR) within Iona Hub.
- Work is currently underway with the programme analyst in creating a security workload task list. This will be evaluated and included in our data capture sheets which will enable us to carry out a test run of the Mental Health Workload & Professional Judgement Tools within an identified ward. This will be completed by February 2024
- A second engagement session was delivered by SG on 8 December 2023 and was well attended by a cross section of staff.
- Workforce Lead remains connected externally with peers from other Health Boards, HIS Hub meetings and Health & Care Staffing Act oversight implementation group and delivered a presentation to the HIS Hub meeting 5 December 2023.

We have dedicated resources from SG and HIS who attend our HCSA Compliance Group as well as providing regular 1:1 catch ups with workforce lead. Feedback is encouraging in that this board is working well towards the enactment in April 2024 with no areas of concern noted.

E-Rostering

The main focus of the Project has been on the implementation of Health roster, Employee Online and Safecare 1 in time for the Safe staffing act coming into force on the 1 April 2024. In addition to this, the Project team have been working on a BAU model. A project plan to support the roll out process for the ward rosters, ensuring they have fully adopted Health roster before the 1 April 2024.

There are a number of additional functions, which we will continue to develop once the main aspects of e-rostering are firmly in place. These tasks will go beyond the 31 March 2024 point in the project plan (Appendix 1) and have been highlighted in red. There further discussion required on the implementation of Loop function. A presentation will be provided to the Health and Care Staffing Compliance Act Group in January 2024 on 'Loop', which is a function of the e-rostering package, which allows staff to book themselves on to any available shifts. This comes a chat function which would require consideration and possible amendments to current information governance guidance.

Tasks that are highlighted in green in the project plan show compliance for the majority of our Monday to Friday rosters.

Risks or issues

- CMT to discuss the implementation of the LOOP function of e-rostering.
- The Project manager and Project Officer posts come to the end of their fixed term on the 31 March 2024 and further discussion required regarding any additional supports required after 1 April 2024.

4 RECOMMENDATION

The Board are invited to note the content and the ongoing work on progress of work to date.

Appendix 1

HCSA Project plan overview

Rag status based on the self-assessment and feedback to date from SG. This will continue to be reviewed and updated by the HCSA Compliance group.

Duties of the Act	Update Report due by	Q3 (Sept – Mar 24)	Q1 (Apr – Jun 24	Q2 (Jul-Sept 24)	Q3 (Oct-Dec 24)	Q4 (Jan-Mar 25)
121a Duty to ensure appropriate staffing	Jan 24					
121c Duty to have real-time staffing assessment in place	Feb 24					
121d Duty to have risk escalation process in place	March 24					
121e Duty to have arrangements to address severe and recurrent risks	March 24					
121f Duty to seek clinical advice on staffing	Feb 24					
121h Duty to ensure adequate time given to clinical leaders	Feb 24					
121i Duty to ensure appropriate staffing: training of staff	Jan 24					
121j Duty to follow the common staffing method	March 24					
121l Training and consultation of staff	Jan 24					
Planning and Security Services	Jan 24					

RAG status

When asked to provide a RAG status, please use this key.

Green	Systems and processes are in place for, and used by, all NHS functions and all professional groups
Yellow	Systems and processes are in place for, and used by, 50% or above of NHS functions and professional groups, but not all of them
Amber	Systems and processes are in place for, and used by, under 50% of all NHS functions and professional groups
Red	No systems are in place for any NHS functions or professional groups

The E-Rostering Project plan overview, in table below shows the key aspects of e-rostering implementation over 2023/24. The rag status indicated current progress against each of these key areas. This will continue to be monitored through the HCSA Compliance Group.

Target Group	2023- 2024		
Quarters	**Q2**	**Q3**	**Q4**
Arran Hub	-Creating Rosters -First Approval -Full Level Approval -Maintaining Rosters -Employee Online -SSTS		-Safe Care 1 -Safe Care 2
Lewis Hub		-SSTS -Creating Rosters -First Level Approval -Safe Care 1 -Maintaining Rosters -Employee Online -Full Approval	-Safe Care 2
Iona Hub		-Maintaining Rosters -SSTS	-Creating Rosters -First Level Approval -Full Approval -Maintaining Rosters -Employee Online -Safe Care 1 & 2
Mull Hub		-Maintaining Rosters -SSTS	-Creating Rosters - First level Approval - Safe Care 1 & 2 -Maintaining Rosters -Employee Online - Full Approval
Supplementary Staffing		-All Wards to have access	
SCN Roster		-SSTS	-Creating Rosters - First Level Approval - Employee Online -Maintaining Rosters -Full Approval -Safe Care 1 & 2

RAG status Green – Completed Amber - started but not completed Red - Not Started

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The Act links closely to the overall clinical and staff governance objectives within TSH.
Workforce Implications	As detailed within the Paper
Financial Implications	This is likely to have financial implications however it is difficult to quantify the levels currently.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board Staff Governance Workforce Governance Group CMT
Risk Assessment (Outline any significant risks and associated mitigation)	Unknown currently
Assessment of Impact on Stakeholder Experience	As detailed within 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).	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:	21 December 2023
Agenda Reference:	Item No: 17
Sponsoring Director:	Interim Workforce Director
Author(s):	Interim Workforce Director
Title of Report:	Organisational Development (iMatter Update)
Purpose of Report:	For Noting

1. SITUATION

This report summarises the status of the 2023 iMatter report within the Board and intention to develop a Board 'Organisational Development Strategy' in 2024.

2. BACKGROUND

At the most recent Staff Governance Committee a detailed report was presented outlining the key themes of the 2023 iMatter report and an analysis of the findings as they related to the State Hospital.

For reference the survey was issued on 23rd May, closing on 19th June, with team reports published on 26th June 2023. From this date the 8-week action planning period commenced, ending 21st August.

- 72% of staff responded - 471 out of 658 staff, which is the same as 2022
- 82% of teams received a report. A total of 12 teams did not achieve a report. This was due to team size and a requirement for those teams to achieve a 100% response rate to protect anonymity.
- The Board's EEI number was 75.
- 53% of teams completed an iMatter Action Plan within the 8-week target timescale.

3. ASSESSMENT

The iMatter survey results for 2023 are broadly similar to last year.

The overall response rates were the same as 2022, with staff continuing to report positive and strong satisfaction in relation to team cohesion, role clarity and line manager support. Slight improvements are evident in relation to staff satisfaction with how performance is managed in the organisation, and perceptions regarding organisational commitment and support for staff health and wellbeing.

While completion of team action plans within the 8-week planning period reduced from 2022, efforts were made beyond this deadline for teams to have their action plans in place.

Key areas identified for ongoing improvement include increasing visibility of Board members, ensuring opportunities for staff involvement in organisational decision-making, and continued focus on supporting the wellbeing agenda across the organisation.

Staff Governance Committee discussed the detailed report which covered in more detail the response rates, areas of strength and challenge, additionally, there was a specific focus on the new questions which were in relation to raising concerns. In response to the response rate and employee engagement index which remained static from 2023, the committee noted this is not surprising, given the challenges and pressures that staff have faced over recent years, as the organisation continues in its recovery from the Coronavirus pandemic and maximize healthy attendance at work.

The national Health & Social Care iMatter Staff Experience Survey for 2023 was published at the end of November. Data comparison is currently being carried out, and key findings will be presented to the Staff Governance Committee and Board in due course.

The committee noted that a new OD manager will start in December, and a key objective for this post will be the development of an 'Organisational Development Strategy'. It was noted that there are many areas of activity already in place across TSH which contribute to organisational development as evidenced in the range of papers presented to the committee. A Strategy providing coherence and a progressive approach to staff engagement and leadership development will support the organisation's response to the iMatter results and ongoing performance against the Staff Governance Standards.

4. RECOMMENDATION

Board Members are invited to note this report and the commitment in relation to an Organisational Development Strategy.

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP / Corporate Objectives	To support 2022/23 Workforce Plan, Wellbeing Agenda and iMatter.
Workforce Implications	Considered in this report
Financial Implications	None identified
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)	Fully outlined and considered in the report
Assessment of Impact on Stakeholder Experience	Fully outlined and considered in the report. It is well evidenced that good workforce morale is directly linked to a more positive patient and staff experience
Equality Impact Assessment	Screened and no implications identified for reporting.
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 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:	21 December 2023
Agenda Reference:	Item No: 18
Sponsoring Director:	Acting Director of Workforce
Author(s):	Acting Director of Workforce
Title of Report:	Whistleblowing Update
Purpose of Report:	For Noting

1 SITUATION

As part of the Whistleblowing Standard, a quarterly update is being provided to the Board on the current situation with any outstanding Whistleblowing Investigations.

2 BACKGROUND

The SPSO (Scottish Public Services Ombudsman) developed a model procedure for handling whistleblowing concerns raised by staff and others delivering NHS services and this was formally published on 1 April 2021. The Independent National Whistleblowing Office (INWO) provides a mechanism for external review of how a Health Board, primary care or independent provider has handled a whistleblowing case. For NHS Scotland staff, these form a 'Once for Scotland' approach to Whistleblowing.

The State Hospital have fully launched the Whistleblowing Standards and the National Policy. A key requirement of the revised standards is notification of case incidence to the Board and Staff Governance Committee.

3 ASSESSMENT

The Quarter 1 update is for 1 July 2023 to 30 September 2023. No Whistleblowing cases were raised during this quarter direct with The State Hospital.

The State Hospital participated in the "Speak Up' Week" during October of 2023. This was organised and facilitated by the Workforce Directorate and the Communications Department. Activates included:

- a word search which had a good response and were able to award 4 winners with prizes,
- a series of communications issued throughout the week, including a joint communication from staff side
- materials were purchased to support stands in wellbeing centre and the main reception
- stands were supported by senior management, communication team, HR / OD team and staff side colleagues at key times throughout the week with

- an article was produced in ‘Vision’ magazine and was available as a leaflet for the stands

4 RECOMMENDATION

Board members are invited to note the Quarter 2 information and confirmation of compliance with the National Whistleblowing Standards.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Links to the National Guidance for Whistleblowing set by the Scottish Government
Workforce Implications	Positive measure in support of Staff Governance Standards.
Financial Implications	N/A
Route to Board Which groups were involved in contributing to the paper and recommendations.	Staff Governance Partnership Forum CMT
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	Failure to adopt would undermine the principles of Partnership Model and Employee Engagement.
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	**X There are no privacy implications.** □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND **SGC (M) 23/03**

STAFF GOVERNANCE COMMITTEE

Approved Minutes of the meeting of the Staff Governance Committee held on Thursday 17 August 2023

This meeting was conducted virtually by way of MS Teams, and commenced at 9.45am.

Chair:

Non-Executive Director	Pam Radage

Present:

Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	Cathy Fallon
Non-Executive Director	Shalinay Raghavan

In attendance:

Occupational Health Secretary	Caron Casey
Training and Professional Development Manager	Sandra Dunlop
Chief Executive	Gary Jenkins
Occupational Health Manager, NHS Dumfries and Galloway	Leanne Keenan
Director of Workforce	Linda McGovern
POA Representative	Garry McKendrick
UNISON Representative	Michelle McKinlay
Head of Planning and Performance	Monica Merson
Board Chair / Non-Executive Director	Brian Moore
Head of Human Resources	Laura Nisbet
Head of Corporate Governance and Board Secretary	Margaret Smith
Personal Assistant	Julie Warren *(Minutes)*
Organisational Development Manager	Brian Young

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Ms Radage welcomed everyone to the meeting, and apologies were noted from Ms Josie Clark, Lead Professional Nurse Advisor, Ms Chelsea Burnside, Occupational Therapist and BOAT / Unison Representative and Ms Jackie McDade, Unison Staff Side Representative.

2 CONFLICTS OF INTEREST

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

3 MINUTES OF THE PREVIOUS MEETING HELD ON 18 MAY 2023

The Committee approved the Minutes of the previous meeting held on 18 May 2023 as an accurate record of the meeting.

The Committee:

1. Approved the minute of the meeting held on 18 May 2023.

4 MATTERS ARISING: ACTION LIST UPDATES

There were no matters arising.

5 ACTION LIST UPDATES

The Committee received the action list and noted progress on the action points from the last meeting.

Ms McGovern provided an update in terms of action point six, Corporate Training Plan and clarified that the differential between medical and nursing training costs was in relation to the differences in continued professional development (CPD) requirements. Programmes for medics tended to be higher in costs or related to conferences. The developments for the learning agenda under Agenda for Change may help to further support nurse development. Medics had contractual right to 30 days study leave within period of three years.

Ms Radage noted that following the committee self-assessment process undertaken a standing item for “areas of good practice” should be added to the agenda.

Members were content to regard all other actions as complete and closed, or with a date to return to the committee.

The Committee:

1. Noted the updated action list.

6 OCCUPATIONAL HEALTH ANNUAL REPORT AND PRESENTATION

Members received and noted the Annual Report which was for the period 2022/23 and had been provided by the previous service provider, SALUS. With the Service Legal Agreement with NHS Dumfries and Galloway having been in place for just under five months, Ms Keenan noted that she would outline the initial focus, current priorities and future opportunities. This also included updates on areas such as case management summary, general immunisation updates as well as Hepatitis B vaccination / Serology Testing, MMR and Varicella Vaccine Appointments and future opportunities.

Ms Keenan advised that a SWOT Analysis was carried out during the transition of Occupational Health (OH) services from the previous OH provider (SALUS) which identified strengths in strong HR and Infection Control engagement, established wellbeing strategy, existing OH building and experienced administrative support. She also outlined potential risks around immunisation and audit. The service was concentrating on the fundamental aspects of OH during implementation of the service, such as management/self-referrals and health clearance, of which immunisation status played a large part.

She further emphasized her concerns in the data contained within the report in relation to Demand and Engagement, in particular, Case Management Referral appointments and the high number of ‘did not attends’ for appointments and vaccinations.

The Committee acknowledged Ms Keenan’s concern in the figures presented and discussion took place around what actions could be taken to ensure staff attended their relevant appointments. Ms McGovern advised that non-availability of staff was being taken forward as an item on the Action Plan for the Task and Finish Group. She further explained that a communication would be issued following the next meeting of the Task and Finish Group to highlight to staff that attendance at scheduled Occupational Health appointments was part of individual's working contract.

Mr Currie suggested that a communication be issued to staff to detail what was a requirement of them and what was optional in terms of attending appointments and that perhaps the figures require to be scrutinised further. Ms Fallon echoed this point and suggestion.

Mr Jenkins requested additional detail in terms of the narrative under Health Surveillance heading. Ms Keenan advised that work would be progressed to evidence if any further health surveillance was required to ensure every staff member was safe.

There was discussion around the table on how health surveillance was being recorded and evaluated. There was agreement that detailed work should be done to establish what the position was and to identify any risks. It was essential to know baseline for data as quickly as possible so that there could be confidence in processes, and acknowledgement of the link required from occupational health to the existing structures for health and safety surveillance.

Ms Fallon made reference to Night Worker's assessments and Vision testing whereby the figures were low and it was reported that four night workers had been identified and screened this year and during the period 2021/2022, six vision screening tests were carried out in relation to Display Screen Equipment (DSE) work. Ms Keenan explained that the statistics were from the previous service provider and it was not mandatory for members of staff to engage in the completion of forms, however it was the role and remit of Managers to take the lead on DSE users and encourage training. Mr Jenkins further advised that DSE practice was carried out and completed in house under the Control Book process.

Mr Connor noted that face-to-face appointments were being held at the Dumfries location, and asked whether these could be facilitated at The State Hospital to accommodate staff closer to their place of work. Ms Keenan advised that appointments had been scheduled at both sites and that best practice was proven to be a telephone consultation however, engagement with the service was disappointingly low.

Ms Raghavan highlighted that staff may be wary of the information sharing and takeover from NHS Dumfries and Galloway Service, and that perhaps it would be beneficial to reassure staff that their information would still be protected and the Occupational Health Service system was a supportive mechanism. Ms Nisbet acknowledged this point and agreed the new service and system in place was an opportunity to promote what information managers and staff have access to in order to engage with the service.

Members acknowledged that the content of this year's Annual Report was of a disappointing nature. Mr Jenkins suggested if it would be beneficial to explore this further with both NHS Lanarkshire and Dumfries and Galloway Services. He referred to the strong key performance indicators in place within the previous SLA, as being a helpful route for assessment of performance. It was agreed that this should be taken forward, and brought back to the committee for review.

Action: Linda McGovern

The Chair took the opportunity and summed up discussion to confirm that a more proactive approach and engagement was required. Staff 'did not attends' case management appointments were a concern and would be summed up to mitigate inefficiencies. A clear statement from the Task and Finish Group on what was expected and required of staff and what was optional would be clarified and circulated site wide.

Action: Linda McGovern

Lastly, Ms Radage reminded the Committee that the new SLA was coming up for its six month anniversary working with The State Hospital and given the early stages, consideration of how to present information in future would be considered and also that sight should not be lost of the positive progress made as detailed within the report.

<u>The Committee</u>:

1. Noted the Occupational Health Service Annual Report.
2. Requested update reporting in regard to the performance metrics, as outlined.

7 CORPORATE RISK REGISTER – STAFF GOVERNANCE UPDATE

The Committee received and noted the Corporate Risk Register Staff Governance update, which detailed the current positon on risks that sit under the Workforce Directorate. Ms McGovern provided an overview of both of these risks i.e. HRD111 – Deliberate Leaks of Information and HRD122 – Compliance with Mandatory Level 2 PMVA Training.

In terms of HRD111, this risk initially sat at High. A Short Life Working Group was established and work was undertaken on reviewing the levels of media leaks over the past 12 months, which were minimal. Additional control measures were put in place including the process for recording on Datix and monitoring Metacompliance levels for Confidentiality Statement, which was now sitting at 95.7% compliance, and the frequency of refresh for staff has been agreed at two years. The overall risk rating has therefore been reduced from High to Medium.

With reference to HRD122, the last update at Health & Safety Committee showed that figures for compliance had dropped to 73.9%. There was concern around a recent increase in RIDDOR figures however further investigation showed that staff involved in incidents were all in date with PMVA refresher training at time of incident. Therefore, the current risk rating has been increased from Low to Medium. To provide assurance to the Committee, it was noted that compliance was improving and the target was to be back on track by end of September 2023. This was also a focus in discussion at the Organisational Management Team (OMT) meetings and given priority during the daily / weekly resourcing meetings.

A further update would be provided at the next Committee meeting in November whereby progress was expected to have been made.

The Committee:

1. Noted the Corporate Risk Register – Staff Governance update.

8 WORKFORCE REPORT INCLUDING TREND ANALYSIS FOR SICKNESS ABSENCE

Members received and noted the Workforce Report, which provided an update on overall workforce performance up to 31 July 2023. Ms Nisbet highlighted key areas from the report and summarised the information under subjects such as attendance management, recruitment, supplementary staffing, employee relations, turnover, job evaluation and PDPR compliance.

In addition to this update, Ms McGovern advised that data was being gathered at this time though not available yet, around whole time equivalent, budgets, age, gender, ethnicity in line with other high secure hospital facilities in England, and Director of Nursing and operations would present this information at the next meeting in November for the Committees awareness.

Action: Karen McCaffrey

Ms Fallon requested additional information around the purpose of the Job Evaluation Steering Group, as this was not clear; and whether this process held up recruiting staff members if job descriptions were not reviewed in a timeous manner, noting the challenges with job matchers' availability. Ms Nisbet advised that staff who support the process were volunteers and carried out this work on top of their own substantive responsibilities to support job-matching panels. Going forward, it is hoped that three panels would be held per month although it was recognised that a working balance was required for staff involved in the process. Ms Fallon queried if panels not taking place affected getting people in to post, which Ms Nisbet confirmed was the case. She further explained that the expected timescale was ten weeks for a Job Evaluation process; however, other factors resulted in the process being extended in certain cases.

In terms of the Workforce Report presented, Mr Connor acknowledged that 41 return to work interviews were completed throughout the month of July, however also noted that there were no return to work interviews completed for 36 members of staff, which was a concern for possibly

missed opportunities to engage with staff. He also noted there were seven departments under the 80% completion threshold for PDPR compliance, which were reported the previous month, and no progress had been made. Ms Merson advised that this topic had been added to the quarterly directorate performance meetings, which were led by the Chief Executive

Ms Fallon also asked if this committee could see the report on shared learning produced from the overview of Employee Relations casework, and it was agreed that this would be the case.

Action: Linda McGovern

Mr Moore further queried whether comparative data could be presented for absence from newer recruits compared to existing staff who had been in the hospital over a longer time. Ms McGovern agreed to take forward with the Task and Finish Group to establish if there was any pattern of absence.

Action: Linda McGovern

Mr Currie expressed the view of ensuring staff on long-term sickness were helped back to work in a swift manner, where possible, and perhaps in a different role to what they are employed to carry out. Ms McGovern advised these actions were routinely taken forward as part of HR processes.

Ms Fallon acknowledged the great piece of work and useful information presented. She also highlighted the good progress made with PR of the hospital with links and engagement with Senior Charge Nurses in line with attracting new recruits.

The Chair welcomed the report and appreciated the work done. She summed up the report noting short-term sickness absence rates were low, however long term sickness figures were increasing. She thanked both Ms Nisbet and McGovern for the very helpful and extensive detail noted within the report.

The Committee:

1. Noted the Workforce Report.
2. Requested further reporting as outlined.

9 TASK AND FINISH GROUP UPDATE RE SICKNESS ABSENCE

The Committee received and noted the update from the Task and Finish Group and their Terms of Reference. Members acknowledged that sickness absence continued to be an upward trajectory over the past several months and at a previous meeting of the Staff Governance Committee it was recommended that a Task and Finish group be established to oversee a number of actions to ensure all supports are in place for staff within the hospital to provide healthy attendance at work.

With reference to the Terms of Reference, Ms McGovern advised that an additional member of staff was to be added to the list of attendance. The work progressed to date was noted and included long and short term analysis work, training, guidance, implementation of the new Occupational Health contract, and role of the Assistant Human Resources Advisor.

Mr Jenkins passed on his comments on the draft Terms of Reference for the group. He suggested the number of attendees be reviewed to focus on a sharp shooting decision-making group and that perhaps success measures were required of what this trajectory looked like. Ms Radage echoed these thoughts on the need for a streamlined group that could take effective succinct action.

Within the Terms of Reference it was noted that an aim would be to 'Achieve a monthly reduction in staff absence rates on a monthly basis, reducing to 5% overall Board wide by December 2023. Individual Directorate reductions would be agreed at the Performance Reviews.' Mr Jenkins highlighted that the clear target was to reach 5% by December. Ms Merson further advised that this target of 5% had been achieved in the last Quarter One last year, so was within the grasp of the hospital and to bear this in mind in future meetings of the Task and Finish Group.

The Chair acknowledged the helpful report and welcomed future updates on progress made in this area. The need for effective speedy action in this area was emphasised, on behalf of the committee.

The Committee:

1. Noted the Task and Finish Group update in relation to sickness absence.

10 WORKFORCE GOVERNANCE GROUP UPDATE REPORT

Members received and noted the Workforce Governance Group update report and Ms McGovern provided members with a summary of the content. Of particular note was the possible industrial action of Junior Doctors. This had been discussed and a full contingency plan was put in place and agreed with the BMA, however this was suspended for the moment pending the outcome of the ballot to the latest offer. The BMA recommended acceptance of the offer though it would not be until September until the hospital fully understand any further issues around this. The Committee were content to note the report.

The Committee:

1. Noted the Workforce Governance Group Report.

11 ON BOARDING SURVEY

The Committee received and noted the Recruitment and Retention Strategy On Boarding Survey Results for Period One. It was recognised that as part of the recruitment and retention strategy, it was established that all new starts would be issued with a link to a survey from the HR Department at three, six and 12-month junctures from their appointment date. The survey captured the information about what had gone well and what could go better for organisational learning, improvement and change of practice where required. All respondents were advised that due to surveys being anonymous, should they have anything specific they wish to be resolved they should discuss this with their direct line manager or Human Resources Representative.

Ms Fallon expressed her concern where two staff reported they had not received information on Fire Safety and not being introduced to their team. Members noted that the Organisational Management Team would be taking forward the actions identified in the paper, as well as the comments noted under the free text section. Mr Young highlighted the comment made "*one respondent did not feel a local induction process was being followed by the department*" and advised that Organisational Development (OD) would also take forward actions in terms of inductions and updating packs.

Mr Moore asked whether there was a consistent approach across the organisation for induction; and also how this compared to local area inductions. Ms Dunlop advised that induction policies were in place, which all staff complete however, departments would have individual standardised induction plans relevant to their service. She further advised that OD were currently refining the Corporate Induction pack so there would be a minimum standard for all staff. It was agreed that this should come back to the committee for information. Ms Fallon also commented on the involvement of Non-Executive Directors in staff inductions and how this could be progressed.

Action(s): Linda McGovern

Mr Jenkins commented on the helpfulness of the data and comments and these could be used to create longitudinal data.

Ms Radage acknowledged the information under the six-month survey results where the focus was around job expectations, tools and resources, concerns, initial PDPR set up, wellbeing and overall feelings of how their first 6 months have went. She felt the information was statistically irrelevant and questioned if there was a correlation of what happens at an early stage to what was

manifested later on.

The Chair summed up the report and felt it useful to have staff comments reported, recorded and actioned.

The Committee:

1. Noted the Recruitment and Retention Strategy - On Boarding Survey Results for Period 1.
2. Requested further reporting as outlined.
3. Asked for an update on Non-Executive Director involvement in staff inductions.

12 HEALTH AND SOCIAL CARE STAFFING/ E-ROSTERING UPDATES

Members received and noted the Health and Social Care Staffing eRostering update which detailed the role of the Board and identified specific actions that required to be progressed to ensure readiness for enactment of the legislation, meanwhile ensuring the Committee remained sighted on the requirements of the legislation.

The Committee noted the content of the report and the ongoing work and progress to date. Mr Jenkins acknowledged the clear graph trajectory though questioned how confident the hospital were on the target to achieve. Ms McGovern advised the RAG status was currently sitting at Amber rating however, staff would seek to push forward as soon as possible. Mr Jenkins stated that there were approximately three Staff Governance Committees scheduled to take place between now and the implementation of the new system in April 2024 and suggested bringing in project milestone reporting and potentially adding to the Corporate Risk Register, given the legislative requirement for the Board to ensure implementation and oversight. Members agreed with having sight of an updated position on Health and Social Care Staffing and eRostering at future meetings until April 2024 when the legislation would be implemented.

Action: Linda McGovern

Mr Moore suggested including this topic in a Board Development Session for Non-Executive Directors in terms of how the legislation would be implemented. Ms Smith agreed to take this forward and add to the Board Development Session planned to take place in September 2023, and further to add as a monthly reporting requirement to the Board as a standing item to enable detailed reporting for assurance.

Action: Karen McCaffrey/ Linda McGovern / Margaret Smith

The Committee:

1. Noted the Implementation for Health and Care Staffing Act and eRostering Update.
2. Agreed that this would be discussed at the Board Development Session taking place on 7 September 2023, and would form monthly reporting to the Board thereafter or as required.

13 WELLBEING QUARTERLY UPDATE

Members received and noted the Organisational Development (OD) and Staff Wellbeing update which detailed the initiatives and activities undertaken within the hospital during May to July 2023. Ms McGovern provided an overview of the report including updates on the newly appointed OD Manager, iMatter, Raising Concerns Report, Staff Wellbeing Activities, Peer Support Network, and Coaching.

Ms Dunlop made reference to page 2, Staff Wellbeing Activities, and advised that the footfall data of ‘310’ was for one month, rather than over a three month period, which emphasized that staff continue to utilise the Wellbeing Centre.

Ms Fallon expressed the view she felt it was heartening to see the data regarding peer support and

six staff members requesting coaching.

Ms Radage thanked Ms McGovern and her team for the positive report and the extensive list of initiatives and events, which took place throughout May to July 2023. She noted the way in which the wellbeing offering helped to provide a safe space for staff, with significant value being seen as this progressed. Mr Young offered assurance that there was considerable work being progressed around evaluation of the strategy, and that more detailed reporting could be brought to the next meeting of the committee.

The Committee:

1. Noted the Wellbeing Quarterly Update Report.

14 NHS EDUCATION FOR SCOTLAND DEANERY QUALITY MANAGEMENT VISIT REPORT – 26 APRIL 2023

The Committee received and noted the report from NHS Education for Scotland (NES) Deanery Quality Management Visit Report on 26 April 2023, which Mr Jenkins provided a summary of. He advised that the NES visit was triggered by the General Medical Council National Training Scheme red flag referred to as "senor training level – clinical supervision out of hours". NES had been informed in the pre-visit paperwork, at the visit and subsequently with the draft report that the State Hospital did not and does not provide any clinical supervision out of hours to senior trainees placed with us during the period of the relevant GMC national training survey. The reason for this was that senior trainees placed with us during day time working hours remained on out of hours rotas within their home health board areas, (for example Glasgow / West of Scotland senior trainees continued on out of hours rota in Greater Glasgow and Clyde, Lothian senior trainees continue out of hours work in Edinburgh, etc.) whilst they were placed at the State Hospital. Therefore, if this flag was to be interpreted it ought to be with respect to the out of hours clinical supervision provided by trainers within the senior trainees' home health boards and not with respect to any trainers at the State Hospital. So in essence, the State Hospital was being marked down for something which does not apply to it. He advised that Professor Lindsay Thomson, Medical Director, had requested that this was kept in mind when interpreting the current data and that this was addressed in future gathering and interpretation of data related to the State Hospital.

In terms of transparency, Members noted the positive report and good practice within The State Hospital with regards to higher training in forensic psychiatry, whilst also acknowledging that there were no quality management issues.

The Committee:

1. Noted the NHS Education for Scotland Deanery Quality Management Visit Report.

15 ONCE FOR SCOTLAND POLICIES: SUPPORTING WORK LIFE BALANCE

Members received and noted the report on the launch for Once for Scotland Policies – Supporting Work Life Balance which Ms McGovern provided an over view of. She advised that Once for Scotland Policies are intended to promote NHS Scotland as a modern exemplar employer, showcasing core values and promoting consistent employment policy and practice that supports the implementation of the staff governance standards. The programme of work created single standardised policies for consistent use across NHS Scotland. Policies were available in a more user friendly way. In April 2020 the first nationally developed suite of policies were received in Boards, these were:

- NHS Scotland Grievance Policy
- NHS Scotland Conduct
- NHS Scotland Attendance Management
- NHS Scotland Capability
- NHS Scotland Investigation Process

Thereafter, NHS Scotland Whistleblowing Policy was launched (effective from April 2021).
On 29 June 2023, The Scottish Workforce and Staff Governance Committee (SWAG) formally approved the 11 policies refreshed under Supporting Work Life Balance. This comprised of the following workforce policies:

- Flexible Work Location
- Flexible Work Pattern
- Retirement
- Career Break
- Special Leave
- Maternity
- New Parent Support
- Shared Maternity and Shared Adoption
- Parental Leave
- Breastfeeding
- Adoption, Fostering and Kinship

Ms Radage questioned how much of a difference there was between the old and new policies. Ms McGovern advised there were changes however, it was likely not to be of great significance.

Mr Currie highlighted that these policies would feed into recruitment and retention and referenced the benefit these would bring to The State Hospital, to which Ms McGovern agreed.

Ms Fallon questioned where the hospital was with the framework for developing the impact of new policies. Mr Young advised he and the Organisational Development Team were looking at a way to take this forward to measure the evaluation of impact and the intent to support HR colleagues at forthcoming staff Question and Answer awareness sessions. Ms Fallon asked if the framework could be pulled together, and Mr Young advised he would be able to support and produce this documentation and also share this at the next Committee.

Action: Brian Young

The Committee acknowledged that local implementation was required and the agreed action plan which was outlined in the report.

The Committee:

1. Noted the Once for Scotland Policies – Supporting Work Life Balance Report.

FORMAL DISMISSAL HEARINGS – NON-EXECUTIVE INCLUSION

Ms McGovern provided a verbal update in terms of Formal Dismissal Hearings – Non-Executive inclusion in relation to national guidance and advised that Non-Executive Directors would be included as part of the dismissal appeal panel. This had not been required at the State Hospital and support and guidance would be provided. Ms McGovern advised that support with case management and training, would be provided by HR staff. Mr Jenkins highlighted the need for a procedural paper to follow this as a supportive mechanism for those involved, and that reference to the change could be made to the Scheme of Delegation.

Action: Linda McGovern

The Committee:

1. Noted the verbal update on Formal Dismissal Hearings – Non-Executive inclusion.
2. Agreed that support and guidance including procedural paper should be produced. Agreed that a review of the Scheme of Delegation may be required, and this should be reviewed.

16 SURVEY – ADDRESSING RACIAL INEQUALITY IN THE WORKPLACE

Ms McGovern advised that a survey was issued to all Public Sector areas in Scotland and was received via the Chief Executive Officer route. She provided assurance that The State Hospital responded to the survey and that the Head of Human Resources and the team were taking forward actions from this, including attendance at national meetings. Ms McGovern further advised that a review was taking place of how HR staff would take forward and obtain support from colleagues given that the previous representation was no longer available at The State Hospital.

The Committee:

1. Noted the verbal update on Addressing Racial Inequality in the Workplace.

17 WHISLEBLOWING UPDATE REPORT

The Committee received and noted the Whistleblowing Report, which provided members with an update on the current situation of any outstanding whistleblowing investigations. It was recognised that no formal Whistleblowing cases were raised during this quarter directly with The State Hospital. Members noted the data for Quarter One and took assurance of the compliance with the National Whistleblowing Standards.

The Committee:

1. Noted the Whistleblowing Update Report for Quarter 1.

18 PARTNERSHIP AGREEMENT

The Committee received and noted the Partnership Agreement, which was recently updated and approved by the Partnership Forum.

Ms Fallon questioned in terms of Section 5.2.4 Staff Governance Committee heading where it stated within its specific responsibilities would include “supporting the remuneration committee to cover staff under executive and senior manager pay arrangements, and validating the work of that committee”. Mr Moore confirmed he would confirm this with Mr David McConnell (Remuneration Committee Chair) as this was part of guidance for Remuneration Committees to ensure evaluation of how this role was being carried out.

Action: Brian Moore / David McConnell

The Committee:

1. Noted the updated Partnership Agreement.

19 PARTNERSHIP FORUM APPROVED MINUTES

Members received and noted the approved Partnership Forum minutes dated 23 May 2023. Clarity was sought in terms of the narrative under item 9b and the position of the Health and Safety Representative. Mr Jenkins clarified that the hospital has a Health and Safety Representative working two days per week within the organisation.

The Committee:

1. Noted the approved minutes of the Partnership Forum held on 23 May 2023.

20 UPDATE REPORT FROM HR AND WELLBEING GROUP

Members received and noted the update from the HR and Wellbeing Group. Ms McGovern provided updates on areas such as organisational development update, workforce report, job evaluation status report, working from home guidance, peer support network promotion and

launch, and presentation on the Equalities Agenda. She advised that as part of the Equalities Agenda, the group had been considering for some time how to support those staff who are within the key characteristics of the legislation. It was recognised that the group were keen to offer different and relevant outreach support to staff. As part of this, the Equality & Diversity Manager from NHS Lanarkshire was invited to present to the Group on how their networks could be utilised to support State Hospital staff too. This was a helpful presentation and NHS Lanarkshire were supportive of assisting in future. Ms McGovern advised that moving forward; the plan was to link closely with the network group within NHS Lanarkshire and open these up to staff within The State Hospital. She advised that an update on this area would be provided at the next committee and detailed within the HR and Wellbeing Group report.

Action: Linda McGovern

The Committee:

1. Noted the update from the HR and Wellbeing Group.

21 AREAS OF GOOD PRACTICE / AREAS OF IMPROVEMENT

Mr Currie advised he was thankful for the discussions which took place today and that there were a number of areas identified where additional information was requested in terms of figures and monitoring and these would therefore set up to strengthen the detail and discussion within future Committee meetings. He also stated that this would allow the Board to make more strategic decisions.

22 ANY ISSUES ARISING TO BE SHARED: GOVERNANCE COMMITTIES

Ms Fallon advised she and Ms Radage had discussed the overlap of Health and Care Staffing legislation and eRostering with the Clinical and Staff Governance Committees and would continue to take forward discussion around this to ensure that the right governance route was being taken.

Action: Ms Pam Radage / Ms Cathy Fallon

The Committee:

1. Noted the update.

23 ANY OTHER BUSINESS

There was no other business raised.

24 DATE AND TIME OF NEXT MEETING

The next meeting will take place at 9.45am on Thursday 16 November 2023.

Meeting concluded 1230 hours.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	21 December 2023
Agenda Reference:	Item No: 19
Title of Report:	Staff Governance Committee – Highlight Report
Purpose of Report:	For Noting

This report provides an update on the key points arising from the Staff Governance Committee meeting that took place on 16 November 2023.

1	Corporate Risk Register Quarterly Update	The Committee received the quarterly report regarding the corporate risks assigned to the Workforce Directorate. The Committee acknowledged the risks and noted work undertaken to mitigate risks, as outlined in the report.
2	Staff Governance Monitoring Return	The Committee considered the draft return which was due for submission to the Scottish Government by 4 December 2023, and which had been considered and approved in Partnership Forum and Corporate Management Team. There was discussion regarding the range of examples reported within the template noting that this is reflective of financial year 22/23. The Committee approved the return for submission to Scottish Government.
3	Workforce Report / Task and Finish Group Attendance Management	A refined workforce report was presented to the Committee outlining the key metrics across workforce data. The progress made in relation to sickness absence was noted in the months of September and October. The developments in recruitment were also highlighted due to ongoing and concentrated efforts throughout 2023.
4	Guidance on Dismissal Appeals	The Committee welcomed guidance which was prepared to support the Non Executives role in Appeal against Dismissal Panels. This was intended to compliment the suite of supporting documents which are contained within the Once for Scotland platform and reassurance was given that this is consistent with the Once for Scotland policy framework and hearing guide.
5	Whistleblowing	Quarterly update report, with no new cases reported, and confirmation of the work which was undertaken for Speak Up Week.
6	Workforce Governance Update	The Committee received an update on the activity within the monthly Workforce Governance Group, and acknowledged the range of development requests, guidance and updates which are discussed within this group.

7	Preparedness for Health and Care (Staffing) Scotland Act: April 2024 go live, and e-rostering implementation	A report was presented to ensure the Committee were sighted on the requirements of the legislation, the role of the Board and to identify any specific actions that required to be progressed to ensure readiness for enactment of the legislation. The State Hospital's Quarter 1 report was submitted to the Scottish Government in July 2023. A response was received providing reassurance that the State Hospital (TSH) is working positively towards our preparedness for enactment in April 2024. The report also gave areas to be considered which will be included in the newly revised Q2 report which is due to be submitted in November 2023. A copy of this submission will be available at the next meeting.
8	Practice Development Update	A report was presented updating on the work of Nursing Practice Development Service, aligned to the key priorities identified for the NPD service. The Committee welcomed the report and had a discussion regarding the merits of peer support alongside other supervision and support models available in TSH.
9	Organisational Development, Learning and Wellbeing Report	A report was presented providing an update on organisational development (OD), learning and wellbeing work streams and associated activities within the State Hospital. This included updates on PDPR completions, statutory and mandatory training compliance, and staff wellbeing activities. Members also welcomed the new streamlined report which would be continued going forward.
10	iMatter Report – State Hospital Survey	A report which summarised the key themes of the 2023 iMatter reports and provides a short analysis of the findings as they relate to the State Hospital was presented to the committee. It was noted that the national report has not yet been compiled, so national comparisons are not possible at this time. There was agreement to link the reporting to the Organisational Development Strategy.
11	Once for Scotland Policies update	Reassurance was given on the implementation of the suite of national policies, in accordance with the locally agreed action plan. In addition, an outline evaluation framework was presented noting that the policies were effective from 1 November 2023 and therefore would need more time for evaluation.
12	Areas of good practice	Progress on streamlining on reporting for the Committee, enabling more focused discussion within the meeting. Continued consideration of potential cross over to other Committees, especially the Clinical Governance Committee.

RECOMMENDATION

The Board is asked to note this update, and that the full meeting minute will be presented, once approved by the Committee.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP / Corporate Objectives	As part of corporate governance arrangements, to ensure committee business is reported timeously
Workforce Implications	None
Financial Implications	None
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board requested, pending approval of formal minutes
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	None
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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	21 December 2023
Agenda Reference:	Item No: 20
Sponsoring Director:	CEO
Author(s):	Head of Corporate Planning and Performance
Title of Report:	TSH Delivery Planning 2024/25
Purpose of Report:	For Noting

1. SITUATION

Scottish Government have produced guidance for NHS Boards to develop delivery planning for 2024-25. The guidance requests that NHS Boards update their medium term plans into three year delivery plans with detailed actions for 2024/25 which are aligned to both their three year financial plans and the ministerial priorities, including recovery drivers. There is an expectation that the delivery plan will be affordable within the context of the Boards financial plan and Boards should ensure that the workforce is in place to support service delivery. The delivery plan should be submitted by 7th March 2024.

2. BACKGROUND

The Annual Delivery Plan (ADP) forms part of the governance and sponsorship arrangements with Scottish Government. These plans have outlined what each Board will deliver across the year and how they intend to take forward activity to progress the recovery drivers, integrating work with the Care and Wellbeing Portfolios where possible. Quarterly reports on progress are submitted to Scottish Government throughout the year to update and discuss delivery and emerging priorities and issues. Recent planning in NHS Scotland has been on an annual basis, with NHS Boards submitting annual delivery plans (ADP).

In 2023-24, the Scottish Government also commissioned NHS Boards to develop medium term plans (MTP) to outline delivery over 3 years. The State Hospital did not provide a medium term plan in 2023/24, in agreement with Scottish Government Health Planning and the Mental Health Policy Team due to ongoing uncertainty about the longer term governance and strategic leadership structure of forensic mental health system

3. ASSESSMENT

The Scottish Government launched in November 2023 the Mental Health and Wellbeing Delivery Plan 2023 – 2025. This plan outlines how Scottish Government intend to deliver on the commitment set with the Mental Health Strategy June 2023. An overarching aim of the delivery plan is to improve the governance, leadership and oversight of mental health services, including forensic services.

Of note for TSH, the commitments to continue to improve support for those in forensic mental health settings, with the lifespan of the plan:

1.1.1 Bring together key stakeholders to agree a clear plan for addressing the Strategic Planning and Governance for Forensic Mental Health Services (recc 1 of the Baron Review)
1.1.2 Develop a plan to deliver services in Scotland for women who need high secure treatment and care in the short and long term
1.1.3 Address the key gaps in data collection and reporting on forensic mental health services by developing an improved system of data collection and monitoring of outcomes
1.1.4 Consider changes to practice and legislation that will improve the delivery of forensic mental health services for service users and put in place a plan for taking these improvements forward.

The above commitments will interconnect with the planning agenda for TSH. However it is difficult to accurately predict beyond 2024/25, what will develop from these commitments and when it is likely to impact on TSH strategic and operational planning

TSH have requested agreement from Scottish Government Health Planning and Mental Health Policy Teams, that we submit An Annual Delivery Plan for 2024-25 with detailed actions for the year, aligned with the financial plan. The production of the medium term or 3 year plan can then follow in 2024 when there is clarity from the Mental Health and Wellbeing Delivery Plan 2023 – 2025 commitments above. A meeting has been planned for early January 2024, at the request of Scottish Government Health Planning to discuss the delivery and financial plan with an aim to ensure financial balance for delivery over 2024/25.

4. RECOMMENDATION

Board members are asked to note the content of the paper.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The Annual Delivery Plan sets out the key delivery priorities for TSH over the period.
Workforce Implications	Not assessed formally – the plan outlies the key strategic responsibilities for TSH in terms of workforce
Financial Implications	Not assessed formally – the plan outlies the key financial responsibilities for TSH
Route to Board Which groups were involved in contributing to the paper and recommendations	Direct to Board
Risk Assessment (Outline any significant risks and associated mitigation)	Not formally assessed
Assessment of Impact on Stakeholder Experience	The plan sets out the key deliverables for TSH and will be monitored by SG
Equality Impact Assessment	An EQIA is not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A/
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One 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:	21 December 2023
Agenda Reference:	Item No: 21
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 31 October 2023
Purpose of Report:	For noting – update on current financial position

1 SITUATION

This report provides information on the financial performance, which is also issued monthly to Scottish Government (SG) along with the statutory financial reporting template.

The Board is asked to note the Revenue and Capital Resource outturn and spending plans.

2 BACKGROUND

The approved annual operating plan for 2023/24 has been submitted to SG and signed off. Initial preparatory work towards 2024/25 budget and a three-year forecast is now underway with draft submissions due in early 2024.

Any remaining residual Covid-related costs are now recognised through specific directorates under "business as usual" and will continue in this manner with due recognition of the resultant pressures from any additional posts therefrom.

Any delay costs from the Perimeter Project, which are being monitored by the Project Board and are reported directly to the Board, are reviewed, quantified for consideration, and reported appropriately.

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £43.860m is primarily the forecast Scottish Government Revenue Resource Limit core and non-core allocations, and additional allocations as anticipated on a recurring basis.

A letter was issued on 1st August from the SG Director of Health Finance and Governance notifying National Boards that there would be a potential 5% or 10% reduction and clawback regarding additional in-year allocations, in order to reduce overall expenditure and increase savings. While the notification specifically exclude TSH's allocations at this stage, we need to remain aware and alert that such options are potentially being considered across NHSScotland.

The October accounts show an overspend to date of £0.045m, with an in-month adverse movement of £0.362m – principally being the effect of salary arrears for Consultants and Specialty Doctors, of which costings have been provided to SG. 2023/24 salary increases for Senior Management, including a one-off payment and arrears, also went through in the same month, with an element of ward nursing also overspent (see 3.4). Pending RRL adjustment has been confirmed with SG at the most recent quarterly finance update meeting.

PAIAW ("Payment as if at work") funding continues to be held as a reserve for the current year, and released monthly to match actual cost. This continues to be a significant element for the Board regarding our high levels of overtime and high nursing vacancies.
Some pressure also potentially remains re prior years' PAIAW still outstanding – with claimants now being in the hand of CLO (and some of whom have now recently been paid.) This was accrued in 2022 and again at March 2023, and the matter remains ongoing.

In the previous year, some costs of the project works started in 2021/22 re eRostering *(see para 3.2)*, M365 licences, and related pressures were accrued to fund an element of anticipated costs in 2022/23 – and from this any unutilised elements were carried forward to 2023/24.

3.2 Key financial pressures / potential benefits.

Revenue (RRL): -
Covid-19
Some posts were reviewed for permanency, and are reviewed for addressing throught directorate budgets.

eRostering Project
While provision was noted for the contractual implementation costs of the eRostering project in 2022/23, this project is now rescheduled nationally by NSS to implement across 2023/24 and 2024/25. Currently unfunded are the additional posts potentially required in order to manage this implementation – being two posts requiring an annual funding of approx. £83k. This pressure has been highlighted and is being addressed.

Clinical Model review update
Current indications are that the budget for overtime should remain in place, while savings targets have been set at 2% - anticipated from leavers at higher points in the bands' scales being replaced with starters at lower points of the scales.

Energy and inflation increases
The rising costs of energy supplies and the knock-on effect on other supply chain deliverables will continue to be closely monitored as it is expected that there could be significant pressure in the winter period in 2023/24 – previously estimated at an increase of £300k (accrued March '23), this has now been revised to £550k.

Extra PH for Coronation holiday
It is noted that there is the cost of one day's additional holiday in 2023/24, recurring from 2022/23 (Platinum Jubilee) for the Coronation holiday.

Benefits
Travel underspend has resulted in budgets being reduced in 2023/24, to reflect changed ways of working.

3.3 2023/24 Budget

The 2023/24 final budget template required by SG has been submitted, including revised savings requirements of £0.8m, with forecast outturn breakeven.

Energy cost increases are anticipated in the coming year due to market price increases, and pressures are noted for taking forward of new posts and structures established through Covid.

While the capital budget for 2023/24 remains at a recurring level of £269k, capital priorities are monitored and agreed through the Capital Group, and requirements for spend in the coming year have been notified to CMT – also noting that additional project funding will be considered when appropriate for any priority projects not affordable through the recurring funding.

3.4 Year-to-date position 2023/24 – allocated by Board Function / Directorate

Directorates	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	Variance (budget less actuals) for period	Budget WTE	Actual WTE
Nursing And Ahp's	22,912	13,619	14,253	(634)	403.08	413.71
Security And Facilities	6,576	3,869	4,014	(144)	123.82	117.15
Utilities	732	427	465	(38)	0.00	0.00
Medical	3,307	1,930	1,834	97	22.75	19.63
Chief Exec	2,340	1,369	1,370	(1)	26.07	25.33
Human Resources Directorate	1,090	640	621	19	16.30	16.89
Finance	3,069	1,824	1,848	(24)	29.18	30.38
Cap Charges	2,868	1,673	1,676	(4)	0.00	0.00
Misc Income	(200)	(117)	(209)	92	0.00	0.00
Central Reserves	1,166	648	56	592	0.00	0.00
	43,860	**25,883**	**25,928**	**(45)**	**621.20**	**623.09**

Nursing

- Spend is now being assessed in detail against budgets to review and confirm accuracy of forecasting. Unutilised central reserves have been phased Apr – Sept to offset overspend. RRL is being addressed re Oct – Mar (balancing from unutilised surplus pay award within allocation).
  Large numbers of vacancies mean that backfill is being covered by overtime; and there have been high numbers of patients boarding out which has also impacted.

- Psychology vacancies continue which helps offset some of the ward nursing overspend.

- PAIAW and overtime reserves now released monthly against pressures.

Security & Facilities

- Utilities has been extracted from Security to show separately in order not to distract the directorate budget from core activity. Accruals brought forward are contributing to funding the pressure to date, including overtime pressures noted.

- There are remaining covid pressures for disposable items being used for patient food delivery, also food price increases are causing pressure in the kitchen and staff restaurant.

Medical

- Base budgets were set on March salaries and inflated by 2.5% for expected pay uplift in 23/24; which has been reviewed following the final pay circular with arrears were paid in October and costings forwarded to SG.

- More Consultant time is being recharged for work done at other Boards; which will reflect in budgets on confirmed receipt of RRL.

CE

- Benefit is noted from vacancy management, while CE & Senior Managers' 23/24 pay increase, including one off payments and arrears, was issued in October.

HR

- Corporate training is noted as having very little spend to date, with forecast being confirmed of anticipated spend to year-end.

Finance

- eHealth strategic RRL has been released non-recurringly for staffing pressures, with further contract costs have now been funded.

Capital Charges

- The budget was adjusted in June 2023 to reflect the increase in 2023/24; which has been met from reserves.

Miscellaneous Income

- The budget recognises income billed for exceptional circumstance patients, with appropriate risk provision for older balances with boards with whom recoverable balances are being discussed.

Central reserves

- These were initially phased to Month 12 (March 2024) – much of which has been released to offset the ward nursing overspend as noted above in 3.4, hence the currently large balance will reduce proportionately as year progresses.

4 ASSESSMENT – SAVINGS

Savings are phased evenly over the year (twelfths), and equate to approx. £0.8m (2%).

Cumulative Savings	Savings - Annual Target	Achieved to date	(under)/over achieved
Directorate	**£'k**	**£'k**	**£'k**
Chief Executive	(39)		(39)
Finance	(57)		(57)
Nursing & AHP's	(440)	336	(104)
Human Resources	(25)		(25)
Medical	(65)		(65)
Security & Facilities	(140)	35	(105)
Total	**(766)**	**371**	**(395)**
1/12ths of target	(447)	371	(76)

It should be noted that of the Hospital's budget only 15% of costs are non-pay related, certain boards also treat vacancy savings, or a proportion thereof, as recurring savings, we still class as non-recurring.

National Boards Contribution

The eight National Boards (formerly Special Boards) continue to work towards joint efficiencies and collaborative working. The recurring level of contribution to the collective £15m savings challenge which the Board agreed and approved for 2022/23 remained at £0.220m, with 2023/24 to be confirmed.

This has now been reflected in the base allocation so removed from anticipated RRL.

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation anticipated from Scottish Government for 2022/23 is £0.269m, which is anticipated to be fully utilised with capital projects planned and agreed through the Capital Group. Certain projects are likely to require requests on a project-by-project basis to SG for additional funding, including anticipated backlog maintenance work required on the Hospital.

With regard to the Perimeter Security Project allocation, there are elements of delays in the Project – now expected to be completing in 2023/24 Q4 – requiring carry forward of unspent monies. SG are up-to-date with the anticipated project outturn and conclusion.

CAPITAL CRL 2023/2024 AS AT OCTOBER 2023	ANNUAL PLAN £'k	YTD SPEND £'k
SECURITAS TECHNOLOGY LTD (previously Stanley)		74
THOMSON GRAY LTD		134
TSH STAFFING		104
BRICK & STEEL		43
PERIMETER SECURITY TOTAL	**671**	**356**
IM&T		17
CAPITAL CRL	**269**	**17**
Backlog Maintenance (awaiting funding)	**405**	**6**
Total CRL	**1,345**	**379**

6 RECOMMENDATION

The Board is asked to note the following position and forecast –

Revenue
The year to date position is an overspend of £0.045m. Forecast for the year remains for a breakeven position to be achieved, with pending RRL adjustment re pay costs (confirmed with SG and with final adjustment due early 2024).

Capital
Some projects are at the evaluation and quotation stage, with forecast for the year being for full utilisation of the annual allocation.

MONITORING FORM

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

NIS Audit Programme 2023

Final Report

The State Hospital

OFFICIAL SENSITIVE

Version Control

Document Creation

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Revision History

Version	Date	Changes Summary
1.0	11 Dec 2023	Final Report

Release Authorisation

Name	Title	Date	Version
Keith Nicholson	Executive Chair	11 Dec 2023	1.0
Marion Chapman	Director Audit & Assurance	11 Dec 2023	1.0
George Irvine	Scottish Health Competent Authority, Digital Health & Care, Scottish Government	11 Dec 2023	1.0
Cara Archibald	Scottish Health Competent Authority, Digital Health & Care, Scottish Government	11 Dec 2023	1.0

Contents

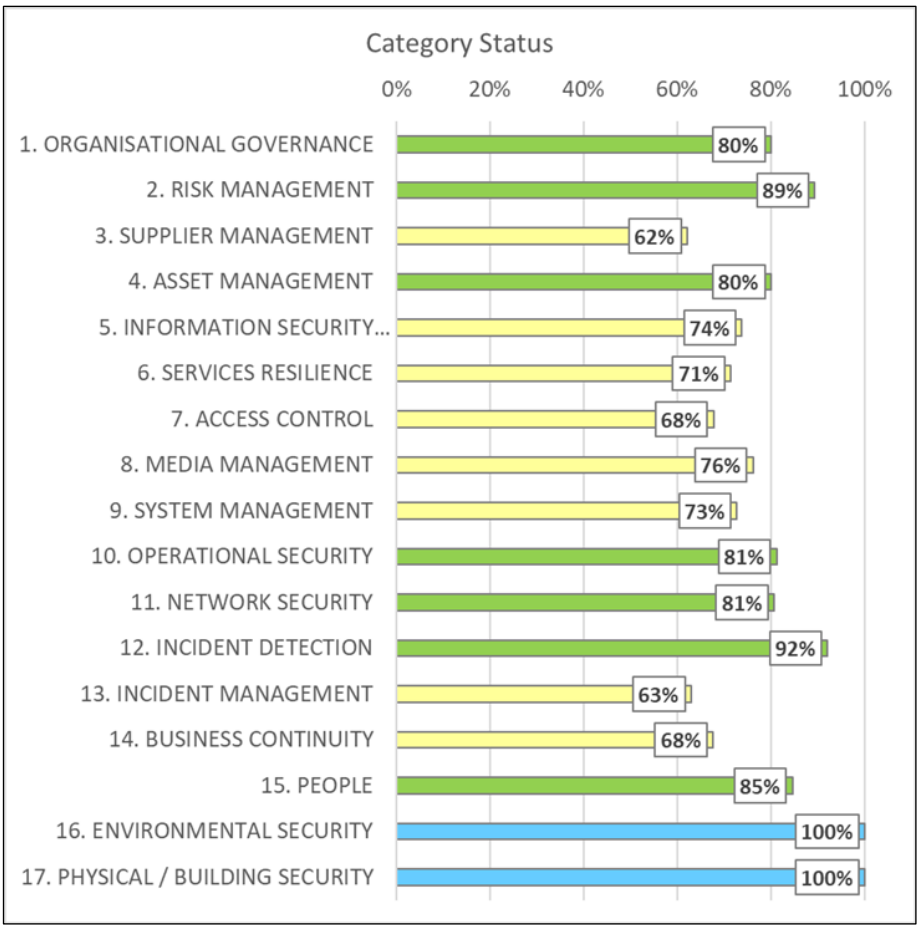
Executive Summary

Key Messages

- The State Hospital is a strongly-performing board with a clear commitment to the NIS audit programme, as shown by the level of attendance of executive and non-executive staff at the management meeting.
- This is reflected in the data analysis summarised below, which shows
  - an overall compliance status of 76%;
  - all 17 categories and 56 (82%) sub-categories rated at 60% compliance or above and nine categories attained levels of over 80%.
  - 279 of the controls have been achieved (65%).
- This is only a single sub-category less than 30% compliant and therefore a priority for development which is 14.4 BC/DR Testing Policies & Procedures.
- The involvement and support of the Chief Executive and SLT to the NIS audit has been a critical factor in this achievement. An approach that is to be commended as an exemplar to other boards.

Board Performance Summary

COMPLIANCE STATUS						
OVERALL	**CATEGORY (17)**		**SUB-CATEGORY (68)**		**CONTROLS (427)**	
76%	**100%**	**2**	**100%**	**25**	**Achieved**	**279**
	≥ 80%	**7**	**≥ 80%**	**11**	**Partially**	**70**
	≥ 60%	**8**	**≥ 60%**	**20**	**Not Achieved**	**66**
	≥ 30%	**0**	**≥ 30%**	**11**	**N/A**	**12**
	<30%	**0**	**<30%**	**0**		
	< 10%	**0**	**< 10%**	**1**		



1. Introduction

Background

In 2020 the Scottish Health Competent Authority commissioned a three-year programme of audits and reviews of health boards to evaluate compliance with the Network & Information Systems (NIS) regulations. This first three-year audit programme cycle has been completed. This report details the outcome of the first audit of the second three-year cycle.

Scope

The scope of the audit is whole-organisation against all controls in both Tier 1 and Tier 2 of the Revised Public Sector Cyber Resilience Framework. All areas of the health board are involved, as controls are assigned to key groups: Senior Management, Procurement / Contracts / Legal, Technical Team, Human Resources / Organisational Development and Facilities / Estates.

Methodology

The following standard Cyber Security Scotland audit methodology summarised in Table 1.1, has been agreed with the Scottish Health Competent Authority (SHCA) to be applied to health boards for the NIS audit process. Additional information on the process and associated guidance to health boards are detailed in the document suite issued to health boards (see www.healthca.scot).

Supporting documents:

- NHS Scotland Health Boards Audit Dates 2023-24, 1pp.
- Network & Information Systems Regulations 2018 : 2023 Audit Programme: Health Board Guidance, 9pp.
- Network & Information Systems Regulations 2018 : 2023 Audit Programme: Evidence Template, 60pp.

Table 1.1 : NIS Regulations Audit and Assurance Methodology:
Summary of 14-Stage Procedure.

PHASE 1	DATA GATHERING
Stage	Details
Site Inspection and first series of individual staff meetings.	The site visits and inspections are designed to be implemented separately to de-risk the process and ensure that site inspections and early staff meetings take place even in the event that other circumstances intervene. At the site inspections the auditor will meet with any members of staff the board wishes to present, as well as those identified in the guidance and have individual staff meetings as required. The auditor will report fully on their observations any supporting or supplementary evidence they are advised of and also on the outcomes of site inspection against relevant controls. This report will contribute to the board audit report.
Stage	Details
Documentary evidence upload	The boards will submit their evidence, new guidance which better explains the nature of evidence has been provided. This follows the policy/process/ implementation approach which makes it much clearer and easier for boards to understand and submit exact evidence. In addition to this there is a new evidence template which enables boards to avoid the necessity of folder construction and labelling and instead upload their evidence in one bulk load. The evidence template allows boards to annotate exactly what evidence they are submitting for a control and allows additional narrative if required. This means that boards should be assured that absolutely no evidence is missed. If the evidence submitted does not meet a control, then the auditors will note the reason for this against the control.

Table 1.1 (continued) : NIS Regulations Audit and Assurance Methodology:
Summary of 14-Stage Procedure.

PHASE II	CONTROLS COMPLIANCE EVALUATIONS
Stage	Details
Evaluation & areas for focus in second series individual staff meetings	As this evidence is evaluated the auditors will compile an agenda to discuss with the board. This will include things like but not exclusively, for example, weak areas of evidence, areas where evidence was submitted but was not relevant and anything else the auditors identify that they feel requires, or could benefit from, further discussion with staff. Related further evidence may be submitted immediately after these meetings and ahead of the interim report. It Is important to note that the evidence evaluation is a long, intensive and detailed process, it is not unusual for 1 control to take over an hour to assess and there are over 400 controls. It is also important to note that whilst additional evidence may be submitted in response to these staff meetings this is not a full resubmission of evidence. Ahead of week number 6 in the evaluation timetable the auditors will issue an agenda, based on their evaluation findings to date, to the board. The board must then ensure that staff are available on the planned date (notified in the guidance at the outset) and arrange the calendar appointments with the auditors/staff on the date allocated. Who the auditors will wish to meet and the amount of time required for each meeting will be determined by the evidence evaluation, for example if a section is scoring highly in compliance, then it is unlikely the auditors will need to meet the team for that work area. During the evaluation phase analysis of the controls also takes place, giving the graphs and tables in the audit report.
Data Analysis	Compliance assessments at sub-category, category and overall evaluations to identify gaps in compliance for discussion.
Second individual staff meetings	The second staff meetings will take place by Teams and will be held on the date allocated to the board in the guidance and timetable. Some flexibility is possible and will be applied if auditors are available but not to the detriment of other boards nor to the extent that a delay of the Interim Report would occur. The boards have, in most cases, months of notice of their timeline and it is their responsibility to make sure staff who can respond to any of the 17 sections of the audit keep their diaries free for the possibility of a meeting. If the board has any specific member of staff they would like to meet with the auditors at this stage of the process they should make the auditors aware of this when they submit their evidence. It is important to note that the auditors understand the audit approach and require the flexibility to ensure that they get the information they need to provide a quality and robust report.
Data Analysis	Revised and updated final compliance assessments at sub-category, category and overall evaluations based on discussions and any supplementary documentation.
Data Presentation	Generation of graphic data representations for inclusion in the Interim Report.

PHASE III	INTERIM REPORT
Stage	Details
Drafting of Interim Report	To include all data analysis, compliance outcomes, and observations from on-site inspections and staff meetings
Quality Assurance	Review of Interim Report and compliance evaluations.
Issue of Interim Report	To boards and SHCA.
Management meeting	This meeting is with the Senior Leadership team, members of the board and ARC as required, determined by the health board. The SHCA will aim to attend all Management Meetings as an observing attendee(s).

Table 1.1 (continued) : NIS Regulations Audit and Assurance Methodology: Summary of 14-Stage Procedure.

PHASE IV	FINAL REPORT
Stage	Details
Drafting of Final Report	To include observations from the management meeting.
Quality Assurance	Review of Final Report and compliance evaluations.
Issue of Final Report	Final report is issued to the SHCA and thence to the boards.

Compliance Assessments

Each control was assessed against the criteria shown in Table 1.2 and the results presented against the control.

Table 1.2: Control Compliance Assessment Criteria.

Control Assessment	Detail
Achieved	Requirement full addressed, comprehensive policies/procedures with evidence of implementation.
Partially Achieved	Requirement partially addressed, inconsistent policies/procedures; absent or inconclusive evidence of implementation.
Not Achieved	Requirement not addressed, inadequate policies/procedures.

The overall compliance status at subcategory, category and overall board status are calculated on the basis of the proportion of controls achieved or partially achieved.

To facilitate clear information design and ready assimilation of the areas of board vulnerability and risk, these ratings are placed into colour bandings as defined in Table 1.3.

Table 1.3: Compliance Status Bandings.

Status	Definition	Detail
Black	Critical	Compliance analysis < 10% compliance Fundamental absence or failure of controls – immediate action is required.
Red	Urgent	Compliance analysis ≥ 10% High risk exposure – absence or failure of key controls exposing the organisation to breach or non-compliance.
Amber	Important	Compliance analysis ≥ 30% Moderate risk exposure – controls are in place but not working effectively, risking compliance or security breach
Yellow	Attention	Compliance analysis ≥ 60% Minor risk exposure – controls or procedures are working effectively but not as efficiently as possible or as required.
Green	Guidance	Compliance analysis ≥ 80% Minor control strengthening changes required or application of protocols enforced.
Blue	Complete	Compliance analysis =100% All requirements in all categories fulfilled.

2. Audit Outcomes

Staff Meetings

The following staff were met through the audit process.

Name	Position	Onsite Meeting	Staff Meeting	Management Meeting
John Fitzgerald	NIS Lead & ISO	✓	✓	✓
Karen Mowbray	Heath Records Manager		✓	
Robin McNaught	Director of Finance & SIRO		✓	✓
Alan Hardy	Head of Risk & Resilience		✓	
Thomas Best	Head of eHealth		✓	
Robert Jamieson	Data Analyst		✓	
Brian Moore	Chair			✓
Alan Connor	Employee Director			✓
Catherine Fallon	NxD			✓
David McConnell	Vice Chair			✓
David Walker	Director of Security, Resilience and Estates			✓
Karen McCaffrey	Director of Nursing and Operations			✓
Pam Radage	NxD			✓
Smith, Margaret	Head of Corporate Governance			✓
Thomas Best	Head of eHealth			✓
Observers				
George Irvine	SHCA	✓		✓
Cara Archibald	SHCA			✓

Observations

In a clear commitment to the NIS Audit programme, the audit preparations were well-organised with the evidence clearly presented and meetings arranged in advance. The presentation of the evidence was specifically cross-referenced to individual controls with complementary narrative to offer explanation to the relevance of the documents provided. In discussions, staff noted that SLT including the Chief Executive, were supportive of the NIS audit, arranging regular meetings to review progress and ring-fencing key staff time to be directed towards the audit programme. As a consequence there was greater awareness of the NIS audit across the health board, including the non-executive board members and the Audit and Risk Committee.

The board has benefited from this level of commitment to the audit process and clarity of evidence, achieving a high level of compliance across the board, with all 17 categories and 56 (82%) of the 68 sub-categories achieving a compliance of 60% or more; nine categories attained levels of over 80%. The board has therefore achieved two of the 60-60-0 Key Performance Indicators, with the third close to achievement; being prevented by only a single subcategory with <30% compliance.

Overall compliance is at 76% a significant achievement, showing strength across the organisation and a high level of performance. This analysis is against the new framework controls which has 42 (10%) new or revised controls in comparison with the framework used in the first audit cycle; for interest only, against the old controls this would represent an overall compliance of 86%.

This achievement is all the more remarkable given this is a small board without dedicated a cyber security officer or team. In our view this is directly related to the involvement of the Chief Executive and SLT in giving organisational guidance and priority to NIS across the health board, thereby offering sufficient time for planning, preparation and evidence submission., An approach that is to be commended and an exemplar to other boards.

Strengths

As illustrated by the structure of this report, compliance with the NIS regulations is a whole-organisation responsibility involving a range of teams and staff. The board has demonstrated strengths in a number of sectors; of particular note are those areas that have achieved compliance levels in excess of 80%; namely:

- 1. Organisational Governance
- 2. Risk Management
- 4. Asset Management
- 10. Operational Security
- 11. Network Security
- 12. Incident Detection
- 15. People
- 16. Environmental Security
- 17. Physical / Building Security

Training is a strength of the board that is worthy of specific mention. In this regard the following are highlighted as examples of Good Practice:

- The Risk Register training slide pack
- The Corporate and Directorate Training plan which includes Information Governance; one auditor noted this the first comprehensive training plan seen in 4 years
- The Board Cyber Security Training slide pack

Areas for development

Ther was only one area that achieved a compliance level below 30%, namely 14.4 BC/DR Testing Policies & Procedures. This should be a high-priority area for development or further evidence enhancement.

The secondary areas for focus should sub-categories be those rated as amber which are:

- 1.3 Adoption Audit and Assurance of Security standards
- 3.5 Security in Cloud Services
- 5.4 Information / Data Classification
- 5.5 Information Asset Register
- 7.3 Privilege Management
- 8.3 Cryptography
- 9.2 Secure Design / Development
- 10.3 Application Security
- 10.5 Data Exfiltration Monitoring
- 11.5 Boundary / Firewall Management
- 13.3 Post-Incident Review & Learning

In should be noted that the gaps in performance within the sub-category on 3.5 Security in Cloud Services are primarily due to the absence of documentation supplied by NSS on national systems which (in common with other boards' experience) remains outstanding.

The board would benefit from further development of documented policies and operational procedures; especially as there is a very high dependency on the knowledge base of a few individuals which would be lost should these staff members leave.

Management Meeting

[The SHCA has noted this section and fully redacted prior to issuing to the Health Board.]

Compliance Status

Table 2.1 summarises the results of the compliance analysis. Collectively the board performance equates to an overall compliance status of 76%.

Table 2.1: Compliance Status Summary.

COMPLIANCE STATUS						
OVERALL	CATEGORY (17)		SUB-CATEGORY (68)		CONTROLS (427)	
76%	100%	2	100%	25	Achieved	279
	≥ 80%	7	≥ 80%	11	Partially	70
	≥ 60%	8	≥ 60%	20	Not Achieved	66
	≥ 30%	0	≥ 30%	11	N/A	12
	<30%	0	<30%	0		
	< 10%	0	< 10%	1		

Figures 2.1 – 2.3 illustrate the respective compliance status at Category, Sub-Category and Control levels. These illustrate that the board performance is very strong with all of the 17 categories achieving compliance levels in excess of 60% with nine over 80% compliant (Figure 2.1).

When these data are broken down to sub-category (Figure 2.2); only 12 have compliance below 60%, with only a single sub-category rated at black or red (14.4 BC/DR Testing Policies & Procedures).

The strength of the organisation is emphasised when the control status is examined (Figure 2.3) with only 66 (15%) of the controls yet to be addressed and 65% rated as Achieved.

Figure 2.1: Compliance status at Category level.

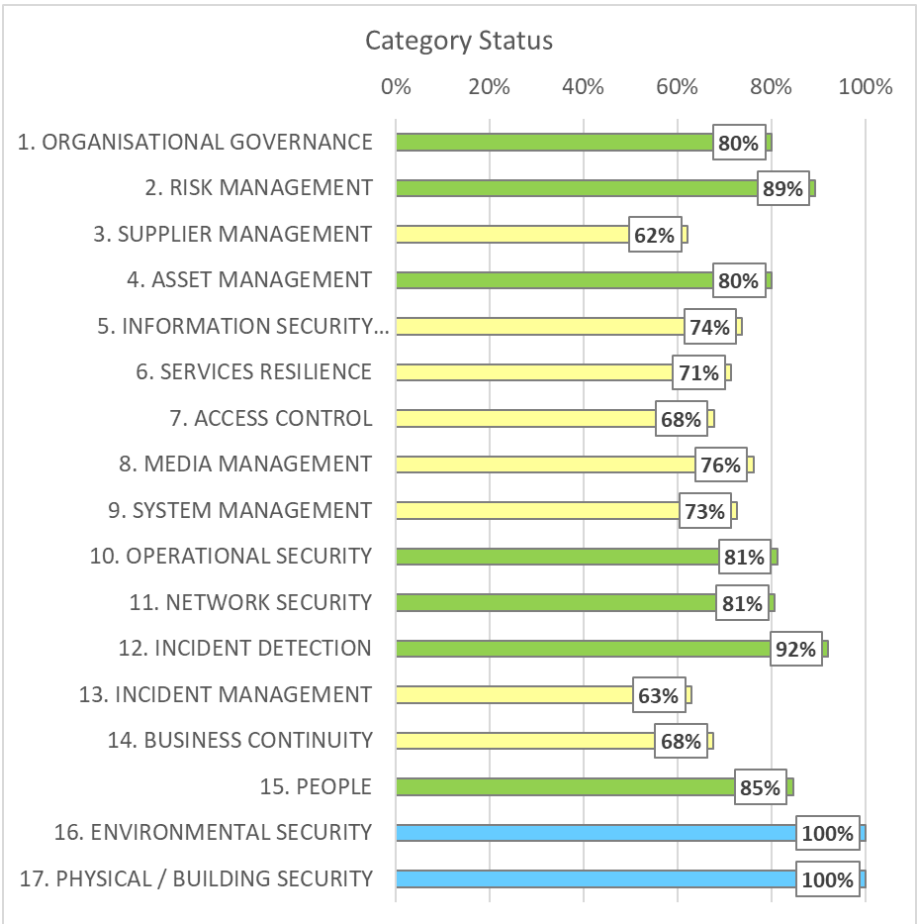


Figure 2.2: Compliance status at Sub-category level.

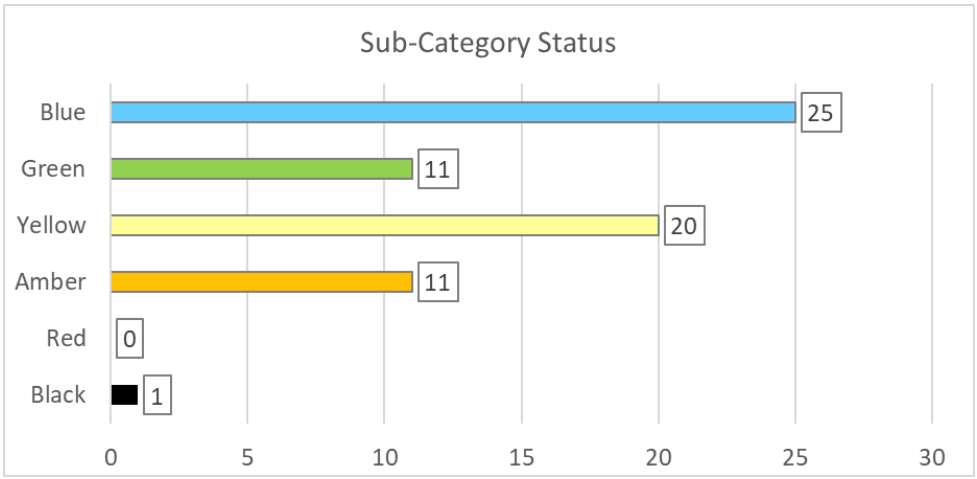
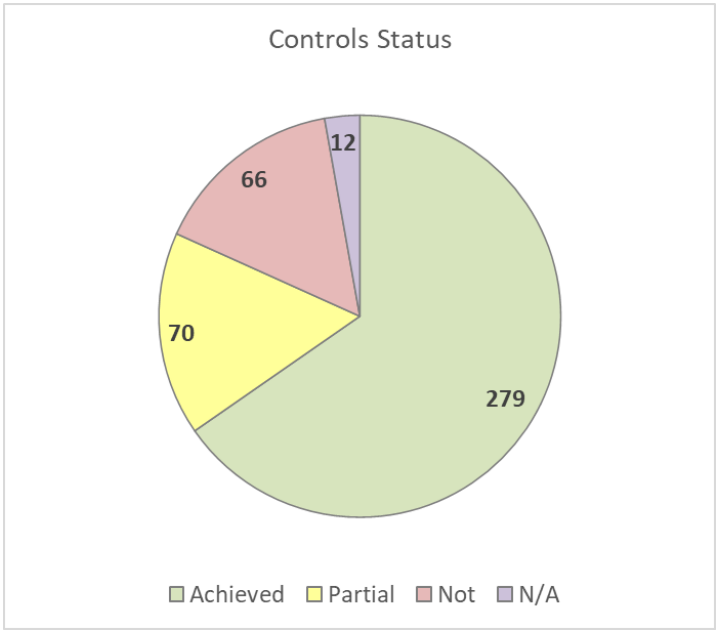


Figure 2.3: Compliance status at Control level.



3. Compliance Breakdown

SENIOR MANAGEMENT

1. ORGANISATIONAL GOVERNANCE				
Appropriate organisational structures, policies, and processes are in place to understand, assess and systematically manage security risks to the organisation's network and information systems.		**2023 GREEN**	**2024**	**2025**
CONTROLS		AUDIT ASSESSMENT		
1.1 Governance Framework: **There is effective organisational security management led at board level and articulated clearly in corresponding policies.**		**2023 Blue**	**2024**	**2025**
TIER 1	1. There is a Board/Senior Management-level commitment to manage the risks arising from the cyber threat.	**Achieved** Evidence submitted satisfies the control.		
	2. There are appropriate data protection and information security policies and processes in place to direct the organisation's overall approach to cyber security.	**Achieved** Evidence submitted satisfies the control.		
	3. There are clear lines of responsibility and accountability to named individuals for the security of sensitive information and key operational services.	**Achieved** Evidence submitted satisfies the control.		
	4. Senior accountable individuals have received appropriate training and guidance on cyber security	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. Significant risks to sensitive information and key operational services have been identified and are managed.	**Achieved** Evidence submitted satisfies the control.		
	2. The organisation has established roles and responsibilities for the security of networks and information systems at all levels.	**Achieved** Evidence submitted satisfies the control.		
	3. The security issues that arise because of dependencies on external suppliers or through the supply chain are detailed, organised and managed.	**Achieved** Evidence submitted satisfies the control.		
1.2 Leadership & responsibility: **There is a board-level individual who has overall accountability for the security of networks and information systems.**		**2023 Blue**	**2024**	**2025**
TIER 1	1. A named Board and Senior Management member of staff have been identified as responsible for organisational cyber resilience arrangements.	**Achieved** Evidence submitted satisfies the control.		
	2. There is a written information security policy in place, which is championed by senior management.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. Direction set at board level is translated into effective organisational practices that direct and control the security of the organisation's networks and information systems.	**Achieved** Evidence submitted satisfies the control.		
	2. The board shall ensure that the organisation has planned and budgeted for adequate resources for the delivery, maintenance and improvement of cyber resilience and network and information security, and that these activities are supported by senior management.	**Achieved** Evidence submitted satisfies the control.		
	3. All key stakeholders required for the delivery of a successful cybersecurity programme are identified and involved.	**Achieved** Evidence submitted satisfies the control.		
	4. There is senior-level accountability and responsibility for the security of networks and information systems with delegated decision-making authority.	**Achieved** Evidence submitted satisfies the control.		

1.3 Adoption Audit and assurance of security standards: **There are in place procedures to provide assurance on the effectiveness of security of systems, services, people and processes.**		**2023 Amber**	**2024**	**2025**
TIER 1	1. There is demonstrable and appropriate independent assurance that five critical network controls are in place: a) firewalls b) secure configuration c) user access control d) malware protection e) patch management	**Not Achieved** Noted that work is underway to gain CE certification.		
TIER 2	1. Security as it relates to technology, people, and processes can be demonstrated and verified by a third party audit at least annually and after any security event(s).	**Partially Achieved** Noted that work is underway to gain CE certification. 22/23 Internal audit activities include information security related elements and an ICO audit took place.		
	2. There are procedures to check security measures that are in place to protect the networks and information systems are effective, and remain effective for the service lifetime.	**Partially Achieved** Policies not supported by associated procedures; single penetration test result submitted. 22/23 Audit activity.		
	3. The assurance methods available are recognised and appropriate methods to gain confidence in the security of essential services are adopted and implemented.	**Partially Achieved** Defined procedures not presented; single penetration test result submitted.		
	4. Audit requirements and activities involving verification of operational systems shall be carefully planned and agreed to minimise disruptions to business processes.	**Partially Achieved** Planning for internal audit activities evidenced.		
	5. The organisation's approach to managing information security and its implementation (i.e. control objectives, controls, policies, processes and procedures for information security) shall be reviewed independently at planned intervals or when significant changes occur.	**Not Achieved** Noted that work is underway to gain CE certification and that 22/23 included some internal audit related elements, but no evidence of planned and regular independent activities.		
	6. Managers regularly review the compliance of information processing and procedures within their area of responsibility with the appropriate security policies, standards and any other security requirements.	**Achieved** Evidence submitted satisfies the control.		
1.4 Regulatory Compliance: **The organisation can demonstrate independent accreditation any additional relevant compliance requirements.**		**INFORMATION ONLY**		
TIER 1	1. If relevant, the organisation can demonstrate compliance with the current PSN controls.	**Not Applicable**		
	2. If relevant, the organisation can demonstrate compliance with the current PCI standard and controls.	**Not Applicable**		
	3. If relevant, the organisation can demonstrate compliance with current relevant Operational Technology standards and controls.	**Not Applicable**		
	4. If relevant, state any specific services that have been accredited to a specific standard.	**Not Applicable**		
TIER 2	No additional requirements.			

2. RISK MANAGEMENT				
Appropriate steps are in place to identify, assess and understand security risks to the network and information systems. This includes an overall organisational approach to risk management.		**2023 GREEN**	**2024**	**2025**
CONTROLS		AUDIT ASSESSMENT		
2.1 Policy & Processes: **The organisation has effective internal processes that manage and mitigate risks to the security of network and information systems and services.**		**2023 Green**	**2024**	**2025**
TIER 1	1. There are information risk management policies and assessment procedures in place.	**Achieved** Evidence submitted satisfies the control.		
	2. Organisations shall identify and manage the significant risks to sensitive information and key operational services.	**Achieved** Evidence submitted satisfies the control.		
	3. Senior management and boards regularly review the organisational cyber risks and threats.	**Achieved** Evidence submitted satisfies the control.		
	4. Executive management should establish key risk indicators (KRIs) in order to monitor any changes in the risk profiles.	**Not Achieved** Evidence submitted does not fulfil the control requirements. Horizon scanning happens in discussion but difficult to evidence. Key risk indicators are metrics that predict potential risks that can negatively impact businesses.		
TIER 2	1. The organisational process ensures that security risks to networks and information systems relevant to essential services are identified, analysed, prioritised, and managed.	**Achieved** Evidence submitted satisfies the control.		
	2. Risk owners are identified.	**Achieved** Evidence submitted satisfies the control.		
	3. The output from the risk management process is a clear set of security requirements that will address the risks in line with the organisational approach to security.	**Achieved** Evidence submitted satisfies the control.		
	4. Significant conclusions reached in the course of the risk management process are communicated to key security decision-makers and accountable individuals.	**Achieved** Evidence submitted satisfies the control.		
	5. The effectiveness of the risk management process is reviewed periodically and improvements made as required.	**Achieved** Evidence submitted satisfies the control.		
2.2 Cyber / Information Risk Assessment: **The organisation has effective and robust risk assessment methodology and processes that identify and prioritise threats and vulnerabilities.**		**2023 Blue**	**2024**	**2025**
TIER 1	1. Key information and IT assets have been identified, risk assessed and prioritised for their vulnerability to cyber-attack.	**Achieved** Evidence submitted satisfies the control.		
	2. Organisations should establish a process to identify security vulnerabilities and rank them according to their level of risk.	**Achieved** Evidence submitted satisfies the control.		
	3. A systematic risk-based approach is taken to information security, data protection and the security of systems and services. This risk assessment takes into consideration: the technology available; cost of implementation; the nature, scope, context and purpose of any data processing; the probability and impact of the risk being realised.	**Achieved** Evidence submitted satisfies the control.		

	4. The criteria for performing risk assessments are well defined to ensure risk assessments produce consistent, valid and comparable results.	**Achieved** Evidence submitted satisfies the control.
TIER 2	1. The risk assessments are based on a clearly articulated set of threat assumptions; these are kept up-to-date through an understanding of changing security threats.	**Achieved** Evidence submitted satisfies the control.
	2. Risk assessments are conducted when significant events potentially affect the essential service, such as replacing a system or a change in the cyber security threat.	**Achieved** Evidence submitted satisfies the control.
	3. The risk assessments are dynamic and are updated in the light of relevant changes, which may include technical changes to networks and information systems, change of use and new threat information.	**Achieved** Evidence submitted satisfies the control.
2.3 Risk Treatment & Tolerance: **The organisation has risk treatment policies and procedures in place with defined risk appetite and mitigation controls documented.**		**2023 Yellow** | **2024** | **2025**
TIER 1	1. The information and cyber risk that the organisation is prepared to tolerate is defined, understood and communicated.	**Achieved** Evidence submitted satisfies the control.
	2. A risk appetite statement shall be produced and used to guide risk management decisions.	**Achieved** Evidence submitted satisfies the control.
TIER 2	1. The organisation shall define and apply an information security risk treatment process that identifies appropriate risk treatment options and associated mitigation controls.	**Partially Achieved** Guidance on risk treatment, and the risks themselves show treatment applied but there is nothing documented specific to information security risks
	2. A risk treatment plan shall be produced	**Achieved** Evidence submitted satisfies the control.
	3. A Statement of Applicability shall be prepared to document the risk treatment and controls adopted.	**Not Achieved** Evidence submitted does not fulfil the control requirements.
	4. The senior management shall assess and sign-off the risk treatment regime, policies and procedures.	**Achieved** Evidence submitted satisfies the control.
2.4 Risk Governance: **Risks to network and information systems are effectively managed, communicated, and regularly considered throughout the organisation and led by senior management.**		**2023 Green** | **2024** | **2025**
TIER 1	1. Responsibility for cyber security risks has been allocated appropriately to named individuals.	**Achieved** Evidence submitted satisfies the control.
	2. Cyber security risks are on the organisational risk register.	**Achieved** Evidence submitted satisfies the control.
	3. Knowledge sharing of risk management through peer-networks is actively undertaken.	**Achieved** Evidence submitted satisfies the control.
	4. The board regularly reviews cyber risks.	**Achieved** Evidence submitted satisfies the control.
	5. All executive and non-executive board members are made aware of the cyber risks of the organisation.	**Achieved** Evidence submitted satisfies the control.
	6. There is board-level accountability for cyber risk with a named individual.	**Achieved**

		Evidence submitted satisfies the control.
	7. Staff members are trained in cyber risk assessment and management relevant to their role.	**Achieved** Evidence submitted satisfies the control.
	8. An organisation-wide risk management culture is promoted by the senior management with demonstrable participation at all levels.	**Achieved** Evidence submitted satisfies the control.
TIER 2	1. Senior accountable officers receive appropriate training and guidance on risk management.	**Achieved** Evidence submitted satisfies the control.
	2. There are clear and well-understood channels for communicating and escalating risks	**Achieved** Evidence submitted satisfies the control.
	3. Senior management regularly reviews the resource allocations to ensure these are sufficient to permit prioritised information security and cyber risk mitigation measures to be implemented.	**Not Achieved** Described at staff meetings and narrative explains the fluid internal approach of the small organisation but unable to evidence.

3. SUPPLIER MANAGEMENT

The organisation understands and manages security risks that arise as a result of dependencies on external suppliers and third party services.		**2023 YELLOW**	**2024**	**2025**
CONTROLS		AUDIT ASSESSMENT		
3.1 Supply Chain Assurance: **The organisation has a deep understanding of the security provisions and assurances around systems and services provided by third parties and their supply chain.**		**2023 Yellow**	**2024**	**2025**
TIER 1	1. Develop and maintain an inventory of all supply chain relationships critical to the operation of the organisation.	**Achieved** Evidence submitted satisfies the control.		
	2. Organisations shall adopt a proportionate, risk-based policy in respect of supply chain cyber security.	**Achieved** Evidence submitted satisfies the control.		
	3. The organisation has assessed, understands and has procedures in place to manage security risks that may arise as a result of dependencies on third party suppliers.	**Partially Achieved** Process/questionnaire developed but not shown in use or clear that all suppliers have responded.		
	4. Documented and suitable assurances have been obtained from suppliers and their immediate supply chain that proportionate and appropriate security measures to protect systems, services, data and information are in place and these are certified or aligned with recognised standards or their equivalent. (e.g. Cyber Essentials, ISO 27001).	**Not Achieved** Example cited shows that there is progress in this area but it does not satisfy this control which includes all suppliers.		
	5. Suppliers and other third parties shall periodically attest and evidence through independent assurance their ability to meet cybersecurity requirements.	**Partially Achieved** Completed on procurement but no indication of periodically reaffirming and attesting. .		
	6. The security requirements and stipulations necessary to ensure GDPR and other relevant regulatory compliance are incorporated into supplier contracts, are mutually agreed and understood.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	No additional requirements			
3.2 Roles and Responsibilities: **The organisation has defined the respective duties and responsibilities of third-party suppliers and the supply chain and these are understood and agreed by all parties.**		**2023 Blue**	**2024**	**2025**
TIER 1	1. Where services are outsourced (for example by use of cloud infrastructure or services), which security related responsibilities remain with the organisation and which are the supplier's responsibility shall be defined and accurately recorded.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. There is a clear and documented shared-responsibility model with suppliers for incident management.	**Achieved** Evidence submitted satisfies the control.		
3.3 Access control: **There is visibility and control on third-party users (or automated functions) that can access organisational systems, services, data and information data and these are appropriately verified, authenticated and authorised.**		**2023 Blue**	**2024**	**2025**
TIER 1	1. Only individually authenticated and authorised users can connect to or access the organisation networks or information systems.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. Both electronic and physical access requires individual authentication and authorisation.	**Achieved** Evidence submitted satisfies the control.		
	2. Third party user access to all networks and information systems is limited to the minimum necessary.	**Achieved** Evidence submitted satisfies the control.		

	3. Additional authentication mechanisms, such as two-factor or hardware-backed certificates are employed, to individually authenticate and authorise all third party remote access to all networks and information systems that support essential services.	**Achieved** Evidence submitted satisfies the control.
	4. The list of external users with access to essential service networks and systems is reviewed on a regular basis, e.g. every 6 months.	**Achieved** Evidence submitted satisfies the control.
3.4 Security in Procurements: **The organisation has security embedded within procurement procedures.**		**2023 Yellow** | **2024** | **2025**
TIER 1	1. Ensure implementation of security considerations as part of procurement processes.	**Achieved** Evidence submitted satisfies the control.
TIER 2	1. Cyber risk and information security related requirements shall be considered as an integral part of the procurement process and, where relevant, included in tender requirements for new systems, services or enhancements to existing provisions.	**Achieved** Evidence submitted satisfies the control.
	2. Organisations shall regularly monitor, review and audit supplier service delivery and associated security provisions	**Partially Achieved** Process cited but not yet showing regularity.
	3. Changes to the provision of services by suppliers, including maintaining and improving existing information security policies, procedures and controls, shall be managed, taking account of the criticality of business information, systems and processes involved and re-assessment of risks.	**Partially Achieved** Process cited but not evidenced in practice.
3.5 Security in Cloud Services: **The organisation has security embedded in cloud-based services.**		**2023 Amber** | **2024** | **2025**
TIER 1	1. It is essential, where cloud services are employed (particularly with respect to IaaS and PaaS), that there is clarity (whether through contractual agreement or other arrangements) whether the responsibility to carry out certain actions (i.e. patching) lies with the organisation or the cloud supplier, and defined in a Shared Security Responsibility Model (SSRM).	**Partially Achieved** Illustrated in broad terms in a MS generic document; lacks specificity for a SSRM compliance.
	2. Cloud service providers appropriately sanitise data storage areas before reallocating to another user.	**Achieved** Evidence submitted satisfies the control.
	3. Multi-factor authentication shall be used for access to all cloud-based accounts and services.	**Achieved** Evidence submitted satisfies the control.
	4. Periodically backup data stored in the cloud. Ensure the confidentiality, integrity and availability of the backup, and verify data restoration from backup for resiliency.	**Achieved** Evidence submitted satisfies the control.
	5. Contracts should Include provisions limiting changes directly impacting CSCs-owned environments/tenants to explicitly authorised requests within service level agreements between CSPs and CSCs.	**Not Achieved.** No evidence submitted.
	6. CSPs must provide the capability for CSCs to manage their own data encryption keys.	**Achieved** Evidence submitted satisfies the control.
	7. The CSP must have in place, and describe to CSCs, the procedure to manage and respond to requests for disclosure of Personal Data by Law Enforcement Authorities according to applicable laws and regulations. The CSP must give special attention to the notification procedure to interested CSCs, unless otherwise prohibited, such as a prohibition under criminal law to preserve confidentiality of a law enforcement investigation.	**Not Achieved.** No evidence submitted.
	8. The CSP must define and implement, processes, procedures and technical measures to specify and document the physical locations of data, including any locations in which data is processed or backed up.	**Not Achieved.** Evidence submitted is generic MS document; no specific documented location cited.

	9. The organisation should establish a formal, documented, and leadership-sponsored Enterprise Risk Management (ERM) program that includes policies and procedures for identification, evaluation, ownership, treatment, and acceptance of cloud security and privacy risks.	**Not Achieved.** No evidence submitted.
	10. The organisation should establish and maintain contact with cloud-related special interest groups and other relevant entities in line with business context.	**Not Achieved.** No evidence submitted.
	11. The CSP should provide application interface(s) to CSCs so that they programmatically retrieve their data to enable interoperability and portability.	**Not Achieved.** No evidence submitted.
	12. Agreements must include provisions specifying CSCs access to data upon contract termination and will include: a. Data format b. Length of time the data will be stored c. Scope of the data retained and made available to the CSCs d. Data deletion policy	**Not Achieved.** No evidence submitted.
	13. Design, develop, deploy and configure applications and infrastructures such that CSP and CSC (tenant) user access and intra-tenant access is appropriately segmented and segregated, monitored and restricted from other tenants.	**Achieved** Evidence submitted satisfies the control.
	14. Use secure and encrypted communication channels when migrating servers, services, applications, or data to cloud environments. Such channels must include only up-to-date and approved protocols.	**Achieved** Evidence submitted satisfies the control.
	15. Service agreements between CSPs and CSCs (tenants) must incorporate at least the following mutually-agreed upon provisions and/or terms: • Scope, characteristics and location of business relationship and services offered • Information security requirements (including SSRM) • Change management process • Logging and monitoring capability • Incident management and communication procedures • Right to audit and third party assessment • Service termination • Interoperability and portability requirements • Data privacy	**Not Achieved.** No evidence submitted.
TIER 2	1. Where cloud-based services are employed, there is sufficient separation of the organisation's data and service from other users of the service.	**Not Achieved.** No evidence submitted.
	Note – the above assessment is based upon cloud-services local to TSH; national systems documentation from NSS had not been supplied to the board.	

TECHNICAL TEAM

4. ASSET MANAGEMENT				
Everything required to deliver, maintain or support networks and information systems and services is determined and understood.		**2023 Amber**	**2024**	**2025**
CONTROLS		AUDIT ASSESSMENT		
4.1 Hardware Assets: **The organisation has visibility and effective management of all hardware assets.**		**2023 Yellow**	**2024**	**2025**
TIER 1	1. All hardware assets are in support and their configuration are managed, tracked and recorded, including all end user devices.	**Achieved** Evidence submitted satisfies the control.		
	2. End user devices are managed to enable organisational controls to be applied over software or applications	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. All assets are identified and inventoried (at a suitable level of detail). The inventory is kept up-to-date.	**Achieved** Evidence submitted satisfies the control.		
	2. Assets are securely managed throughout their lifecycle, from creation through to eventual decommissioning or disposal.	**Achieved** Evidence submitted satisfies the control.		
	3. All items of equipment containing storage media shall be verified to ensure that any sensitive data and licensed software has been removed or securely overwritten prior to disposal or re-use.	**Achieved** Evidence submitted satisfies the control.		
	4. Assets are prioritised according to their importance to the delivery of the essential service.	**Not Achieved** Stated in narrative but not evidenced.		
	5. Responsibility for managing the physical assets has been assigned	**Partially Achieved** Referred to in policy but not clear.		
	6. Assets management is in place; assets shall not be taken off-site without prior authorisation with associated documentation.	**Not Achieved** Its not clear what the process for taking assets on and off site is.		
	7. Security is applied to all assets used off-site.	**Achieved** Evidence submitted satisfies the control.		
4.2 Software Assets: **The organisation has visibility and effective management of all software assets.**		**2023 Blue**	**2024**	**2025**
TIER 1	1. Software running on computers and network devices is kept up-to-date and has the latest security patches installed. Specifically: a) Software running on computers and network devices that are connected to or capable of connecting to the internet is licensed and supported (by the software vendor or supplier of the software) to ensure security patches for known vulnerabilities are made available. b) Updates to software (including operating system software and firmware) running on computers and network devices that are connected to or capable of connecting to the internet are installed in a timely manner (e.g. within 14 days of release or automatically when they become available from vendors). c) Out-of-date software (i.e. software that is no longer supported) is removed from computer and network devices that are connected to or capable of connecting to the internet.	**Achieved** Evidence submitted satisfies the control.		
	2. All software and application assets with licence and configuration details must be tracked and recorded	**Achieved** Evidence submitted satisfies the control.		
	3. Software vulnerabilities monitoring, including using in-support software, must be implemented.	**Achieved**		

		Evidence submitted satisfies the control.		
TIER 2	No additional requirements.			
4.3 Infrastructure management: **The organisation recognises critical infrastructure assets and dependencies.**		**2023 Green**	**2024**	**2025**
TIER 1	1. The installation of software shall be controlled and shall not be permitted by general users.	**Achieved** Evidence submitted satisfies the control.		
	2. Minimum configuration baselines are established for critical network assets and applied during deployment.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. Network assets shall be regularly maintained to ensure service continuity.	**Partially Achieved** Evidence submitted shows firmware updates are undertaken; this control is seeking evidence of regular maintenance e.g. via a contract		

5. INFORMATION SECURITY MANAGEMENT					
Proportionate security measures are in place to protect information, data, services and systems from cyber-attack.			**2023 YELLOW**	**2024**	**2025**
CONTROLS			AUDIT ASSESSMENT		
5.1 Security Policy & Processes: **The organisation has developed and continues to improve a set of protection policies and processes that manage and mitigate the risk of security-related service disruption or data loss.**			**2023 Green**	**2024**	**2025**
TIER 1	1.	Appropriate policies and processes that direct the organisation's overall approach to securing systems are defined, implemented, communicated and enforced.	**Achieved** Evidence submitted satisfies the control.		
	2.	Security governance, risk assessment and technical security practices are documented.	**Achieved** Evidence submitted satisfies the control.		
	3.	Each organisation shall determine the boundaries and scope of its security policy. This should be defined to cover all relevant operations, which shall include interfaces and dependencies between activities performed by the organisation and those that are performed by other organisations.	**Achieved** Evidence submitted satisfies the control.		
	4.	Information security shall be addressed in project management, regardless of the type of project.	**Partially Achieved** Shown in early stages of establishing a project via process documents but not seen in practice.		
	5.	Key security performance indicators are defined with relevant metrics and targets and reported to the executive management.	**Not Achieved** No evidence submitted.		
	6.	Acceptable usage policies that define the proper use of technology by all personnel are in place. (These include remote access, wireless, removable electronic media, laptops, tablets, handheld devices, email and Internet.)	**Achieved** Evidence submitted satisfies the control.		
	7.	The security policy and procedures clearly define information security responsibilities for all personnel.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1.	Policies and processes are reviewed at suitably regular intervals to ensure they remain relevant to threats, business processes, accommodate lessons learned and remain appropriate and effective.	**Achieved** Evidence submitted satisfies the control.		
	2.	Security policies and processes are integrated with other organisational policies and processes.	**Achieved** Evidence submitted satisfies the control.		
	3.	All relevant legislative statutory, regulatory, contractual requirements and the organisation's approach to meet these requirements shall be explicitly identified, documented and kept up to date (e.g. GDPR Security Outcomes; NIS regulations).	**Achieved** Evidence submitted satisfies the control.		
5.2 Lifecycle Management: **Information assets are managed throughout their lifecycle, from creation through to eventual decommissioning or disposal.**			**2023 Green**	**2024**	**2025**
TIER 1	1.	Information and data should be classified according to retention and disposal policies and legal requirements.	**Not Achieved** Not evidenced.		
	2.	Personal data processed should be catalogued, adequate, relevant and limited to what is necessary for the purpose of the processing, and it should not be kept for longer than is necessary.	**Achieved** Evidence submitted satisfies the control.		
	3.	Technical controls are in place to prevent unauthorised or unlawful processing of personal data that might remain in memory when technology is sent for repair or disposal.	**Achieved** Evidence submitted satisfies the control.		

	4. Information and data records shall be protected from loss, destruction, falsification, unauthorised access and unauthorised release, in accordance with legislation, regulatory, contractual or business requirements.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. Information, data and media destruction and disposal processes should have assurance procedures and have an audit trail from collection to destruction.	**Achieved** Evidence submitted satisfies the control.		
5.3 Storage: **The organisation knows where data and information are stored and has security in place whether on premise, mobile, removable or cloud based storage is employed.**		**2023** **Yellow**	**2024**	**2025**
TIER 1	1. There are suitable physical or technical means including encryption to protect stored data from unauthorised access, modification or deletion through unauthorised access to storage media.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. There is a detailed understanding and mapping of data and information flows from creation, transit, processing and storage.	**Not Achieved** Does not appear to be an established and embedded process.		
	2. The organisation has processes to remove or minimise unnecessary copies or unneeded historic records.	**Partially Achieved** Despite documentation its not clear from narrative that the process is enforced and maintained.		
	3. Where outsourced or third-party storage is employed, appropriate secured measures are in place and enforced, with appropriate assurance procedures consistent with data retention policies.	**Not Applicable** Not used in TSH.		
	4. All data is sanitised from all devices and equipment before disposal.	**Achieved** Evidence submitted satisfies the control.		
5.4 Information / Data Classification: **Information is classified in terms of legal requirements, value, criticality and sensitivity to unauthorised disclosure or modification, to ensure it receives an appropriate level of protection in accordance with its importance to the organization.**		**2023** **Amber**	**2024**	**2025**
TIER 1	1. All data and information assets have been identified and classified.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. Information has been classified in terms of legal requirements, value, criticality and sensitivity to unauthorised disclosure or modification.	**Not Achieved** Evidence submitted does not fulfil the control requirements.		
	2. An appropriate set of procedures for information labelling has been developed and implemented in accordance with the information classification scheme adopted by the organization	**Not Achieved** It appears that some labelling takes place internally, but no overarching guidance submitted in evidence, and it is noted that a project is underway nationally using M365, which TSH is dependent upon.		
5.5 Information Asset Register: **Data and information assets are identified and an inventory of these assets is created and maintained.**		**2023** **Amber**	**2024**	**2025**
TIER 1	1. Key information assets have been identified and recorded.	**Achieved** Evidence submitted satisfies the control.		
	2. Key information assets have been assessed for their vulnerability to cyber-attack.	**Achieved** Evidence submitted satisfies the control.		
	3. All data and information assets have been catalogued by type and classification and recorded in an information assets register.	**Achieved** Evidence submitted satisfies the control.		

	4. The information asset register records where the information/data are held and which computer systems or services process it.	**Not Achieved** Not on the IAR.
	5. The purpose for processing the personal data held by the organisation has been described and recorded.	**Not Achieved** Evidence submitted does not fulfil the control requirements.
	6. Organisations shall know and record: a) What sensitive information they hold or process b) Why they hold or process that information c) Where the information is held d) Which computer systems or services process it e) The impact of its loss, compromise or disclosure	**Partially Achieved** Not all elements are covered by the evidence submitted. Various documents and processes need pulled together and recorded centrally on the IAR.
TIER 2	1. Procedures for handling assets shall be developed and implemented in accordance with the information classification scheme.	**Achieved** Evidence submitted satisfies the control.
	2. The register maintains a current understanding of the location, quantity and quality of data and information stored.	**Not Achieved** Not recorded on the IAR.
	3. Hardware and software assets associated with information and information processing have been identified	**Not Achieved** Evidence is not clear.
	4. An inventory of information assets has been established and is maintained through recognised process.	**Partially Achieved** There is an inventory, but its content is limited and the process to maintain it is not clear.
	5. Assets maintained in the inventory have ascribed owners.	**Achieved** Evidence submitted satisfies the control.
5.6 Information / Data Transfer Controls: **The organisation has an understanding of information / data flows including the transfer of data to third parties and the associated security protocols that are in place.**		**2023 Blue** | **2024** | **2025**
TIER 1	1. Data at rest on all devices and in databases is protected by appropriate measures including physical protection (when hosted within a secure data centre) and encryption.	**Achieved** Evidence submitted satisfies the control.
	2. There are technical controls in place (such as appropriate encryption) to prevent unauthorised or unlawful processing of personal data, whether through unauthorised access to user devices or storage media, backups, interception of data in transit or at rest.	**Achieved** Evidence submitted satisfies the control.
	3. Data in transit accessed by remote workers and third parties is protected by encryption and the application of a virtual private network (VPN).	**Achieved** Evidence submitted satisfies the control.
	4. Protect data in transit using well-configured TLS (e.g. v. 1.2 or above).	**Achieved** Evidence submitted satisfies the control.
TIER 2	1. There is a current understanding and record of the data links and routes used to transmit data.	**Achieved** Evidence submitted satisfies the control.
	2. Appropriate physical or technical means are applied to protect data that travels over an untrusted carrier.	**Not Applicable** Only SWAN connection used.
	3. Formal transfer policies, procedures and controls shall be in place to protect the transfer of information through the use of all types of communication facilities.	**Achieved** Evidence submitted satisfies the control.
	4. Agreements shall address the secure transfer of business information between the organization and external parties.	**Achieved** Evidence submitted satisfies the control.

6. SERVICES RESILIENCE				
Network and information systems are designed to be resilient to cyber security and operational adverse incidents.		**2023 YELLOW**	**2024**	**2025**
CONTROLS		AUDIT ASSESSMENT		
6.1 Services Resilience: **Systems are appropriately segregated and resource limitations are mitigated.**		**2023 Yellow**	**2024**	**2025**
TIER 1	1. Key operational services have been identified with resource, technology and service dependencies defined (e.g. power, bandwidth, cooling, data, people).	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. Key operational systems are segregated from other business and external systems by appropriate technical and physical means (e.g. separate network and system infrastructure with independent user administration).	**Achieved** Evidence submitted satisfies the control.		
	2. Geographical constraints or weaknesses (e.g. single communications line or channel) have been identified and mitigated.	**Partially Achieved** Two communications lines within the grounds are within a single point of failure. Mitigation planned but yet to be implemented.		
	3. Systems that key services depend upon have redundancy and are replicated to an alternative location.	**Achieved** Evidence submitted satisfies the control.		
	4. There are alternative physical paths and service providers for network connectivity with known separacy and diversity of bearers.	**Achieved** Evidence submitted satisfies the control.		
	5. Dependencies, resource and geographical limitation assessments are regularly reviewed with update mitigations when required.	**Partially Achieved** Dependencies have been identified; review period and mitigations to be implemented.		
	6. Organisations annually conduct and document an organisational resilience assessment.	**Not Achieved** Narrative notes this is to be implemented .		

7. ACCESS CONTROL				
Access to information, services and systems is controlled, managed and monitored through policies and procedures.		**2023 YELLOW**	**2024**	**2025**
CONTROLS		AUDIT ASSESSMENT		
7.1 Account Management: **User accounts are effectively managed throughout their lifecycle to provide minimum access to sensitive information or key operational services.**		**2023 Yellow**	**2024**	**2025**
TIER 1	1. All user account creation is subject to a provisioning and approval process.	**Achieved** Evidence submitted satisfies the control.		
	2. All default passwords are removed and changed to an alternative, strong password.	**Achieved** Evidence submitted satisfies the control.		
	3. There is a robust password policy which avoids users having weak passwords, such as those trivially guessable.	**Achieved** Evidence submitted satisfies the control.		
	4. Password or account sharing between users is not permitted.	**Achieved** Evidence submitted satisfies the control.		
	5. User accounts and special access privileges are removed or disabled when no longer required (e.g. when an individual changes role or leaves the organisation) or after a pre-defined period of inactivity (e.g. 3 months).	**Partially Achieved** There is a process to follow. Special access rights not included and not clear if inactive accounts are picked up.		
	6. Unnecessary user accounts (e.g. Guest accounts and unnecessary administrative accounts) should be removed or disabled.	**Partially Achieved** Stated but not clear on process.		
	7. There should be no generic or common accounts accessed by multiple individuals.	**Not Achieved** Account Management Policy suggests these do exist although warns of the issues with them.		
TIER 2	No additional requirements.			
7.2 Identity Authentication: **Procedures are in place to verify, authenticate and authorise access to the organisational networks and information systems.**		**2023 Yellow**	**2024**	**2025**
TIER 1	1. Each user authenticates using a unique username and strong password before being granted access to applications, computers and network devices.	**Achieved** Evidence submitted satisfies the control.		
	2. Users that can access personal data are appropriately authenticated.	**Achieved** Evidence submitted satisfies the control.		
	3. Users who have privileged access are strongly authenticated by multi-factor or device authentication measures.	**Partially Achieved** MFA being deployed as a work in progress.		
	4. Multi-factor authentication shall be used for access to enterprise level social media accounts.	**Partially Achieved** MFA deployed on Twitter other accounts indicated as a work in progress.		
TIER 2	1. Additional authentication mechanisms, such as multi-factor or hardware-backed certificates are employed for all systems that operate or support key services.	**Partially Achieved** MFA being deployed as a work in progress.		
	2. There is an auditable, robust procedure in place to verify each user and issue minimum required access rights.	**Achieved** Evidence submitted satisfies the control.		

	3. Attempts by unauthorised users to connect to systems are alerted, promptly assessed and investigated.	**Achieved** Evidence submitted satisfies the control.		
7.3 Privilege Management: **The allocation and use of privileged access rights to networks and information systems is restricted and controlled.**		**2023** **Yellow**	**2024**	**2025**
TIER 1	1. Special access privileges are restricted to a limited number of authorised individuals.	**Achieved** Evidence submitted satisfies the control.		
	2. Details about special access privileges (e.g. the individual and purpose) are documented, kept in a secure location and reviewed on a regular basis (e.g. quarterly).	**Partially Achieved** Stated in new policy (awaiting approval) but process to be enforced. Noted that special access is limited to 4 people.		
	3. Special access privileges are controlled, periodically reviewed and removed or disabled when no longer required.	**Partially Achieved** Stated in new policy (awaiting approval) but process to be enforced.		
	4. Users who have privileged access accounts are strongly authenticated by two-factor or hardware authentication measures.	**Partially Achieved** Stated in new policy (awaiting approval) and MFA to be introduced.		
	5. Access to sensitive information and services is only provided to authorised, known and individually referenced users or systems.	**Achieved** Evidence submitted satisfies the control.		
	6. Access to logging data is limited to those with business need and no others. Legitimate reasons for accessing logging data are given in use policies and users are trained on this.	**Partially Achieved** Included in new policy awaiting approval.		
TIER 2	1. Systems and devices supporting the delivery services are only administered or maintained by authorised privileged users.	**Partially Achieved** Stated in new policy (awaiting approval) but process to be enforced.		
	2. Privileged access (e.g. to systems controlling the essential service or system administration) is carried out with separate accounts that are closely monitored.	**Partially Achieved** Separate accounts evidenced but monitoring process unclear.		
	3. All privileged access to networks and information systems is routinely validated and subject to real-time security monitoring, with all privileged user sessions recorded and stored for offline analysis and investigation.	**Not Achieved** Stated as not in place.		
	4. Temporary, time-bound rights for privileged access and external third-party support access are employed where appropriate.	**Achieved** Evidence submitted satisfies the control.		
	5. The use of utility programs that might be capable of overriding systems and applications shall be restricted.	**Partially Achieved** Stated in new policy (awaiting approval) but process to be enforced.		
	6. Access to program source code shall be restricted.	**Partially Achieved** Stated in new policy (awaiting approval) but process to be enforced.		
7.4 Administrator Account Management: **System administrator accounts are controlled and monitored with the activity logs protected and regularly reviewed.**		**2023** **Yellow**	**2024**	**2025**

TIER 1	1. Administrative accounts should only be used to perform legitimate administrative activities, and should not be granted access to email or the internet.	**Not Achieved** No narrative or evidence provided.
	2. Administrative accounts should have complex passwords different from standard user accounts.	**Partially Achieved** Complexity stated but they are the same as standard user accounts.
	3. Highly privileged administrative accounts should not be used for high risk or day to day user activities, for example web browsing and email.	**Not Achieved** No narrative or evidence provided.
	4. Administrators do not conduct 'normal' day-to-day business from their high privilege account and use normal accounts for standard business use.	**Partially Achieved** Stated in new policy (awaiting approval) but process to be enforced.
TIER 2	1. The list of system administrators is regularly reviewed, e.g. every 3-6 months.	**Partially Achieved** New policy (awaiting approval) but process to be enforced.

8. MEDIA MANAGEMENT				
Fixed and portable storage media and devices are managed and data / information is appropriately protected.		**2023 YELLOW**	**2024**	**2025**
CONTROLS		AUDIT ASSESSMENT		
8.1 Storage Media: **Policies and procedures are in place to protect stored data and prevent unauthorised disclosure, modification, removal or destruction of information stored on media.**		**2023 Green**	**2024**	**2025**
TIER 1	1. The organisation can identify and account for all removable media.	**Achieved** Evidence submitted satisfies the control.		
	2. Tracking and recording of all assets that store personal identifiable information, including end user devices and removable media is in place.	**Achieved** Evidence submitted satisfies the control.		
	3. Where removable media is to be reused then appropriate steps should be taken to ensure that previously stored information will not be accessible	**Partially Achieved** Process described but not documented. Noted that reuse is rare and requests in last few years rejected.		
	4. All data important to the delivery of the essential service is sanitised from all removable media before disposal.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	No additional requirements.			
8.2 Mobile Media / Devices: **The organisation can identify and account for all mobile end-user devices and removable media and monitors the data protection measures that are in place on mobile devices.**		**2023 Yellow**	**2024**	**2025**
TIER 1	1. Where the use of removable media is required to support the business need, it is limited to the minimum media types and users needed.	**Achieved** Evidence submitted satisfies the control.		
	2. Removable media is automatically scanned for malware when it is introduced to any system.	**Achieved** Evidence submitted satisfies the control.		
	3. Any media brought into the organisation is scanned for malicious content before any data transfer takes place.	**Achieved** Evidence submitted satisfies the control.		
	4. All removable media is formally issued to individual users who are accountable for its use and safe keeping.	**Achieved** Evidence submitted satisfies the control.		
	5. Users do not use unofficial media, such as USB sticks given away at conferences.	**Achieved** Evidence submitted satisfies the control.		
	6. Sensitive information is encrypted on removable media.	**Achieved** Evidence submitted satisfies the control.		
	7. Where removable media is to be reused or destroyed then it will be done securely with appropriate steps taken to ensure that previously stored information is not accessible.	**Partially Achieved** Process described but not documented. Noted that reuse is rare and requests in last few years rejected. Destruction certificate.		
	8. All users are made aware of their personal responsibilities for following the removable media security policy.	**Partially Achieved** With new policies to aid enforcement awaiting approval.		
	9. A secure baseline build and configuration is applied to all mobile devices.	**Achieved** Evidence submitted satisfies the control.		

	10. The organisation has the ability to remotely wipe and/or revoke access from all mobile devices.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. Mobile devices are catalogued, tracked and configured according to best practice for the platform, with appropriate technical and procedural policies in place.	**Achieved** Evidence submitted satisfies the control.		
	2. The data held on mobile devices is minimised.	**Achieved** Evidence submitted satisfies the control.		
	3. Some data may be automatically deleted off mobile devices after a certain period.	**Not Achieved** No narrative or evidence submitted.		
	4. Procedures are implemented for the management of removable media in accordance with the classification scheme adopted by the organisation.	**Not Achieved** No narrative or evidence submitted.		
8.3 Cryptography: **There is proper and effective use of cryptography to protect the confidentiality, authenticity and/or integrity of information at rest, in transit and on mobile devices or removable media.**		**2023** **Amber**	**2024**	**2025**
TIER 1	1. Sensitive information should be encrypted at rest on devices, databases and media and when transmitted electronically, especially over an untrusted carrier.	**Achieved** Evidence submitted satisfies the control. Untrusted carrier not used; only SWAN.		
TIER 2	1. There is a policy on the adoption of cryptography including the use and protection of cryptographic keys and their lifetime management.	**Partially Achieved** Draft policy awaiting approval.		
	2. Cryptographic authentication, integrity, and non-repudiation controls such as digital signatures and message authentication codes, and cryptographic key management is implemented as and where required as per the policy.	**Not Achieved** No narrative or evidence submitted.		

9. SYSTEM MANAGEMENT				
Information systems are protected from cyber-attack throughout their lifecycle.		**2023 YELLOW**	**2024**	**2025**
CONTROLS		AUDIT ASSESSMENT		
9.1 Secure Configuration: **The network and information systems that support the delivery of essential services are securely configured.**		**2023 Yellow**	**2024**	**2025**
TIER 1	1. Unnecessary software (including application, system utilities and network services) should be removed or disabled.	**Partially Achieved** Evidence submitted and narrative indicate this is a work in progress.		
	2. The auto-run feature should be disabled (to prevent software programs running automatically when removable storage media is connected to a computer or when network folders are accessed).	**Achieved** Evidence submitted satisfies the control.		
	3. A personal firewall (or equivalent) should be enabled on desktop PCs and laptops, and configured to disable (block) unapproved connections by default.	**Achieved** Evidence submitted satisfies the control.		
	4. A secure baseline build is implemented for all systems, platforms and components, including hardware and software to reduce the level of inherent vulnerability.	**Achieved** Evidence submitted satisfies the control.		
	5. Any functionality or application, services or ports not required to support a user or business need is removed or disabled.	**Partially Achieved** Evidence submitted and narrative indicate this is a work in progress.		
	6. The secure build profile is managed by a configuration control process and any deviation from the standard build is documented and approved.	**Partially Achieved** Configuration control in place; approval process for the changes illustrated was not enumerated.		
	7. Automatic session locking is configured on enterprise assets after a defined period of inactivity	**Achieved** Evidence submitted satisfies the control.		
	8. Default vendor system security credentials, unsecure configurations and unnecessary services are update or disabled to reduce potential risk and vulnerabilities	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. Network and system configurations changes are managed, secure and documented.	**Achieved** Evidence submitted satisfies the control.		
	2. Network and information systems are regularly reviewed and validated to ensure that they have the expected, secured settings and configuration.	**Not Achieved** No narrative or evidence submitted.		
	3. There are regular reviews and updates to technical knowledge about networks and information systems, such as documentation and network diagrams, and these are securely stored.	**Partially Achieved** Reviews occur, frequency is unclear.		
	4. Only permitted software can be installed and standard users cannot change settings that would impact security or business operation.	**Achieved** Evidence submitted satisfies the control.		
9.2 Secure Design / Development: **Information security is designed and implemented within the development lifecycle of information systems and networks.**		**2023 Amber**	**2024**	**2025**
TIER 1	1. The exception handling processes is configured to ensure that error messages returned to internal or external systems or users do not include sensitive information that may be useful to attackers.	**Not Achieved** No narrative or evidence submitted.		
TIER 2	1. A secure development policy with guidance is in place that defines rules for the development of software and systems and is applied.	**Partially Achieved** Will be addressed by ISP14 System Acquisition policy once approved.		

	2. Appropriate procedures shall be implemented to ensure compliance with legislative, regulatory and contractual requirements related to intellectual property rights and use of proprietary software products.	**Partially Achieved** Will be addressed by ISP18 Compliance policy once approved.		
	3. The organisation shall supervise and monitor the activity of outsourced system development.	**Partially Achieved** Will be addressed by ISP14 System Acquisition policy once approved.		
	4. Change control procedures are in place to manage the development lifecycle.	**Achieved** Evidence submitted satisfies the control.		
	5. Appropriate expertise is employed to design and review network and information systems.	**Not Achieved** No narrative or evidence submitted.		
	6. The networks and information systems are designed to have simple data flows between components to support effective security monitoring.	**Not Achieved** No narrative or evidence submitted.		
	7. The networks and information systems are designed to be easy to recover.	**Achieved** Evidence submitted satisfies the control.		
9.3 Change Control Procedures: **Changes to systems and software configurations are controlled by formal change control procedures.**		**2023 Blue**	**2024**	**2025**
TIER 1	1. Policies that set out configuration control and change management processes for all systems are in place.	**Achieved** Evidence submitted satisfies the control.		
	2. Define and implement a process to proactively roll back changes to a previous known good state in case of errors or security concerns.	**Achieved** Evidence submitted satisfies the control.		
	3. The ability of users to change configuration is restricted. Users with 'normal' privileges are prevented from installing or disabling any software or services running on the system.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. Modifications to software are restricted and all changes are subject to change control procedures.	**Achieved** Evidence submitted satisfies the control.		
	2. Only permitted software can be installed and standard users cannot change settings that would impact security or business operation.	**Achieved** Evidence submitted satisfies the control.		
	3. Change management is in place to control changes to business processes, information processing facilities and systems with alerts of changes deviating from the established baseline.	**Achieved** Evidence submitted satisfies the control.		
9.4 System Testing: **Testing of security functionality shall be carried out during development of new systems, upgrades and new versions or configurations.**		**2023 Yellow**	**2024**	**2025**
TIER 1	1. Regular automated testing is undertaken to evaluate the effectiveness of security measures, including virus and malware scanning, vulnerability scanning and penetration testing.	**Partially Achieved** Testing occurs but has yet to be automated.		
	2. The results of any testing and remediating action plans are recorded.	**Achieved** Evidence submitted satisfies the control.		
	3. Regular penetration testing for the presence of known vulnerabilities or common configuration errors is undertaken with third-parties to ensure that security controls have been well implemented and are effective	**Partially Achieved** Pen testing result submitted; no indication of regularity or a scheduled programme.		
TIER 2	1. Regular testing by third-parties is undertaken to identify vulnerabilities in the networks and information systems.	**Partially Achieved**		

		Pen testing result submitted; no indication of regularity or a scheduled programme.
	2. Penetration testing is undertaken following changes to operating systems, business applications and software development and deployment; this is recorded in a penetration test protocol.	**Partially Achieved** Pen testing occurs but no protocol for when pen test should be undertaken.
	3. Test data shall be securely marked, protected and controlled.	**Achieved** Evidence submitted satisfies the control.
	4. Acceptance testing programs and related criteria shall be established for new information systems, upgrades and new versions.	**Achieved** Evidence submitted satisfies the control.

10. OPERATIONAL SECURITY				
Appropriate technical and organisational measures are in place to protect systems and digital services from cyber-attack.		**2023 GREEN**	**2024**	**2025**
CONTROLS		AUDIT ASSESSMENT		
10.1 Malware Policies & Protection: **Detection, prevention and recovery controls to protect against malware shall be implemented.**		**2023 Blue**	**2024**	**2025**
TIER 1	1. Malware protection software is: a. installed and actively running on all computers that are connected to or capable of connecting to the internet and generates audit logs b. kept up-to-date (e.g. at least daily, either by configuring it to update automatically or through the use of centrally managed deployment). c. configured to i. scan files automatically upon access (including when downloading and opening files, accessing files on removable storage media or a network folder) ii. scan web pages when being accessed (via a web browser). iii. prevent connections to known malicious websites on the internet (e.g. by using website blocklisting). d. configured to perform regular scans of all files (e.g. daily). e. preventing connections to malicious websites on the internet (e.g. by using website blocklisting).	**Achieved** Evidence submitted satisfies the control.		
	2. Content filtering capability is present on all external gateways to prevent malicious code being deployed to common desktop applications such as the web browser. The antivirus and malware solutions used at the perimeter are different to those used to protect internal networks and systems in order to provide some additional defence in depth.	**Achieved** Evidence submitted satisfies the control.		
	3. Anti-malware policies and standards are developed and implemented across the organisational infrastructure.	**Achieved** Evidence submitted satisfies the control.		
	4. End user device protection is in place through anti-virus software and application allowlisting.	**Achieved** Evidence submitted satisfies the control.		
	5. If stand-alone workstations are present, these are provided as required, equipped with appropriate anti-virus software capable of scanning the content on any type of media.	**Not Applicable** No stand-alone workstations.		
TIER 2	No additional requirements.			
10.2 Email Security: **Information involved in electronic messaging shall be appropriately protected.**		**2023 Blue**	**2024**	**2025**
TIER 1	1. The NCSC Active Cyber Defence (ACD) programme is implemented where appropriate and available.	**Achieved** Evidence submitted satisfies the control.		
	2. Transport Layer Security Version 1.2 or above (TLS v. 1.2) is used for sending and receiving email securely.	**Achieved** Evidence submitted satisfies the control.		
	3. Domain-based Message Authentication Reporting and Conformance (DMARC) is in place along with Domain Keys Identified Mail (DKIM) and Sender Policy Framework (SPF) records.	**Achieved** Evidence submitted satisfies the control.		
	4. Spam and malware filtering is present and DMARC is enforced on inbound email.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	No additional requirement.			

10.3 Application Security: **Applications are tested for susceptibility to security vulnerabilities on development and following system changes.**		2023 Amber	2024	2025
TIER 1	1. The NCSC's Web Check service has been adopted.	**Achieved** Evidence submitted satisfies the control.		
	2. Policies and procedures with baseline requirements for application security have been developed; these should include multi-factor authentication.	**Not Achieved** No evidence submitted. Narrative indicates an internal-facing application so this control applies. Website security details from NSS not submitted.		
	3. Critical and data-sensitive applications are identified and are subjected to penetration testing to identify business logic vulnerabilities after code scanning and automated security testing.	**Not Achieved** No evidence submitted. Narrative indicates an internal-facing application so this control applies.		
	4. Web applications are routinely scanned and regularly penetration tested for the presence of known security vulnerabilities (such as described in the top ten Open Web Application Security Project (OWASP) vulnerabilities) and common configuration errors.	**Partially Achieved** Pen-test report submitted; regularity of scanning/testing unclear.		
TIER 2	No additional requirements.			
10.4 Vulnerability Management & Scanning: **Network and information systems are managed to prevent exploitation of technical vulnerabilities.**		2023 Blue	2024	2025
TIER 1	1. The NCSC Active Cyber Defence (ACD) programme is implemented where appropriate and available.	**Achieved** Evidence submitted satisfies the control.		
	2. There is a defined policy and supporting process to identify vulnerabilities, prioritise and mitigate those vulnerabilities.	**Achieved** Evidence submitted satisfies the control. Note the Device Vulnerability and Patch Management Policy is an example of Good Practice.		
	3. Regular vulnerability scans are conducted via automated vulnerability scanning tools against all networked devices and any identified vulnerabilities are remedied or managed within an agreed time frame.	**Achieved** Evidence submitted satisfies the control.		
	4. Regular discovery scans to detect unknown devices are undertaken and any anomalous findings are investigated.	**Achieved** Evidence submitted satisfies the control.		
	5. Antivirus and malicious code checking solutions are deployed to scan inbound and outbound objects at the network perimeter. Any suspicious or infected malicious objects are quarantined for further analysis.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. Information about vulnerabilities for all software packages, network equipment and operating systems is obtained in a timely fashion.	**Achieved** Evidence submitted satisfies the control.		
	2. Vulnerabilities are prioritised and subject to a risk assessment to determine the organisation's exposure and vulnerability.	**Achieved** Evidence submitted satisfies the control.		
10.5 Data Exfiltration Monitoring: **Network traffic is monitored to identify unusual activity.**		2023 Amber	2024	2025
TIER 1	1. Network traffic, services and content is limited to that required to support business need (for example, by setting effective firewall rule sets).	**Partially Achieved** Draft policy in place awaiting approval and enforcement.		
TIER 2	1. Data leakage prevention measures should be applied to systems, networks and any other devices that process, store or transmit sensitive information.	**Partially Achieved** Draft policy in place narrative indicates solution under testing.		

10.6 Browser Management: **Web browsers should be configured to minimise security vulnerabilities and risk.**		2023 Blue	2024	2025
TIER 1	1. Browsers are kept current and configured to mitigate against code exploits.	**Achieved** Evidence submitted satisfies the control.		
	2. Unnecessary browser plugins or scripting languages are disabled	**Achieved** Evidence submitted satisfies the control.		
TIER 2	No additional requirements.			
10.7 Monitor / Audit User Activity: **User access and activity are monitored to identify unauthorised access attempts, policy violations and unusual behaviour.**		2023 Yellow	2024	2025
TIER 1	1. All user access and activity is monitored, particularly access to sensitive information and the use of privileged account actions.	**Achieved** Evidence submitted satisfies the control.		
	2. The monitoring capability has the ability to identify unauthorised or accidental misuse of systems or data. It is able to tie specific users to suspicious activity.	**Achieved** Evidence submitted satisfies the control.		
	3. Activities that are outside of normal, expected bounds; policy violation; suspicious or undesirable behaviour (such as access to large amounts of sensitive information outside of standard working hours) are recorded and investigated.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. All user's access is logged and monitored for offline analysis and investigation as required.	**Achieved** Evidence submitted satisfies the control.		
	2. Logging facilities and log information shall be protected against tampering and unauthorised access.	**Not Achieved** Evidence submitted does not clearly specify logging protection.		
	3. All actions involving all logging data (e.g. copying, deleting or modification, or even viewing) can be traced back to a unique user.	**Not Achieved** Evidence submitted does not clearly specify logging audit trail.		
	4. Audit logs recording user activities, exceptions, faults and information security events are created, maintained securely and regularly reviewed.	**Partially Achieved** Evidence submitted does not clearly specify logging security or review period.		
	5. Attempts by unauthorised users to connect to systems are alerted, promptly assessed and investigated where relevant.	**Achieved** Evidence submitted satisfies the control.		

11. NETWORK SECURITY				
Appropriate measures are in place to ensure the protection of information systems and information held in networks.		**2023 GREEN**	**2024**	**2025**
CONTROLS		AUDIT ASSESSMENT		
11.1 Patch Management: **Operating systems and software packages on networks and devices are kept up-to-date with the latest security patches installed.**		**2023 Blue**	**2024**	**2025**
TIER 1	1. All security patches for software running on computers and network devices that are connected to or capable of connecting to the internet are installed in a timely manner (e.g. within 14 days of release or automatically when available from vendors).	**Achieved** Evidence submitted satisfies the control.		
	2. There is a defined policy and supporting process to identify vulnerabilities, prioritise and mitigate those vulnerabilities. The policy specifies specific patch application periods and a process for auditing compliance.	**Achieved** Evidence submitted satisfies the control.		
	3. Critical vulnerabilities are patched within 14 days.	**Achieved** Evidence submitted satisfies the control.		
	4. Where a vulnerability is being actively exploited then mitigating action (e.g. patch applied) is immediately taken.	**Achieved** Evidence submitted satisfies the control.		
	5. Where a patch is not deployed (or available) within the timescales above there is alternative mitigating actions employed, such as disabling or reducing access to the vulnerable service.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	No additional requirements.			
11.2 End-Point Device Management: **Devices that are used to access organisational networks, information systems and data are known and recorded with integrated security management policies and systems.**		**2023 Blue**	**2024**	**2025**
TIER 1	1. Unnecessary peripheral devices are disabled.	**Achieved** Evidence submitted satisfies the control.		
	2. Technical policies are applied and controls exerted on devices over software and applications.	**Achieved** Evidence submitted satisfies the control.		
	3. Devices used to access sensitive information and data or key operational services are authenticated and authorised.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. Dedicated devices are used for privileged actions (such as administration or accessing the essential service's network and information systems). These devices are not used for directly browsing the web or accessing email.	**Achieved** Evidence submitted satisfies the control.		
	2. Device identity management which is cryptographically backed is performed and only known devices are able to access systems.	**Achieved** Evidence submitted satisfies the control.		
	3. Privileged access is only granted on owned and managed devices that are technically segregated and secured to the same level as the networks and systems being maintained.	**Achieved** Evidence submitted satisfies the control.		
11.3 Internal Segregation: **Networks and information systems are segregated into appropriate security zones.**		**2023 Yellow**	**2024**	**2025**
TIER 1	1. Information services, sensitive data, users and information systems are segregated into appropriate security zones on networks.	**Achieved** Evidence submitted satisfies the control.		
	2. Key operational systems are segregated in a highly trusted, more secure zone isolated with appropriate network security controls.	**Achieved** Evidence submitted satisfies the control.		

TIER 2	1. Development, testing, and operational environments shall be separated to reduce the risks of unauthorised access or changes to the operational environment.	**Achieved** Evidence submitted satisfies the control.
	2. Internet services are not accessible from operational systems	**Not Achieved** No narrative or evidence provided.
	3. Logging data is segregated from the rest of the network, and is not affected by disruption or corruption of network data.	**Not Achieved** No narrative or evidence provided.
11.4 Wireless Security: **Wireless access points should be securely configured and segregated as appropriate.**		**2023 Blue** | **2024** | **2025**
TIER 1	1. Wireless access points are securely configured.	**Achieved** Evidence submitted satisfies the control.
	2. All wireless access points only allow known devices to connect to corporate Wi-Fi services.	**Achieved** Evidence submitted satisfies the control.
	3. Security scanning tools are in place to detect and locate unauthorised or spoof wireless access points.	**Achieved** Evidence submitted satisfies the control.
TIER 2	No additional requirements.	
11.5 Boundary / Firewall Management: **Manage access to ports, protocols and applications by filtering and inspecting all traffic at the network perimeter.**		**2023 Amber** | **2024** | **2025**
TIER 1	1. One or more firewalls (or equivalent network device) are installed on the boundary of the organisation's internal network(s).	**Achieved** Evidence submitted satisfies the control.
	2. The default administrative password for any firewall (or equivalent network device) is changed to an alternative, strong password.	**Achieved** Evidence submitted satisfies the control.
	3. Each rule that allows network traffic to pass through the firewall (e.g. each service on a computer that is accessible through the boundary firewall) is subject to approval by an authorised individual and documented (including an explanation of business need).	**Not Achieved** No narrative or evidence provided.
	4. A high risk ports, protocols and services block list should be written and added to firewall policy as a default ruleset. Unapproved services, or services that are typically vulnerable to attack (such as Server Message Block (SMB), NetBIOS, tftp, RPC, rlogin, rsh or rexec), are disabled (blocked) at the boundary firewall by default.	**Not Achieved** No narrative or evidence provided.
	5. Firewall rules that are no longer required (e.g. because a service is no longer required) are removed or disabled in a timely manner.	**Not Achieved** No narrative or evidence provided.
	6. The administrative interface used to manage boundary firewall configuration is not accessible from the internet. (The interface is protected by additional security arrangements, which include using multi-factor authentication, a strong password, encrypting the connection (e.g. using SSL), restricting access to a limited number of authorised individuals and only enabling the administrative interface for the period it is required.)	**Not Achieved** No evidence submitted.
	7. The firewall rule set should deny traffic by default and an allowlist should be applied that only allows authorised protocols, ports and applications to exchange data across the boundary.	**Not Achieved** No narrative or evidence provided.
TIER 2	1. Traffic crossing the network boundary (including IP address connections as a minimum) is monitored.	**Achieved** Evidence submitted satisfies the control.

11. 6 Administrator Control: **System administrators are strongly authenticated and authorisation is reviewed.**		**2023 Yellow**	**2024**	**2025**
TIER 1	1. Administrator access to any network component is properly authenticated and authorised.	**Achieved** Evidence submitted satisfies the control.		
	2. Default administrative passwords for network equipment are changed.	**Achieved** Evidence submitted satisfies the control.		
	3. Changes to the authoritative DNS entries can only be made by strongly authenticated and authorised administrators.	**Not Achieved** No evidence submitted.		
TIER 2	1. The list of system administrators is regularly reviewed, e.g. every 6 months.	**Partially Achieved** Account Management policy in place, narrative notes that reviews occur but periodicity unclear.		
11.7 IP & DNS Management: **Organisational IP ranges are known, recorded and managed; DNS changes and queries are effectively managed.**		**2023 Blue**	**2024**	**2025**
TIER 1	1. The NCSC's ACD P-DNS service is implemented where appropriate and available.	**Achieved** Evidence submitted satisfies the control.		
	2. The UK Public Sector DNS Service is used to resolve internet DNS queries.	**Achieved** Evidence submitted satisfies the control.		
	3. Organisational IP ranges are known and recorded.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	No additional requirements.			
11.8 IoT Management: **Internet-facing devices should be securely configured and segregated as appropriate.**		**2023 Blue**	**2024**	**2025**
TIER 1	1. There is an inventory of all internet-facing devices.	**Not Applicable** Narrative states that there are no IoT devices		
	2. There is the discovery capability to identify and profile every device on the network.	**Not Applicable** Narrative states that there are no IoT devices		
	3. Data access and data flows from devices are known, understood and documented.	**Not Applicable** Narrative states that there are no IoT devices		
	4. Devices are monitored with alerting to identify any anomalous behaviour or compromise.	**Not Applicable** Narrative states that there are no IoT devices		
TIER 2	1. Devices are categorised on the basis of risk profile and criticality.	**Not Applicable** Narrative states that there are no IoT devices		
	2. Devices are grouped on the basis of risk profile with appropriate security policies applied.	**Not Applicable** Narrative states that there are no IoT devices		
	3. High-risk or critical devices are hosted on segmented networks which are secured from the corporate infrastructure.	**Not Applicable** Narrative states that there are no IoT devices		
	4. Assurances have been provided from suppliers of IoT devices that these confirm to the UKG Code of Practice for Consumer IoT Security and the ETSI Cyber Security for Consumer Internet of Things: Baseline Requirements.	**Not Applicable** Narrative states that there are no IoT devices		
	5. Bluetooth IoT devices are set up as non-discoverable mode	**Not Applicable** Narrative states that there are no IoT devices		

	6. IoT devices' firmware are patched with the security measures issued by manufacturers	**Not Applicable** Narrative states that there are no IoT devices

12. INCIDENT DETECTION					
Organisations shall have in place monitoring systems and procedures to detect cyber-attacks.			**2023 GREEN**	**2024**	**2025**
CONTROLS			AUDIT ASSESSMENT		
12.1 Detection Capability: **Attempts to access or compromise systems are alerted, promptly assessed and investigated.**			**2023 Blue**	**2024**	**2025**
TIER 1	1.	Attackers attempting to use common cyber-attack techniques should not be able to gain access to data or any control of technology services without being detected.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1.	Detection (and prevention and recovery) controls to protect against malware are in place.	**Achieved** Evidence submitted satisfies the control.		
	2.	Policy violations are detected against an agreed list of suspicious or undesirable behaviour.	**Achieved** Evidence submitted satisfies the control.		
	3.	There is the capability to investigate AV alerts.	**Achieved** Evidence submitted satisfies the control.		
	4.	Threat intelligence services are in place and used to enable risk-based and threat-informed decisions based on business needs and inform anomalous activity profiles.	**Achieved** Evidence submitted satisfies the control.		
	5.	There is a sufficient understanding of normal system activity (e.g. which system components should and should not be communicating with each other) to ensure that searching for system abnormalities is an effective way of detecting malicious activity.	**Achieved** Evidence submitted satisfies the control.		
	6.	Descriptions of some system abnormalities that might signify malicious activity are maintained and updated, informed by past attacks and threat intelligence that takes into account the nature of attacks likely to impact on the networks and information systems.	**Achieved** Evidence submitted satisfies the control.		
	7.	Routine search for system abnormalities are undertaken and alerts generated.	**Achieved** Evidence submitted satisfies the control.		
12.2 Security Monitoring: **Risk-based organisational monitoring policy and procedures are in place for the timely identification of security events.**			**2023 Green**	**2024**	**2025**
TIER 1	1.	The network is monitored with intrusion detection and prevention solutions that are configured by qualified staff. These solutions should provide both signature-based capabilities to detect known attacks, and heuristic capabilities to detect unusual system behaviour. Coverage includes internal and host-based monitoring.	**Achieved** Evidence submitted satisfies the control.		
	2.	Inbound and outbound traffic traversing network boundaries is monitored to identify unusual activity or trends that could indicate attacks. Unusual network traffic (such as connections from unexpected IP ranges overseas) or large data transfers automatically generate security alerts.	**Achieved** Evidence submitted satisfies the control.		
	3.	Policies and processes are in place to promptly manage and respond to incidents detected by monitoring solutions.	**Achieved** Evidence submitted satisfies the control.		
	4.	Alerts generated by the system monitoring strategy are based on business need and an assessment of risk. This includes both technical and transactional monitoring as appropriate.	**Achieved** Evidence submitted satisfies the control.		

	5. The monitoring capability has the ability to identify the unauthorised or accidental misuse of systems processing personal data and user access to that data, including anomalous user activity. It can tie specific users to suspicious activity.	**Achieved** Evidence submitted satisfies the control.
	6. A centralised capability has been deployed that can collect and analyse information and alerts from across the organisation. This is automated due to the volume of data involved, enabling analysts to concentrate on anomalies or high priority alerts.	**Achieved** Evidence submitted satisfies the control.
	7. The monitoring and analysis of audit logs is supported by a centralised and synchronised timing source that is used across the entire organisation to support incident response and investigation.	**Achieved** Evidence submitted satisfies the control.
	8. Processes are in place to test monitoring capabilities, learn from security incidents and improve the efficiency of the monitoring capability.	**Partially Achieved** Learning exercises not demonstrated.
TIER 2	1. As well as the network boundary, monitoring coverage includes internal and host-based monitoring.	**Achieved** Evidence submitted satisfies the control.
	2. The process for bringing new systems online includes considerations for access to monitoring data sources.	**Not Achieved** Evidence submitted is unclear.
	3. Monitoring staff: a) are responsible for investigating and reporting monitoring alerts. b) have roles and skills that covers all parts of the monitoring/investigation workflow. c) have workflows that address all governance reporting requirements, internal and external. d) are empowered to look beyond fixed workflows to investigate and understand non-standard threats, by developing their own investigative techniques and making new use of data.	**Achieved** Evidence submitted satisfies the control.

13. INCIDENT MANAGEMENT				
Well-defined incident management processes are in place, documented and regularly tested.		**2023 YELLOW**	**2024**	**2025**
CONTROLS		AUDIT ASSESSMENT		
13.1 Incident Response Protocol: **A risk-based and up-to-date incident response plan is in place.**		**2023 Yellow**	**2024**	**2025**
TIER 1	1. Cyber incident response policies and process are in place and these integrate with central cyber incident reporting , notification and coordination protocols.	**Achieved** Evidence submitted satisfies the control.		
	2. Staff are trained in incident response with assigned roles and responsibilities and the organisation carries out exercises to test response plans.	**Partially Achieved** Training is not specifically related to a cyber incident and testing not evidenced.		
	3. There is an incident response capability and management plan in place, documented, with clear pre-defined processes, actions, roles and responsibilities and clear terms of reference for decision-making and incident management.	**Achieved** Evidence submitted satisfies the control.		
	4. Specialist training is provided as required to the incident response team.	**Not Achieved** Whilst staff are trained to respond to incidents, it's not specifically related to information security and there is no evidence of specialist training for cyber/information incidents.		
	5. In the event of an incident the response team is provided with audit logs holding user activities, exceptions and information security events to assist in investigations.	**Not Achieved** No evidence submitted.		
	6. The contact details of key personnel are readily available to use in the event of an incident.	**Partially Achieved** Noted at a high level but the staff who will be required as part of the incident response team should be detailed.		
	7. The supporting policy, processes and plans are risk based and cover any legal or regulatory reporting requirements.	**Partially Achieved** Evidence that incidents are reported, for example to the ICO, is not included.		
	8. All incidents are recorded regardless of the need to report them.	**Achieved** Evidence submitted satisfies the control.		
	9. All plans supporting security incident management (including business continuity and disaster recovery plans) are regularly tested.	**Achieved** Evidence submitted satisfies the control.		
	10. The outcome of the tests and knowledge from incident management events are used to inform the future development of the incident management plans.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. The incident response plan is communicated and understood by the wider organisational business and integrated with supply chain response plans.	**Achieved** Evidence submitted satisfies the control.		
	2. Thresholds for incident definitions, classifications and assessments are in place.	**Achieved** Evidence submitted satisfies the control.		
	3. Alternative communication arrangements and critical document response plans are available in alternative secure locations in the event of the primary channels not being available.	**Partially Achieved** Stated but not evidenced in documentation.		
	4. Procedures for the identification, collection, acquisition and preservation of evidence have been defined and implemented	**Partially Achieved**		

		New documentation yet to be approved will cover this. Section 6 of current IG20 cited but there is not a section 6 in the document submitted.		
13.2 Incident Reporting Procedure: **Security events are reported through defined procedures known to staff.**		**2023 Yellow**	**2024**	**2025**
TIER 1	1. The organisation promotes an incident reporting culture that empowers staff to voice their concerns about poor security practices and security incidents to senior managers, with positive recognition and without fear of recrimination.	**Achieved** Evidence submitted satisfies the control.		
	2. Users (employees and contractors) are security aware, know their responsibilities, and understand how to report any observed or suspected security weaknesses in systems or services and how to respond to incidents.	**Achieved** Evidence submitted satisfies the control.		
	3. Users are encouraged to report any security weaknesses or incident as soon as possible, without fear of recrimination.	**Achieved** Evidence submitted satisfies the control.		
	4. There are communication plans in place in the event of an incident and all internal and external reporting requirements are identified in the incident management plan. This includes notifying the relevant supervisory body, senior accountable individuals, the National Cyber Security Centre (NCSC), the Information Commissioner's Office (ICO) and law enforcement as applicable.	**Not Achieved** Stated as in documentation but not clearly signposted.		
	5. The effectiveness of security training and awareness activities in incident management is monitored and tested.	**Not Achieved** No evidence submitted.		
TIER 2	No additional requirement.			
13.3 Post-Incident Review & Learning: **The organisation reviews incidents and uses lessons learned from incidents to improve security measures.**		**2023 Amber**	**2024**	**2025**
TIER 1	1. The senior team should take ownership of the lessons process to ensure that any actions required to improve the organisation's cyber resilience are undertaken.	**Achieved** Evidence submitted satisfies the control.		
	2. Post-incident evidence is collected, preserved and analysed to identify and remedy the root cause.	**Partially Achieved** Evidenced in templates but not in process.		
	3. Root cause analysis is conducted routinely as a key part of the lessons learned activities following an incident. This is comprehensive, covering organisational process issues, as well as vulnerabilities in networks, systems or software.	**Partially Achieved** Several policies cited but the narrative is repetitive and does not signpost to the evidence and its not clear how staff can be guided by so much documentation.		
	4. Lessons-learned reviews are conducted: actions taken during an incident are logged and reviewed to evaluate the performance of the incident management process.	**Partially Achieved** Several policies cited but the narrative is repetitive and does not signpost to the evidence and it's not clear how staff can be guided by so much documentation.		
	5. Post incident lessons are assessed and lessons implemented into future iterations of the incident management plan and the monitoring capability.	**Partially Achieved** Several policies cited but the narrative is repetitive and does not signpost to the evidence and it's not clear how staff can be guided by so much documentation.		

TIER 2	1. There is a documented incident review process/policy which ensures that lessons learned from each incident are identified, captured, and acted upon.	**Partially Achieved** Several policies cited but the narrative is repetitive and does not signpost to the evidence and it's not clear how staff can be guided by so much documentation.
	2. Lessons learned cover issues with reporting, roles, governance, skills and organisational processes as well as technical aspects of networks and information systems.	**Partially Achieved** Several policies cited but the narrative is repetitive and does not signpost to the evidence and it's not clear how staff can be guided by so much documentation.
	3. Improvements identified as a result of lessons learned exercises are prioritised, with the highest priority improvements completed quickly.	**Partially Achieved** Several policies cited but the narrative is repetitive and does not signpost to the evidence and it's not clear how staff can be guided by so much documentation.

14. BUSINESS CONTINUITY				
Information security continuity shall be embedded in the organisation's business continuity management systems.		**2023 YELLOW**	**2024**	**2025**
CONTROLS		AUDIT ASSESSMENT		
14.1 Data Recovery Capability: **Recovery controls are in place and tested to protect against information /data being lost or compromised.**		**2023 Blue**	**2024**	**2025**
TIER 1	1. A data recovery capability is in place that includes a systematic approach to the backup of essential data.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. The organisation has applied suitable physical or technical security to protect this backup stored data from unauthorised access, modification or deletion.	**Achieved** Evidence submitted satisfies the control.		
14.2 Backup Policies & Procedures: **Backup copies of information, software and system images shall be taken and tested regularly.**		**2023 Yellow**	**2024**	**2025**
TIER 1	1. There is a backup policy and measures are in place to routinely maintain backup media.	**Partially Achieved** Back-ups are included in over arching policy but no specific policy was identified for the back up process.		
	2. The ability to recover archived data for operational use is regularly tested.	**Not Achieved** No evidence submitted.		
	3. Physical backup media (where used) is held in a physically secure location, offsite.	**Achieved** Seen at site visit.		
TIER 2	1. Backup copies of information, data, software and system images are taken, tested, documented and routinely reviewed.	**Partially Achieved** Not clear on the testing.		
	2. There are secured backups of data to allow services to continue should the original data not be available.	**Achieved** Evidence submitted satisfies the control.		
	3. Automatic and tested technical and procedural backups are secured at centrally accessible or secondary sites to recover from an extreme event.	**Achieved** Evidence submitted satisfies the control.		
14.3 Disaster Recovery Policies & Procedures: **The organisation has well defined and tested processes in place to ensure the continuity of key operational services in the event of failure or compromise.**		**2023 Green**	**2024**	**2025**
TIER 1	1. A disaster recovery plan is in place and updated at least annually or upon significant changes.	**Achieved** Evidence submitted satisfies the control.		
	2. Contingency mechanisms to continue to deliver services in the event of any failure, forced shutdown, or compromise of any system or service have been identified, documented and tested.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. Restore times to operational service are known and documented.	**Achieved** Evidence submitted satisfies the control.		
	2. The resources needed to carry out any required response activities are known, with arrangements in place to make these resources available.	**Achieved** Evidence submitted satisfies the control.		
	3. The types of information that will likely be needed to inform response decisions, and arrangements are in place to make this information available, including with third-party suppliers as appropriate and where required.	**Achieved** Evidence submitted satisfies the control.		
	4. Disaster response team members have the skills and knowledge required to decide on the response actions necessary to limit harm, and the authority to carry them out.	**Achieved** Evidence submitted satisfies the control.		

	5. Back-up mechanisms are available that can be readily activated to allow continued delivery of essential services (although possibly at a reduced level) if primary networks and information systems fail or are unavailable.	**Achieved** Evidence submitted satisfies the control.		
14.4 BC/DR Testing Policies & Procedures: **Scenario-based exercises and processes to test recovery response plans are planned and performed.**		**2023** **Black**	**2024**	**2025**
TIER 1	1. Restoring the service to normal operation is a well-practised scenario.	**Not Achieved** Noted that ad hoc back up restores take place in a live environment as required.		
TIER 2	1. The established and implemented information security continuity controls are tested and reviewed at regular intervals in order to ensure that they are valid and effective.	**Not Achieved** No evidence submitted.		
	2. Business continuity and disaster recovery plans are tested annually for practicality, effectiveness and completeness to ensure they remain valid.	**Not Achieved** Noted that the newly developed plans will be tested.		
	3. Exercise scenarios are based on incidents experienced by the organisation, other organisations, or are composed using experience or threat intelligence.	**Not Achieved** Narrative notes that exercise scenarios have not been carried out to date.		
	4. Exercise scenarios are documented, regularly reviewed, and validated.	**Not Achieved** Narrative notes that exercise scenarios have not been carried out to date.		
	5. Exercises are routinely run, with the findings documented and used to refine incident response plans and protective security, in line with the lessons learned.	**Not Achieved** Narrative notes that exercise scenarios have not been carried out to date.		
	6. Exercises test all parts of the response cycle relating to particular services or scenarios (e.g. restoration of normal service levels).	**Not Achieved** Narrative notes that exercise scenarios have not been carried out to date.		
14.5 Data Protection Impact Assessments (DPIA): **DPIAs are undertaken to determine the impact of the intended processing on the protection of personal data where the processing is likely to result in a high risk to the rights and freedoms of individuals. The DPIA should consider the technical and organisational measures necessary to mitigate that risk.**		**2023** **Blue**	**2024**	**2025**
TIER 1	1. The business impact of loss of availability of the service is known, understood and mitigated.	**Achieved** Evidence submitted satisfies the control.		
	2. Conduct a Data Protection Impact Assessment (DPIA) to evaluate the origin, nature, particularity and severity of the risks upon the processing of personal data.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. The impact on services of all relevant scenarios, including unauthorised data access, modification or deletion, or when authorised users are unable to appropriately access this data, are understood and documented.	**Achieved** Evidence submitted satisfies the control.		
	2. These impact statements are validated regularly, e.g. annually.	**Achieved** Evidence submitted satisfies the control.		
14.6 BC Contingency Plan: **Contingency mechanisms are in place to continue to deliver services in the event of any failure or compromise of any system or service.**		**2023** **Green**	**2024**	**2025**
TIER 1	1. Organisation-wide contingency mechanisms and plans to continue to deliver services in the event of any failure, forced shutdown, or compromise of any system or service have been identified, documented, and implemented.	**Achieved** Evidence submitted satisfies the control.		

TIER 2	1. Business Impact Analysis is undertaken to identify critical systems and information assets and suitable arrangements are in place to protect then recover to agreed objectives (RPO/RTOs).	**Achieved** Evidence submitted satisfies the control.
	2. Suitable alternative transmission paths are available where there is a risk of impact on the delivery of the essential service due to resource limitation (e.g. transmission equipment or service failure, or important data being blocked or jammed).	**Achieved** Evidence submitted satisfies the control.
	3. Information security continuity is embedded in the organisation's wider business continuity management planning.	**Not Achieved** No evidence submitted.
	4. Key roles are duplicated and operational delivery knowledge is shared with all individuals involved in the operations and recovery of the essential service.	**Achieved** Evidence submitted satisfies the control.
	5. The resources that will be needed to carry out any required response activities, and arrangements are in place to make these resources available.	**Achieved** Evidence submitted satisfies the control.
	6. The types of information that will likely be needed to inform response decisions are known and documented and arrangements are in place to make this information available.	**Achieved** Evidence submitted satisfies the control.
	7. Where necessary, arrangements are in place to augment incident response capabilities with external support (e.g. specialist providers of cyber incident response capability).	**Achieved** Evidence submitted satisfies the control.

15. PEOPLE

The organisation has policies and procedures in place to ensure staff and contractors are screened, trained and know their security responsibilities.		**2023 GREEN**	**2024**	**2025**
CONTROLS		AUDIT ASSESSMENT		
15.1 Prior to Employment: **Employees and contractors understand their responsibilities and are suitable for the roles for which they are considered.**		**2023 Yellow**	**2024**	**2025**
TIER 1	1. Pre-employment checks have been performed on all candidates proportional to the role and responsibilities, the classification of the information to be accessed and the perceived risks.	**Achieved** Evidence submitted satisfies the control.		
	2. Employee and contractor contract terms and conditions shall state their responsibilities for information security.	**Partially Achieved** Not evidenced for contractors.		
TIER 2	No additional requirements.			
15.2 During Employment: **Staff and contractors are aware of and fulfil their information and cyber security responsibilities.**		**2023 Green**	**2024**	**2025**
TIER 1	1. A staff induction process is in place for new users (including contractors and third party users).	**Achieved** Evidence submitted satisfies the control.		
	2. As part of the induction process staff are made aware of their personal responsibility and obligations to comply with the corporate security policies with regards to system security, data handling, and acceptable use.	**Achieved** Evidence submitted satisfies the control.		
	3. The terms and conditions for their employment, or contract, should be formally signed or otherwise acknowledged and retained to support any subsequent disciplinary action.	**Achieved** Evidence submitted satisfies the control.		
TIER 2	1. There is an established workflow processes that reviews, adds or revokes the access controls and permissions of staff that join, leave or move roles.	**Achieved** Evidence submitted satisfies the control.		
	2. Information security responsibilities and duties that remain valid after termination or change of employment shall be defined, communicated to the employee or contractor and enforced.	**Not Achieved** Evidence submitted does not fulfil the control requirements.		
	3. All employees and external party users shall return all of the organisational assets in their possession upon termination of their employment, contract or agreement.	**Achieved** Evidence submitted satisfies the control.		
	4. Conflicting duties and areas of responsibility shall be segregated to reduce opportunities for unauthorised or unintentional modification or misuse of the organisation's assets.	**Partially Achieved** Access control used where possible but due to the small team full segregation not possible.		
	5. Users shall ensure that unattended equipment has appropriate protection.	**Achieved** Evidence submitted satisfies the control.		
	6. A clear desk policy for papers and removable storage media and a clear screen policy for information processing facilities shall be adopted.	**Achieved** Evidence submitted satisfies the control.		
15.3 Staff Training & Awareness Culture: **All employees and contractors receive appropriate awareness education and training with regular assessments and updates as relevant for their job function.**		**2023 Green**	**2024**	**2025**
TIER 1	1. Appropriate staff training, awareness-raising and disciplinary processes with regard to cyber resilience are in place for staff at all organisational levels.	**Achieved** Evidence submitted satisfies the control.		

	2. All employees receive regular training on cyber security risks to the organisation. This is tracked and refresher training is completed at suitable intervals.	**Achieved** Evidence submitted satisfies the control.
	3. There is a culture of awareness and education about cyber security across the organisation.	**Achieved** Evidence submitted satisfies the control.
	4. All users should be aware of the policy regarding acceptable account usage and their personal responsibility to adhere to corporate security policies including removable media security and mobile device utilisation.	**Achieved** Evidence submitted satisfies the control.
	5. The effectiveness of security training is monitored through user feedback to determine the effectiveness and value of the security training provided to all users.	**Achieved** Evidence submitted satisfies the control.
	6. Employees receive appropriate training, support and technology to help them manage personal data securely.	**Achieved** Evidence submitted satisfies the control.
	7. Senior accountable individuals promote a culture of awareness and education about cyber security across the organisation.	**Achieved** Evidence submitted satisfies the control.
	8. Cyber security information and good practice guidance is easily and widely available.	**Achieved** Evidence submitted satisfies the control.
TIER 2	1. Individuals' cyber security training is monitored to ensure update training is completed and delivered at regular intervals.	**Achieved** Evidence submitted satisfies the control.
	2. Cyber security training and awareness activities are evaluated for efficacy through staff testing programmes (.e.g. phishing exercises).	**Not Achieved** No evidence was submitted.
15.4 Staff Skills Assessment: **Staff, including SMT and board members, are appropriately trained in cyber security and risk assessment.**		**2023 Yellow** | **2024** | **2025**
TIER 1	1. A formal assessment of security skills is undertaken.	**Not Achieved** Evidence submitted does not fulfil the control requirements.
	2. Staff in security roles should be encouraged to develop and formally validate their security skills through enrolment on a recognised certification scheme.	**Achieved** Evidence submitted satisfies the control..
TIER 2	1. Necessary roles for the security of networks and information systems have been identified and appropriately capable and knowledgeable staff fill those roles.	**Achieved** Evidence submitted satisfies the control..
15.5 Mobile / Remote Working Policy: **The organisation has in place policies and security measures to manage the risks introduced by people using mobile devices and remote working.**		**2023 Blue** | **2024** | **2025**
TIER 1	1. A policy and supporting security measures shall be adopted to manage the risks introduced by using mobile devices including BYOD to protect information and data accessed, processed or stored at remote sites.	**Achieved** Evidence submitted satisfies the control.
TIER 2	1. Where working arrangements allow for remote or hybrid working, routers provided by the organisation for home-working are renamed with new passwords to prevent unauthorised access via default settings.	**Not Applicable** Not supplied by TSH.

FACILITIES / ESTATES

16. ENVIRONMENTAL SECURITY				
Appropriate procedures are in place to reduce the risks from internal and external environmental threats and hazards.		**2023 BLUE**	**2024**	**2025**
CONTROLS		AUDIT ASSESSMENT		
16.1 Equipment Location: **Equipment shall be sited and protected to reduce environmental impacts on information systems and service delivery.**		**2023 Blue**	**2024**	**2025**
TIER 1	1. Equipment on premise and with third parties is sited and protected to reduce the risks from physical and environmental threats and hazards.	**Achieved** Evidence submitted and seen on site satisfies the control.		
	2. Network and connectivity cabling is resilient, and protected from interception, interference or damage with redundancy in place.	**Achieved** Evidence submitted and seen on site satisfies the control.		
TIER 2	No additional requirements.			
16.2 Power Resilience: **Equipment shall be protected from power failures and other disruptions caused by failures in supporting utilities.**		**2023 Blue**	**2024**	**2025**
TIER 1	1. Dependencies on supporting infrastructure (e.g. power, cooling) are identified and recorded.	**Achieved** Evidence submitted and seen on site satisfies the control.		
	2. Equipment is protected from power failures and surges and other disruptions caused by failures in supporting utilities such as telecommunications with redundancy in place.	**Achieved** Evidence submitted and seen on site satisfies the control.		
TIER 2	No additional requirements.			

17. PHYSICAL / BUILDING SECURITY				
To prevent unauthorised physical access, damage and interference with the organisation's information systems and services.		**2023 BLUE**	**2024**	**2025**
CONTROLS		AUDIT ASSESSMENT		
17.1 Access Control: **Building and secure areas access shall be protected by appropriate entry controls to ensure that only authorised personnel are allowed admittance.**		**2023 Blue**	**2024**	**2025**
TIER 1	1. Appropriately secure accommodation, and appropriate policies and practices governing its use, are in place to protect personnel, hardware, programs, networks and data from loss, damage or compromise.	**Achieved** Evidence submitted and seen on site satisfies the control.		
TIER 2	1. Delivery and loading areas and other access points are controlled.	**Achieved** Evidence submitted and seen on site satisfies the control.		
17.2 Internal Security: **Internal security perimeters shall be defined with policies and active alerting systems used to protect areas that contain sensitive data, critical information and essential information systems.**		**2023 Blue**	**2024**	**2025**
TIER 1	1. Secure accommodation areas are defined and segregated to protect areas that contain either sensitive data or information processing facilities.	**Achieved** Evidence submitted and seen on site satisfies the control.		
	2. Appropriate policies and practices governing use of the secure accommodation and access are in place.	**Achieved** Evidence submitted and seen on site satisfies the control.		
TIER 2	1. Secure areas are protected by entry controls to ensure that only authorised personnel are allowed access.	**Achieved** Evidence submitted and seen on site satisfies the control.		
	2. Physical security for offices, rooms and facilities shall be defined and implemented; to include, for example, intruder detection, fire and flood alarms and alerting systems.	**Achieved** Evidence submitted and seen on site satisfies the control.		

Paper No. 23/129

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	21 December 2023
Agenda Reference:	Item No: 22
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Director of Finance and eHealth
Title of Report:	Network & Information Systems Review – Outcome
Purpose of Report:	For Noting

1 SITUATION

The State Hospital (TSH) was subject to a compliance progress review of Network & Information Systems by Cyber Security Scotland during October 2023, following the previous review in October 2022.

2 BACKGROUND

In 2020 the Scottish Health Competent Authority commissioned a three-year programme of audits and reviews of health boards to evaluate compliance with the Network & Information Systems (NIS) regulations. The initial audit programme was completed and unless incident reports or significant system changes in a health board merit a more frequent audit exercise, audits are conducted every third year. In intervening years, Compliance Reviews are being undertaken – to which this report relates - the primary objective of the review being to assess progress on implementing the recommendations from the initial audit and progress on the control requirements.

3 ASSESSMENT AND OUTCOMES

A considerable amount of evidence was submitted up front to the reviewers – each piece of evidence requested for the review being "mapped" and cross-referenced to one or more controls set out. The documentary evidence was then reviewed and assessed for compliance.

3.1 PROCESS

The 17 categories of the review were as follows –

- Organisational Governance
- Risk Management
- Supplier Management
- Asset Management
- Information Security Management

- Services Resilience
- Access Control
- Media Management
- System Management
- Operational Security
- Network Security
- Incident Detection
- Incident Management
- Business Continuity
- People
- Environmental Security
- Physical / Building Security

3.2 REVIEW

While the compliance status outcome from the 2022 review was raised from previous reviews, this was only from 28% to 36%.

In response to this rating, and in order to aim for a stronger submission in 2023, a significant programme of work began early in the year to reduce this level of risk exposure, and this was progressed as a priority. The individual assessment points in the review were all confirmed with allocated responsibilities across directorates for provision of documented processes in support of compliance.

These actions were tracked fortnightly by the monitoring group (Director of Finance & eHealth, Head of eHealth and IT Security Officer – reporting to Chief Exec). There was full engagement with regular in-person meetings for all of the departments from whom contributions and evidence were deemed essential – principally eHealth, Estates, Health Records, HR, Information Governance, Risk and Security – and a considerable effort by all of those involved in prioritising this has provided a strong contribution.

Additionally, while the previous review was conducted wholly remotely, on 5 June 2023 the independent reviewer also undertook a site visit at TSH which, with support predominantly from eHealth, Security and Estates, enabled a fuller appraisal of the physical aspects of our site and systems.

Once the submission had been considered, and before the issue of the interim report, the reviewers then held 1-2-1 meetings with senior personnel (NIS lead, SIRO, eHealth and Risk) in order to confirm certain elements of the submission.

3.3 OUTCOME

It is very pleasing to report that the approach taken for this submission and review has been successful in achieving an extremely positive outcome.

The overall assessment is a rating of 76% - a significant improvement on 2022, “showing strength across the organisation and a high level of performance” and which sees us described as “a strongly-performing board with a clear commitment to the NIS audit programme”.
(All 17 categories were rated above the 60% compliance level, with 9 being 80% or better, and two at 100%. It is also interesting to note that, had our submission been rated against the same framework as in 2022, then our Board’s compliance rating would have been 86%.)

The report is particularly praising of the “involvement and support of the Chief Executive and SLT to the NIS audit” – seen as a “critical factor in this achievement” and “an approach that is to be

commended and an exemplar to other boards." The raised level of awareness and commitment from all levels was a key factor in the review.

During the outcomes meeting with the Board on 6 December, one of the areas also highlighted by the reviewer was the strength of TSH training – noting that the inclusion of a training plan was the first they had seen from their reviews.

There was only one sub-category in the review noted to be a priority for development – and that relates to business continuity / disaster recovery testing policies & procedures. This is a development area common with most other Boards and it will now be reviewed between the NIS and Risk teams for a plan to be put in place to take it forward.

The report is attached as an appendix to this paper, and attention is drawn in particular to the sections covering Executive Summary (p.5) and Observations and Strengths (pp.9-10, within Outcomes).

Great credit is due to John Fitzgerald, Infrastructure Operations and IT Security Manager, who co-ordinated the submission, together with Head of eHealth Thomas Best and the other department leads and their teams who were closely involved throughout (Risk – Allan Hardy, Security – Jim Irvine, Estates – Kenny Andress, IG – Ken Lawton, Health Records – Karen Mowbray, Procurement – Stuart Paterson, HR – Laura Nisbet)

The report is currently issued in interim format, with a final version now due to be received following the closing outcomes meeting held by the reviewer with the Board on 6 December. Again from this meeting the reviewers were complimentary of a level of senior engagement higher than from many boards – being attended by five non-executive directors, three directors and the Head of Corporate Governance. Once the final report is received, this will be circulated to the Board.

3.3 POST REVIEW

The NIS lead and team will now consider the areas for development, and a plan will be put in place in 2024 to address these.

4 RECOMMENDATION

The Board is to note the report, and the outcomes therefrom.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	21 December 2023
Agenda Reference:	Item No: 23
Sponsoring Director:	Chief Executive
Author(s):	Head of Corporate Planning and Business Support Clinical Quality Facilitator
Title of Report:	Q2 2023/24 Corporate KPI Performance Report
Purpose of Report:	For Noting

1. SITUATION

This report presents a high-level summary of organisational performance through the reporting of Key Performance Indicators (KPI's) for Q2: July - September 2023. Trend data is also provided to enable comparison with previous performance. The national standards directly relevant to the State Hospital are Psychological Therapies Waiting Times and Sickness Absence. Additional local Key Performance Indicators (KPIs) are reported to the Board and are included in this report. Board planning and performance are monitored by Scottish Government through the Annual Operational Plan for 2023-24 which was submitted to Scottish Government in July 2023 to outline the priority areas of development.

2. BACKGROUND

Members receive quarterly updates on KPI performance as well as an Annual Overview of performance and a Year-on-Year comparison each June.

The calculation for a quarterly figure is an average of all 3 month's totals.

3. ASSESSMENT

The following sections contain the KPI data for Q2 and highlight any areas for improvement in the next quarter through a deep dive analysis for KPI's that have missed their targets.

There are 7 KPI's which have reached and / or exceeded their target this quarter and there are 5 KPI's which are off target this quarter, these are:

- Patients have their care and treatment plans reviewed at 6 monthly intervals
- Patients will undertake 150 mins of exercise per week
- Patients will have a healthier BMI
- Sickness absence rate (National HEAT standard is 4%, TSH target is 5%)

- Patients have their clinical risk assessment reviewed annually.

Performance Indicator	Target	RAG Q3 22/23	RAG Q4 22/23	RAG Q1 23/24	RAG Q2 23/24	Actual	Comment
Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	A	A	A	90.3%	This indicator remains in the amber zone from Q3 22/23
Patients will be engaged in psychological treatment	85%	G	G	A	G	86%	This indicator has increased to Green for Q2
Patients will be engaged in off-hub activity centers	90%	G	G	G	G	96.0%	This includes drop-in sessions which took place in hubs, grounds and Skye Centre
Patients will undertake an annual physical health review	100%	G	G	G	G	100%	Green compliance for this amended KPI
Patients will undertake 150 minutes of exercise each week	60%	G	G			62%	The target for this KPI has been increased as at April 2023
Patients will undertake 150 minutes of exercise each week	70%			A	A	66%	Achievement has increased from 63.3% though remains in Amber for this 2nd quarter
Patients will have a healthier BMI	25%	R	R	R	R	7%	This indicator remains in the red zone
Sickness absence rate (National HEAT standard is 4%)	** 5%	R	R	R	R	8.43%	July's figure was 8.5%. August's figure was 8.1%. September's figure was 8.7%.
Staff have an approved PDR	*80%	G	G	G	G	84.3%	This indicator remains in the green zone
Patients transferred / discharged using CPA	100%	G	G	G	G	100%	This indicator remains in the green zone
Patients requiring primary care services will have access within 48 hours	*100%	G	G	G	G	100%	This indicator remains in the green zone
Patients will commence psychological therapies <18 weeks from referral date	**100%	R	A	G	G	100%	As at 30 September 2023, there were no instances of any patient waiting beyond the specified wait time
Patients have their clinical risk assessment reviewed annually.	100%	G	A	G	A	92.6%	As at 30 September 2023, there were 104 patients in the hospital. Nine were new admissions. Six patients had an out of date / no risk assessment
Attendance at CPA Reviews							

Definitions for red, amber and green zone:

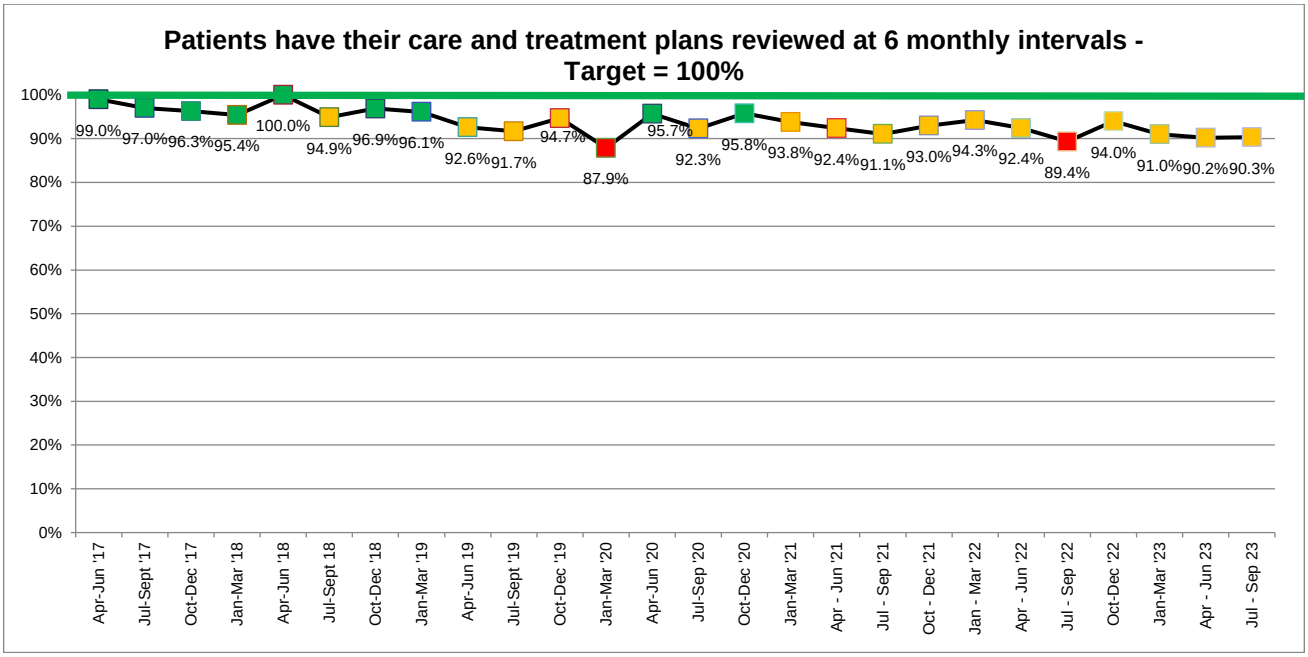
- For all but item 6 and 7 green is 5% or less away from target, amber is between 5.1% and 10% away from target and Red will mean we are over 10% away from target
- For item 6: 'Patients have a healthier BMI' green will be 3% or less away from target, amber will be between 3.1% and 5% away from target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

No 1: Patients Have their Care and Treatment Plan Documentation Reviewed and uploaded to RiO at 6 Monthly Intervals

Target: 100%
Data for current quarter: 90.3%
Performance Zone: Amber

This is a Mental Health Act requirement for any patients within high secure settings. This indicator measures the assurance of patients receiving admission, intermediate and annual case reviews. Care and Treatment Plans are reviewed by the multidisciplinary teams at case reviews and objectives are set for the next 6 months.



This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In July and August 2023 the compliance was 91.26% and in September 2023 was 88.5% giving a quarterly compliance of 90.3%, which is a slight increase from last quarter's figure. This indicator remains in the amber zone.

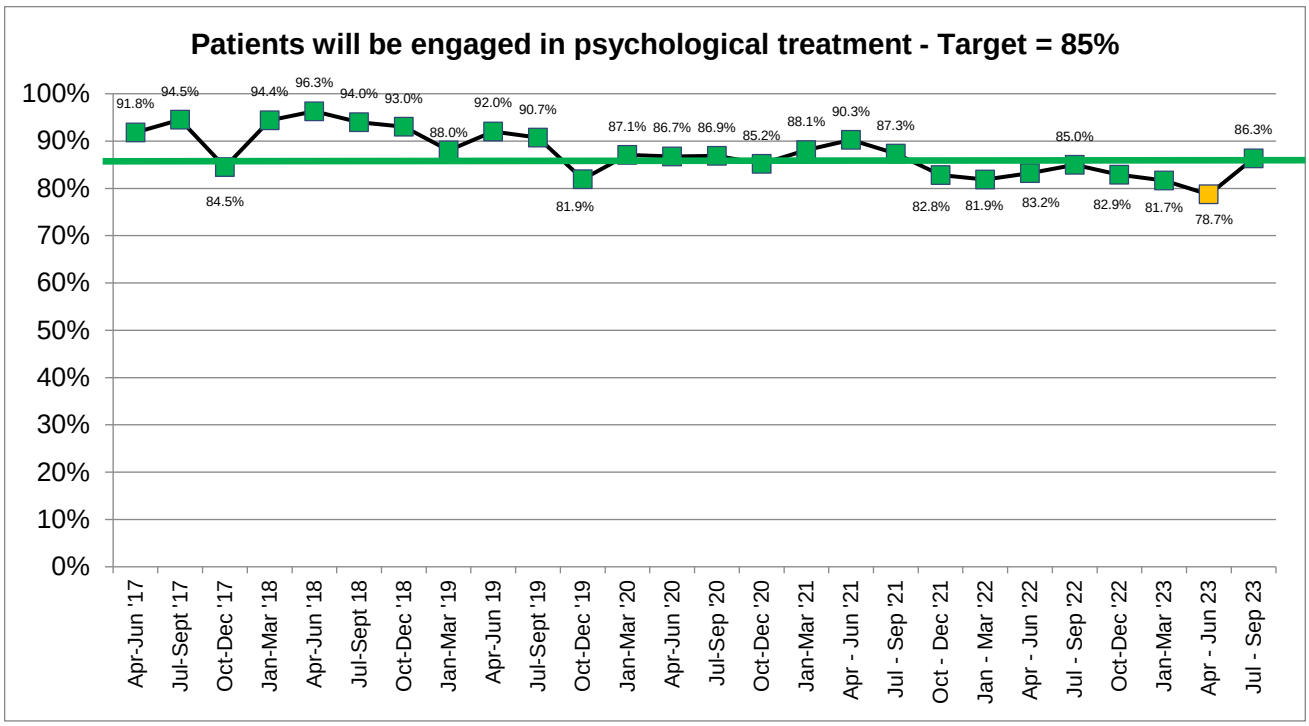
On 30 September 2023 there were 104 patients in the hospital. Nine of these patients were in the admission phase. Twelve CPA documents had not been reviewed within the 6-month period, or within the agreed admission phase. All of these CPAs have been held with no documents being uploaded to RiO within allocated timescales.

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 2: Patients will be engaged in Psychological Treatment

Target: 85%
Data for current quarter: 86%
Performance Zone: Green

This indictor is a main priority of National Mental Health Indicators. This indicator measures the percentage of patients who are engaged and involved in psychological treatment.

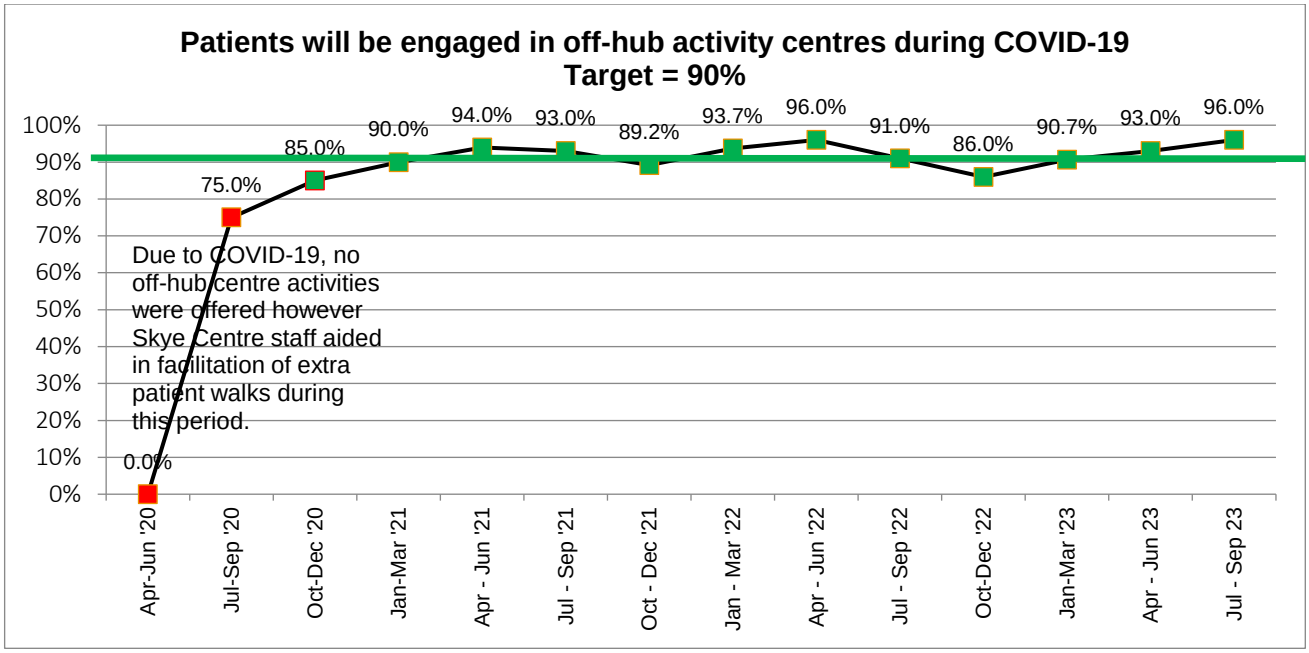


This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In July 2023, the compliance was 86%, August 2023 was 87% and September 2023 was 86% giving a quarterly compliance of 86%, which is an increase from the Q1 2023/24 figure of 78.7%. This indicator moves into the green zone.

No 3.1: Patients will be Engaged in Off-Hub Activity Centers

Target: 90%
Data for current quarter: 96%
Performance Zone: Green

This measures the number of patients who are engaging in some form of timetable activity which takes place off their hub. The sessions may not necessarily directly relate to the objectives in their care plan however are recognised as therapeutic activities.



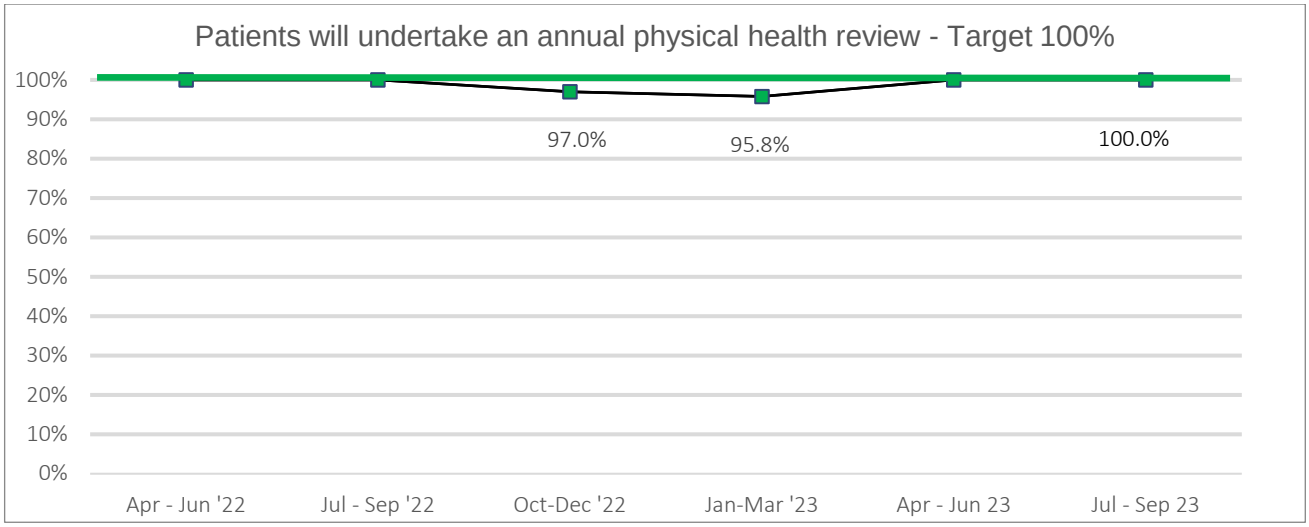
This indicator includes data gathered pertaining to scheduled activity in addition to all off-ward drop-in activity rates at the Skye Centre from July 2020 onwards.

The Activity Oversight Group was established in August 2022 to provide oversight and direction for patient activity. This group have commissioned a revision of the activity target for patients. This will replace this current KPI, it will reflect activity across the different services and be a more accurate indicator related to patient timetabled sessions and activity for every patient.

No 4: Patients will Undertake an Annual Physical Health Overview

Target: 100%
Data for current quarter: 100%
Performance Zone: Green

This indicator is linked to the National Health and Social Care Standards produced by Healthcare Improvement Scotland (HIS). The indicator measures the uptake of the annual physical health review. The target has been increased to 100% from the 90% target before to recognize that the Annual Physical Health Overviews should be carried out for every patient every year.



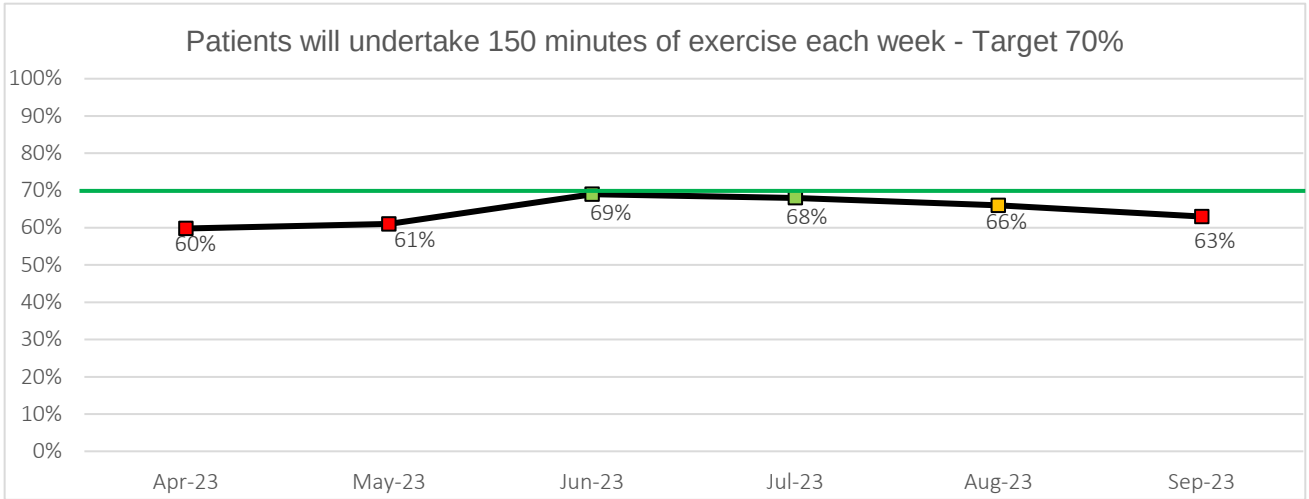
As at 1 April 2022, this KPI was amended to incorporate the uptake of an annual physical health review by all of our patients, rather than the previous data collection of an offering of a review. This KPI now charts the completion of an annual physical health overview by the Practice Nurse. The Practice Nurse then refers appropriate patients on for face to face review by the GP. The GP conducts these consultations to complete the physical assessment of the annual health review.

During Q2, 100% of patients who were eligible for an annual physical health review were reviewed by the Practice Nurse. Out of these 26, 25 were reviewed in addition by the GP. One patient did not attend their face-to-face consultation; this was due to the patient refusing. Two further offers have been made to reschedule.

No 5: Patients will be Undertake 150 Minutes of Exercise Each Week

Target: 70%
Data for current quarter: 66%
Performance Zone: Amber

This links with national activity standards for Scotland. This measures the number of patients who undertake 150 minutes of moderate physical activity each week.



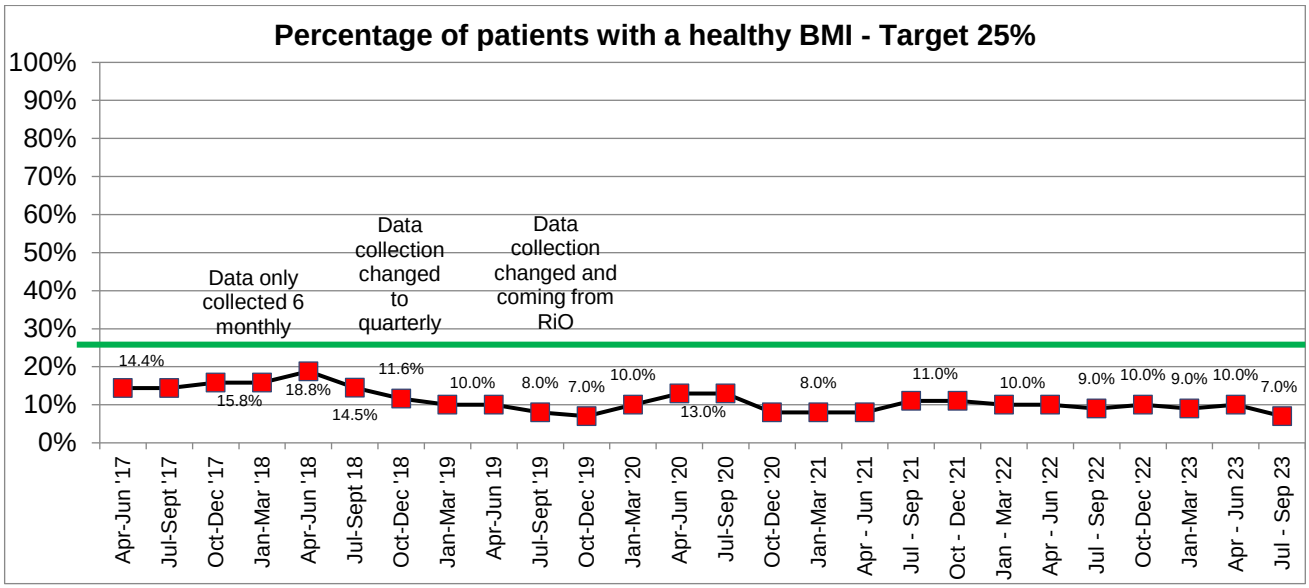
At the Board meeting in June 2022, the Board agreed to change the corporate KPI from 80% of patients will achieve 90 minutes of moderate physical activity per week to 60% of patients will achieve 150 minutes of moderate physical activity per week as at 1st April 2022, following guidance released by the WHO and reviewed by the Physical Health Steering Group (PHSG). This was then reviewed after 4 quarters and agreement was again reached to increase the target to 70% for 2023/24. The graph shows the data by month since the change in the KPI as we do not have enough data points yet to graph into quarters.

This data is recorded and calculated when patients participate for more than 10 minutes of moderate activity and does not include patients being escorted / or using grounds access to and from the Skye Centre (unless it has been agreed by the patient's keyworker). It does include all other types of physical activity as per the timetable e.g. escorted walks, grounds access, football, hub gym.

The Activity Oversight Group have also provided an organisational overview of activity. The focus of the group over 2022/23 has been on stabilisation and creating a firm foundation for ongoing support and promotion to increase the patients activity.

No 6: Patients will have a Healthy BMI

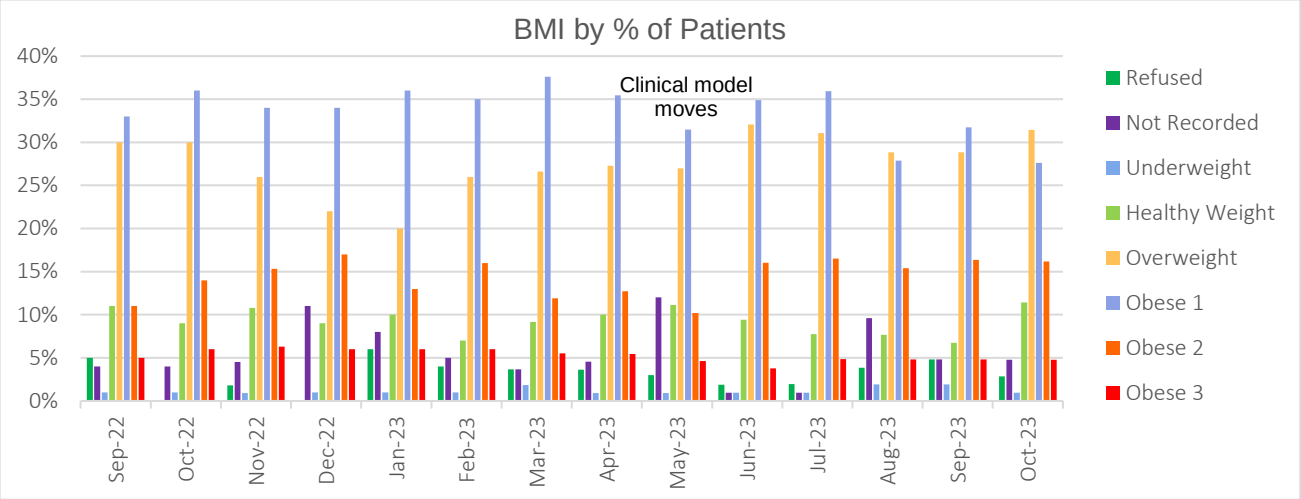
Target: 25%
Data for current quarter: 7%
Performance Zone: Red
This correlates towards the national target from the care standards as well as a corporate objective of TSH. This is an aspirational target and a local priority due to the obesity issue of our patient group.



During this quarter, 10 patients moved down to a healthier BMI band.

The PHSG are currently reviewing the reporting format of patient weight and BMI movement data in order for more meaningful information to be available and to be shared with Clinical Teams. This also includes review work across a local KPI to limit weight gain of patients from admission to equal to or less than 5% of admission weight over first 12 months following admission. Of the 12 patients that have completed the first 12-month cycle, 4 (33.3%) have met the local KPI by remaining under the 5% weight gain target. The Supporting Healthy Choices group have developed an action plan and currently reviewing patient data to provide focused approach for each of the services.

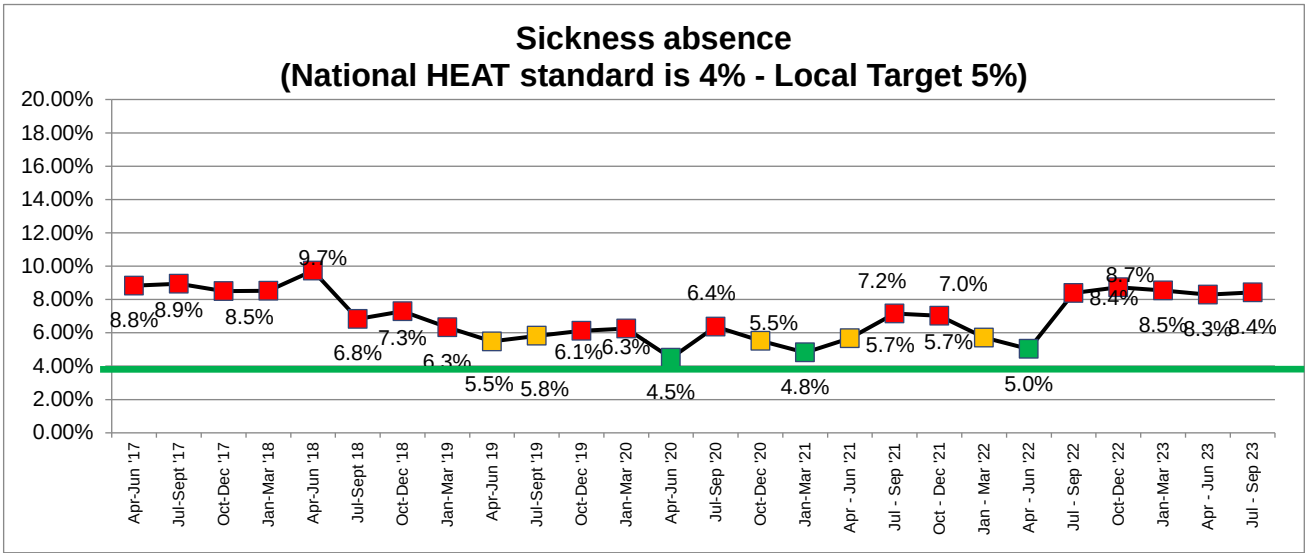
Dietetics are also working to address issues regarding the completion of monthly weight recording by wards which has been impacting data collection.



No 7: Sickness Absence (National Heat Standard is 4% - Local Standard Is 5%)

Target: 5%
Data for current quarter: 8.43%
Performance Zone: Red

This relates to the National Workforce Standards and measures how many staff are absent through sickness. This excludes any COVID-19 related absences which are measured / reported separately. The State Hospital uses the data provided from SWISS for this KPI to align with all NHS Scotland Boards to ensure valid comparisons across Scotland can be achieved. The figures provided via SWISS data slightly differ from SSTS figures; this is due to the SWISS contractual hours being averaged over the 12-month period and the figures from SSTS are based on the contractual hours available within that month.



Reducing sickness absence is an organisational priority and is monitored through a number of Committees. Reasons for short term are anxiety / stress / depression, cold / flu, back problems and for long-term remains as anxiety / stress/ depression and musculoskeletal / injury / fracture and back problems. As well as the HR Advisors holding their regular meetings with Managers to review all employees who require support whether at work or absent from work, an Assistant HR Advisor is now in place and will assist Managers on reviewing compliance and quality of return to work

interviews, ensuring reasons for absence are recorded, and ensure policy compliance. Senior Charge Nurses have met with the Training & Professional Development Manager alongside HR, to review 5 year analysis of their staff. They have then met with their teams to recognise and commend where there has been positive attendance at work, as well as addressing those with absence higher than the expected standard and agreeing actions for improvement in attendance. Participation in these meetings is monitored by Lead Nurses.

Implementation of the new Occupational Health provider has allowed The State Hospital to review the approach to Early Intervention as well as quality and frequency of management referrals to the OH service. Case reviews with OH are encouraged, in partnership, to form supportive plans for staff at the earliest opportunity. Key enablers have been introduced for example reasonable Adjustment Guidance (which included opportunities for line managers to attend development sessions with the Business Disability Forum) and reviewed arrangements for Temporary Assignments.

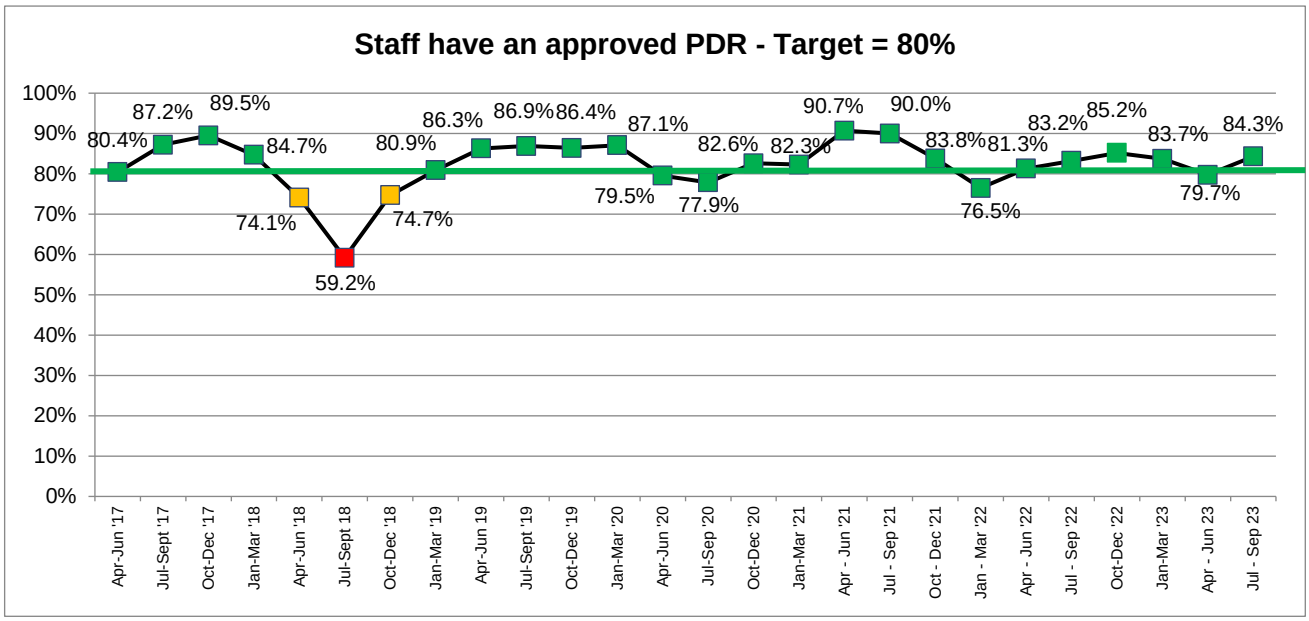
The establishment of the Attendance Management Task and Finish group has seen fortnightly meetings taking place throughout Q2. This group reports to the Staff Governance Committee and will provide regular updates to the Partnership Forum, Workforce Governance Group and Corporate Management Team.

HR attend weekly meetings to support action plans for the areas with the highest absence: Nursing, Skye Centre, Housekeeping and Security. These Sub Groups present their departmental findings and action plans to the Task and Finish Group meeting fortnightly. The Task and Finish group will continue to oversee staff absence rates on a monthly basis. HR will continue to support implementation of the Attendance Management Policy, support sub-group management in the consideration of other Workforce Policies, which are in place to support staff and work towards actions that are sustainable and provide stability to the organisation in relation to attendance.

No 8: Staff have an Approved PDR

Target: 80%
Data for current quarter: 84.3%
Performance Zone: Green

This indicator relates to the National Workforce Standards; measuring the percentage of staff with a completed PDR within the previous 12 months.

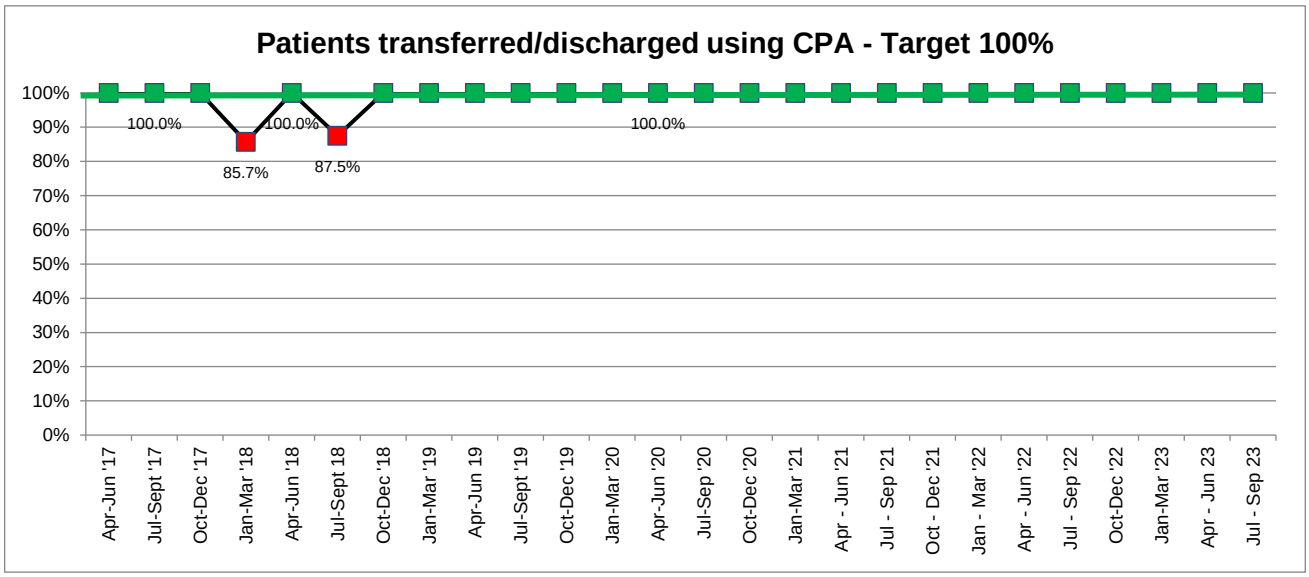


This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In July 2023 the compliance was 83.1%, August 2023 was 84.6% and September 2023 was 85.1% giving a quarterly compliance of 84.3%, which is an increase from 79.74% in Q1. This indicator remains with the green zone.

No 9: Patients are Transferred/Discharged using CPA

Target: 100%
Data for current quarter: 100%
Performance Zone: Green

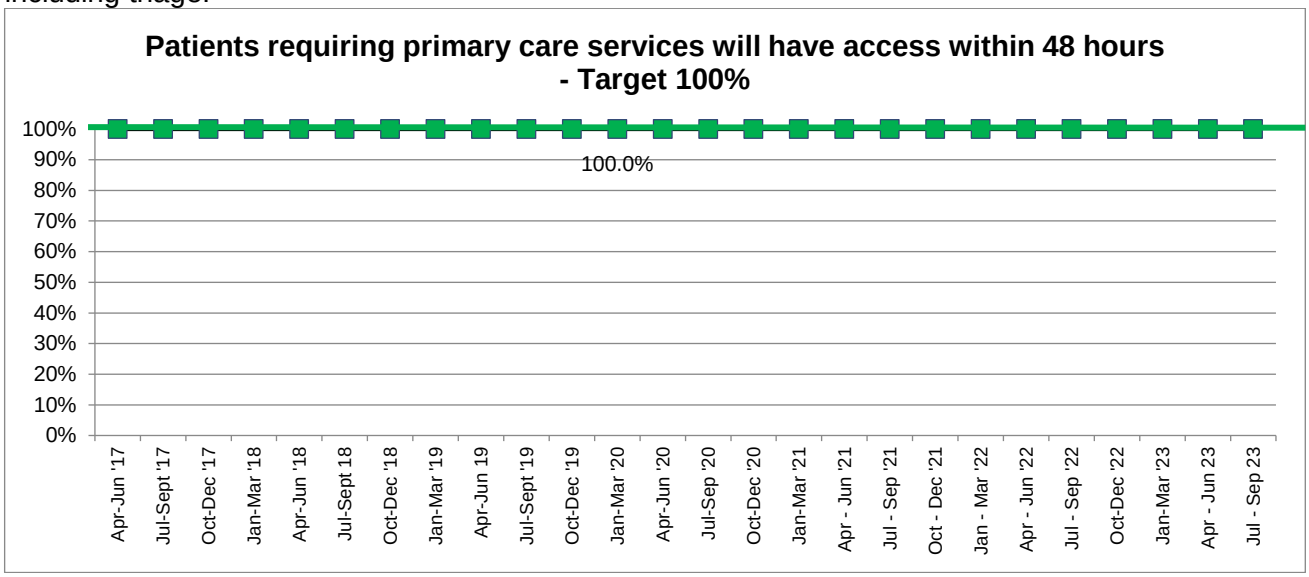
The indicator is linked to the Mental Health Act, 2003 and the streamlining of discharges and transfers. The number of patients transferred out using CPA process are measured through this indicator.



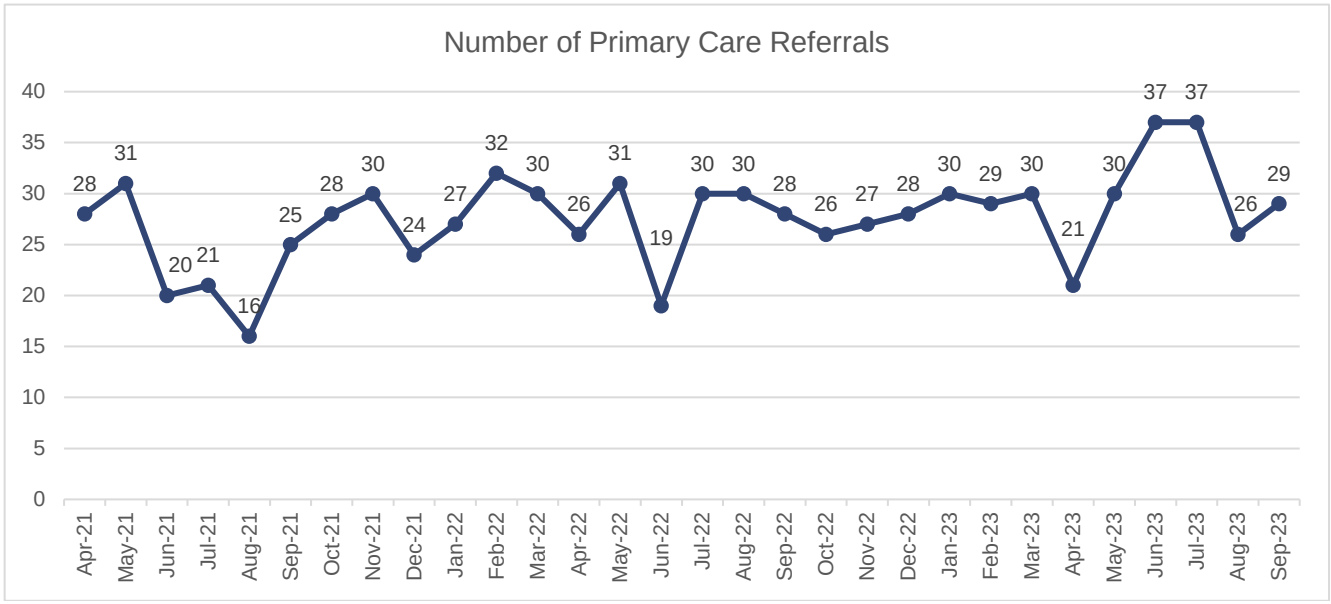
No 10: Patients Requiring Primary Care Services Will Have Access within 48 Hours

Target: 100%
Data for current quarter: 100%
Performance Zone: Green

This indicator is linked to National Health and Social Care Standards as published by Healthcare improvement Scotland (HIS). Primary care services include any service at our Health Centre including triage.



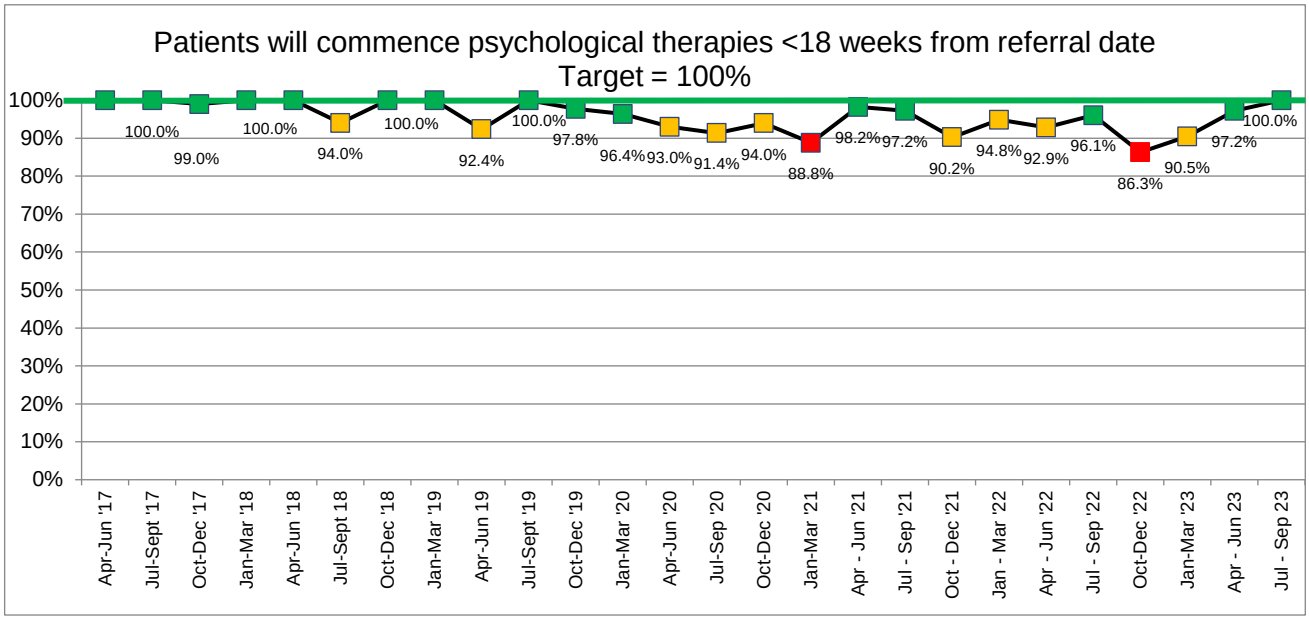
All referrals made to the Health Centre have been actioned within 48 hours. The referrals are triaged when received and onward referral to the most appropriate specialist. These have been actioned by a range of practitioners, including the GP who attends for 2 sessions per week and the Practice Nurse.



No 11: Patients will Commence Psychological Therapies <18 Weeks from Referral Date

Target: 100%
Data for current quarter: 100%
Performance Zone: Green

The indicator correlates to National Mental Health Indicators for Scotland to ensure that no patient waits more than 18 weeks to commence some form of psychological therapy. The data required for this calculation are the number of patients waiting to engage in a psychological intervention to which they were referred who has not already completed another psychological intervention whilst waiting.

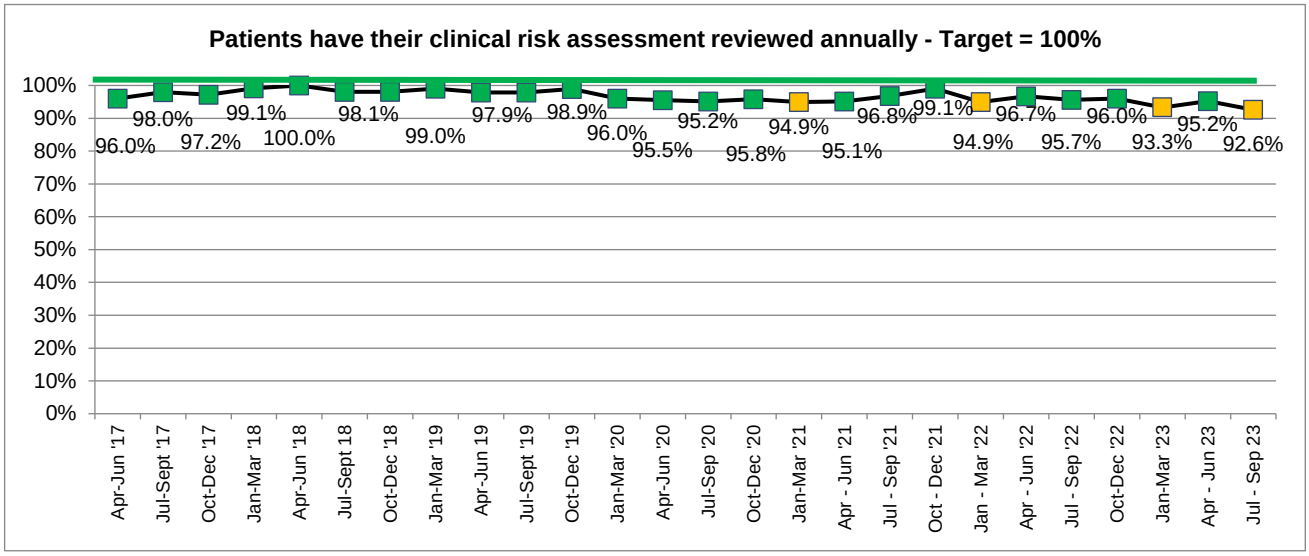


There were no patients waiting beyond the expected referral timeframe to commence psychological therapies during Q2. All patients who are waiting for a therapy should still have regular contact with their psychology team and during their pre-CPA interviews.

No 13: Patients have their Clinical Risk Assessment Reviewed Annually

Target: 100%
Data for current quarter: 92.6%
Performance Zone: Amber

The indicator links with the Mental Health Care and Treatment Act Scotland, 2003. Examples of clinical risk assessments would be a HCR20 / SARA.

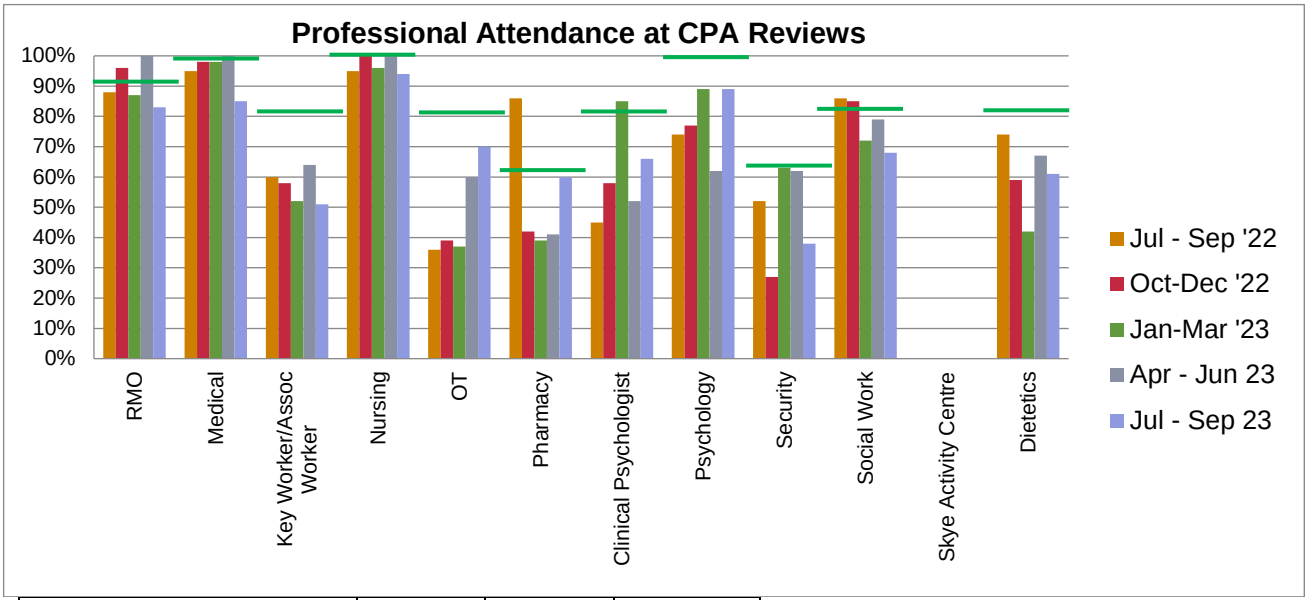


During Q2 there has been an increase in the number of risk assessments which were not closed off within RiO by their expected submission date.

No 15: Professional Attendance at CPA Review

Target: Individual for each profession

Local priority area set out in within CPA guidance. The reasoning behind this indicator is that if patients have all of the relevant and important professions in attendance, then they should receive a better care plan overall.



Profession	Jul 23 n=14	Aug 23 n=17	Sept 23 n=16
RMO	93%	77%	81%
Medical	93%	82%	81%
KW/AW	64%	59%	31%
Nursing	93%	100%	72%
OT	79%	77%	56%
Pharmacy	50%	59%	69%
Psychologist	43%	65%	88%
Psychology	86%	82%	100%
Security	29%	29%	56%
Social Work	50%	71%	81%
Dietetics	67%	64%	56%

The targets for attendance are set to reflect what is reasonable to expect from each discipline and have been in place for over 5 years. Attendance at case reviews was recorded as both physical and virtual attendance.

RMO – attendance for this profession has decreased from 100% to 83% in Q2. This indicator moves in to the amber zone for this quarter. There were 7 occasions where the VAT was not completed.

Medical – this profession moves to the red zone for this quarter, decreasing to 85% in Q2.

Key Worker/Associate Worker – attendance figures decreased from 64% to 54% for this quarter. On the 20 occasions where a key worker / associate worker was unable to attend the CPA, a nursing representative attended in their place.

Nursing – during Q2, nursing attendance decreased from 100% to 94%; this profession moves into the amber zone.

OT – attendance has continued to increase during Q2 from 60% to 70%. OT remains in the red zone for this quarter. This can be mainly attributed to staff vacancies and staff sickness within the department.

Pharmacy – attendance for this quarter has continued to increase from 41% to 60% meaning this profession moves into the green zone. Lack of attendance can be attributed mainly to staff annual leave and workload.

Clinical Psychologists – this profession's attendance has increased from 52% in Q1 to 66% in Q2. This indicator remains in the red zone. One instance where the VAT form was not completed and a combination of annual leave, staffing and a change of case review date made up this percentage.

Psychology – this professions attendance has increased from 62% to 89%. This profession remains in the red zone. On 11 occasions where the Psychologist was unable to attend, a Psychology representative attended in their place.

Security - attendance from security has continued to decrease this quarter to 38%. Security moves into the red zone. This can be attributed to staff annual leave.

Social Work – attendance has decreased in Q2 from 79% to 68% therefore this profession moves into the red zone. This can be attributed to staff annual leave

Dietetics – attendance from dietetics has decreased from 67% to 61%. This profession remains in the red zone. This can be attributed staff having other commitments and staff not being available.

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 TSH Key Performance Indicators links to both the TSH corporate objectives and the Annual Delivery Plan 2023-2024. The KPI's provide assurance to TSH Board on key areas of performance. Some of the KPI's are national targets which TSH is held accountable for performance nationally, others are local priorities for TSH Board. The TSH Performance Framework proves an overview of how performance is managed across TSH.
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.	Via Strategic Planning and Performance Group
Risk Assessment (Outline any significant risks and associated mitigation)	If KPI's are off target the improvement plan to address this is detailed in the paper
Assessment of Impact on Stakeholder Experience	Not formally assessed
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).	
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:	21 December 2023
Agenda Reference:	Item No: 24
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Programme Director
Title of Report:	Perimeter Security and Enhanced Internal Security Systems Project (Public Session)
Purpose of Report:	For Noting

1. SITUATION

This report to the Board summarises the current status of the Perimeter Security and Enhanced Internal Security Systems project. Board members are asked to note the overall project update, the financial report and any current issues under consideration by the Project Oversight Board.

2. BACKGROUND

The Governance for the project is provided by a Project Oversight Board (POB) co-chaired by the Chief Executive and the Director of Security, Estates and Facilities.

The Project Oversight Board meets monthly. The POB last met on 19th December 2023 and is scheduled to meet again on 18th January 2024.

The Programme Director provided an update on the current status on the project, the Project Risk Register and financial details.

3. ASSESSMENT

a) General Project Update:

The project is in the final stages. All quality targets are being met; project timescales have moved(see Project Timescales at 3b below) and costs are projected to overspend (See Finance – Project Cost at point 3c below).

b) Project Timescales

Programme revision 53 has been accepted. Revision 54 is in preparation at the time of writing; a verbal update will be provided. Revision 53 forecasts completion in early April 2024.

The installation of technology is substantially complete and currently forecast for completion before the financial year end. The elements of the project forecast to run over the financial year end are production of documentation.

c) Finance – Project cost

The project is proceeding according to the current projected cost plan, in that the contract with Securitas is due to underspend against budget, including available contingencies. Project management costs and associated contingencies have been affected by changes in the project timescale. The project currently has a potential overspend (exclusive of VAT) of approximately £633k, 6.7% of the projected final cost. This has increased by approximately £53k since the October report to the Board.

The key project outline at the end of November 2023 is:

Project Start Date:	April 2020
Planned Completion Date:	April 2024
Contract Completion Date:	May 2022
Main Contractor:	Securitas Technology Limited
Lead Advisor:	Thomson Gray
Programme Director:	Doug Irwin

Total Project Cost Projection (Exc. VAT) at 08/12/23:	£9,424,902
Total costs to date (exc. VAT & retention) at 08/12/23:	£9,139,648
Total costs to end of project (Exc. VAT & retention)	£ 285,225

The cash flow schedule planned for the months to come is confirmed on a rolling basis in order to ensure that the Hospital's cash flow forecast is aligned and that our SG funding drawdown is scheduled accordingly. All project payments are processed only once certification is received confirming completion of works to date.

While it is not a prerequisite of the project, regular reports to the SG Capital team are also being provided to notify of progress against total budget.

A Rounded breakdown of actual spend to date (Exc. VAT) at the end of November 2023 is:

Securitas	£ 7.269m
Thomson Gray	£ 0.991m
Doig & Smith	£ 0.008m
HVM	£ 0.192m
Staff Costs	£ 0.774m
Income	-£ 0.094m
Total	**£ 9.140m**

VAT has been excluded from calculations of amounts paid due to the need for the reclaim to be applied for and assessed.

4 RECOMMENDATION

That the Board **note** the current status of the Project

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Update paper on previously approved project
Workforce Implications	N/A
Financial Implications	The projected overspend is regularly communicated to Scottish Government and is an ongoing action at Project Oversight Board.
Route to the Board Which groups were involved in contributing to the paper and recommendations?	Project Oversight Board
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Contract agreement stipulates compliance with Fairer Duty in respect of the remuneration of staff and contractors.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ϒ There are privacy implications, but full DPIA not needed ϒ There are privacy implications, full DPIA included.

Paper No. 23/132

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	21 December 2023
Agenda Reference:	Item No: 25
Sponsoring Director:	Chief Executive
Author(s):	Head of Corporate Governance/Board Secretary
Title of Report:	Board Workplan 2024
Purpose of Report:	For Decision

1 SITUATION

The Board is asked to review its workplan for the coming year to identify the key considerations and actions required during 2024, and to provide assurance on planned areas of reporting.

2 BACKGROUND

The Board considers and approves a workplan annually, supported by the Board Secretary, to ensure that each component part of the workplan is allocated to meeting(s) throughout the year.

3 ASSESSMENT

The workplan has been developed to encompass the key focus areas for the Board in the coming year, and is enclosed at **Appendix A**. The workplan is developed based on planned workstreams, and reporting will be stood up to reflect change that may occur throughout this period.

The Corporate Objectives for the 2024/25 will be reviewed at the meeting in February, and it is noted that the Annual Delivery Plan is due to be submitted to Scottish Government on 7 March 2024, but will be published through Board papers following agreement of it by government. The three year Workforce Plan is to be reviewed annually, and the workplan reflects this time frame to ensure Board oversight. An Organisational Development Strategy will be brought to the Board at its February meeting.

The Board will continue to receive dedicated reporting around key areas of risk and resilience, including infection prevention and control as well as bad capacity, linking this to the wider forensic estate. An interim evaluation of the impacts of the changed clinical model will be brought to the April meeting of the Board, with detailed oversight through the governance committees in terms of clinical care and staffing. A 12 month report will be brought to the October meeting of the Board.

Patients' Physical Health will continue to be an area for improvement in performance and the Supporting Healthy Choices project will formally report to the Board twice within the year.

Assurance reporting on the implementation of Health and Care (Staffing) Act as well as e-rostering will continue to April 2024, and the Board will them receive a standing report at each meeting on the staffing position, in preparation of annual reporting for 2024/25.

The Board has valued the opportunity to hear directly from patients, as well as carers and volunteers during 2023, and this is scheduled again for the coming year. A stand alone Carers Strategy is being developed, and will be presented to the Board in October.

Dedicated reporting on quality improvement and assurance will be provided at each meeting, and a Quality Strategy will be developed and then presented in August.

A further key area of work for the Board in 2024 will be its Digital Strategy, and this will be reviewed at the session in June 2024. The Network and Information Security final report should be available for publication at the February meeting to conclude the assessment, with a further update scheduled to provide assurance on the work progressing for the next assessment.

The Perimeter Security and Enhanced Internal Security Systems Project is expected to be completed by April 2024, and a final scheduled report on project completion will come to the Board at its June meeting. Climate Emergency and Sustainability reporting will be formally reported annually.

Development of the Communications function has been a key area of focus during 2023 with reporting to every second meeting of the Board, and given the progress made, it is proposed within the workplan that this will change to formal reporting twice a year including an annual report.

Finally, the Board has just undertaking a self-assessment as part of the Blueprint for Good Governance, and an improvement template will be submitted to Scottish Government by 31 March 2024. This will be brought back to the Board formally twice a year, as well as continuing to form a part of Board Development Sessions.

4 RECOMMENDATION

The Board is asked to:

- Review the revised workplan and discuss whether this provides a robust structure for the consideration and scrutiny of the Board's business in 2024, advising whether any change or addition is required.

- Approve the plan as a basis for managing Board business in 2024.

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MONITORING FORM

How does the proposal support current Policy / Strategy / ADP / Corporate Objectives	To support the Board's Corporate Objectives and strengthen reporting to and oversight by the NHS Board with planned reporting throughout year
Workforce Implications	There are no implications as a result of this report
Financial Implications	There are no impacts to consider.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Requested by the Board as part of workplan, and directed through the Corporate Management Team.
Risk Assessment (Outline any significant risks and associated mitigation)	The workplan is developed to provide assurance to the Board, and there are no additional risks to consider
Assessment of Impact on Stakeholder Experience	This is considered by the Board in setting its workplan
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 2024

February 2024	April 2024	June 2024	August 2024	October 2024	December 2024
• 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	• Board Minute and Actions • Chair's Report • CEO Report • Workplan 2025
• Governance Committee Minutes • Clinical Forum Minutes	• Governance Committee Minutes • Clinical Forum Minutes • Corporate Governance Update	• Governance Committee Minutes • Clinical Forum Minutes • Governance Committee Annual Reports	• Governance Committee Minutes • Clinical Forum Minutes	• Governance Committee Minutes • Clinical Forum Minutes • Corporate Governance Update	• Governance Committee Minutes • Clinical Forum Minutes • Annual Review Feedback (2023/24)
• Corporate Risk Register • Infection Prevention and Control • Bed Capacity	• Corporate Risk Register • Infection Prevention and Control • Bed Capacity	• Corporate Risk Register • Infection Prevention and Control • Bed Capacity	• Corporate Risk Register • Infection Prevention and Control • Bed Capacity	• Corporate Risk Register • Infection Prevention and Control • Bed Capacity	• Corporate Risk Register • Infection Prevention and Control • Bed Capacity

February 2024	April 2024	June 2024	August 2024	October 2024	December 2024
• Supporting Health Choices Programme • Quality Assurance and Improvement	• Patient, Carer & Volunteer Stories • Clinical Model – Interim Evaluation • Quality Assurance and Improvement	• Quality Assurance and Improvement	• Patient, Carer and Volunteer Stories • Supporting Healthy Choices Programme • Implementation of Specified Persons Annual Report • Quality Assurance and Improvement • Quality Strategy	• Medical Appraisal and Revalidation Annual Report • Medical Education Report • Clinical Model –12 month Evaluation • Quality Assurance and Improvement • Carers Strategy	• Patient, Carer and Volunteer Stories • Patient Independent Advocacy Annual Report • Quality Assurance and Improvement
• Workforce Report • Health and Care Staffing Implementation • Organisational Development Strategy • Whistleblowing Quarter 3 Report	• Workforce Report • Health and Care Staffing • Whistleblowing Quarter 4 Report and Annual Report • Staff Wellbeing Report	• Workforce Report • Health and Care Staffing • Workforce Plan 2022/25 – Annual Review	• Workforce Report • Health and Care Staffing • Whistleblowing Quarter 1 Report	• Workforce Report • Health and Care Staffing • Staff Wellbeing Report	• Workforce Report • Health and Care Staffing • Whistleblowing Quarter 2 report and Annual Statement

February 2024	April 2024	June 2024	August 2024	October 2024	December 2024
• Finance Report • Corporate Objectives 2024/25 • Performance Report Quarter 3 • Security Project • Network and Information Security	• Finance Report • Annual Review of Standing Documentation • Security Project • Communications Update	• Finance Report • Annual Accounts • Performance Annual Report • Security Project – Final Report • PAMS Submission • Risk and Resilience Annual Report • Digital Inclusion Strategy	• Finance Report • Performance Report Quarter 1 • Complaints Annual Report	• Finance Report • Communications Annual Report • Information Governance Annual Report • eHealth Annual Report • Network and Information Security	• Finance Report • Performance Report Quarter 2 • Corporate Risk Register • Climate Emergency and Sustainability Annual Report 2023/24