THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 22 FEBRUARY 2024
at 9.30 Hybrid Meeting: in Boardroom and on MS Teams
A G E N D A

9.30pm			
1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 21 December 2023	For Approval	TSH(M)23/11
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 24/01
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
9.50am	**RISK AND RESILIENCE**		
7.	**Corporate Risk Register** Report by the Director of Security, Resilience and Estates	For Decision	Paper No. 24/02
8.	**Finance Report to 31 January 2024** Report by the Director of Finance & eHealth	For Noting	Paper No. 24/03
9.	**Infection Prevention and Control Report** Report by the Director of Nursing and Operations	For Noting	Paper No. 24/04
10.	**Bed Capacity Report:** **The State Hospital and Forensic Network** Report by the Medical Director	For Noting	Paper No. 24/05
10.30am	**CLINICAL GOVERNANCE**		
11.	**Supporting Healthy Choices** Report by the Medical Director	For Noting	Paper No. 24/06
12.	**Quality Assurance and Quality Improvement** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 24/07
13.	**Clinical Governance Committee:** Approved Minutes of meeting held 9 November 2023	For Noting	CGC(M) 23/04

	Report of meeting held 8 February 2024		Paper No.24/08
11.am	**BREAK**		
11.20am	**STAFF GOVERNANCE**		
14.	**Staff Governance Report** Report by the Workforce Directorate	For Noting	Paper No. 24/09
15.	**Implementation Planning:** **Health and Care Staffing (Scotland) Act and e-Rostering** Report by the Director of Nursing and Operations	For Noting	Paper No. 24/10
16.	**Whistleblowing:** - **Quarter 3 Report** Report by the Acting Director of Workforce	For Noting	Paper No. 24/11
17.	**Staff Governance Committee:** Approved Minutes of meeting held 16 November 2023	For Noting	SGC(M) 23/04
	Report of meeting held 15 February 2024		Paper No. 24/12
12 noon	**CORPORATE GOVERNANCE**		
18.	**Corporate Objectives 2024/25** Report by the Head of Corporate Governance	For Decision	Paper No. 24/13
19.	**Performance Report – Quarter 3** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 24/14
20.	**Network Information Security** Report by the Director of Finance & eHealth	For Noting	Paper No. 24/15
21.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 24/16
22.	**Audit and Risk Committee:** Approved Minutes of meeting held 28 September 2023		ARC(M) 23/04
	Report of meeting held 25 January 2024		Paper No. 24/17
23.	**Any Other Business**		Verbal
24.	**Date of next meeting:** 9.30am on 25 April 2024		Verbal
25.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
26.	**Close of Session**		Verbal

Estimated end at 12.45pm

THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 23/11**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 21 December 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:

Patient Advocacy Service Manager	Rebecca Carr [Item 8]
Skye Centre Manager	Jacqueline Garrity Item 7]
Mental Health Manager, Social Work	David Hamilton
Head of Communications	Caroline McCarron
Head of Planning and Performance	Monica Merson
Acting Director of Workforce	Laura Nisbet
Head of Corporate Governance/Board Secretary	Margaret Smith [Minutes]
Chair, Patient Advocacy Service	Michael Timmons [Item 8]
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 MINUTE OF THE PREVIOUS MEETING

The minute of the previous meeting held on 26 October 2023 was noted to be an accurate record of the meeting.

The Board:

1. Approved the minute of the meeting held on 26 October 2023.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

There were no matters arising for discussion, from the previous meeting minute. Ms Smith presented a summary of the rolling action list (Paper No. 23/114) including the work completed and in progress. This included confirmation that in relation to Item 9 relating to the fencing required for the visitors centre; with this confirmed to be progressed week beginning 15 January 2024 to resolve the issue.

Mr Moore noted the update on the use of Attend Anywhere where possible for external patient appointments under Item 19, and Professor Thomson confirmed that this would be live in January 2024. The Health Centre were looking at clinics that patients do attend to see if any of those could be conducted virtually. She also advised that there had been a detailed audit of patient admissions to acute care outwith TSH over a five-year period. This audit had provided assurance on the consistent numbers being transferred to Accident and Emergency as well as the appropriateness of the clinical decision making that lay behind this. Reporting would be presented to the Corporate Management Team (CMT) in January 2024 on the detail behind the report.

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 confirmed that Non-Executive Directors had attended a dedicated seminar in respect of Cyber Security as well as the outcome meeting of the Network Information Security (NIS) audit review. Mr Moore advised that he had also attended the Patients' Advocacy Service (PAS) AGM meeting, the Patient Partnership Group (PPG), as well as the staff Long Service Award ceremony. The staff awards ceremony had been very positive, and demonstrated the commitment of staff in their service to the State Hospital (TSH). He added that the focus in the PPG had been on Christmas activity, and had been engaging and a pleasure to attend. He also commented on patient success in the Koestler awards as a positive development.

The Chair confirmed that the Annual Review meeting had taken place with Scottish Government relating to the period of April 2021 to March 2023, and had been constructive; and that the outcome letter in this regard had just been received and would be published in the usual way.

Mr Moore summarised the main focus of the NHS Board Chair meeting in November which had included the National Care Service. He also confirmed that the Director General and Chief Executive Officer of NHS Scotland, Ms Caroline Lamb, had written to all NHS Board Chairs to underline the financial pressures being faced, and the responsibility of Boards in relation to financial governance. Mr McConnell then confirmed that he had attend the December meeting of NHS Board Chairs, on behalf of the State Hospital, and that the focus of the meeting had been the financial position of NHS Scotland, and the need to ensure financial sustainability, as well as winter pressures. There had been key focus on workforce and the need for new and innovative ways of working including collaboration across NHS Boards.

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. Firstly, at the end of October 2023, he had hosted the inaugural meeting of the Healthcare in Custody NHS Leads from NHS Boards and Integration Joint Boards, with a view to putting infrastructure in place for Scotland going forward.

He had attended an event at NHS Golden Jubilee, along with other colleagues, regarding the new national specification for psychological therapies and interventions. He had also attended an event held to celebrate 20 years of the Forensic Network for Scotland.

Mr Jenkins confirmed that he had met with the Minster for Social Care, Mental Wellbeing and Sport, Ms Maree Todd, in relation to the female high secure pathway. There was agreement for TSH, Medium Secure units and the Scottish Prison Service to explore a collaborative approach to improving access for female patients, given their specific needs. Mr Jenkins noted the position on the options and appraisal process, and the work being progressed in conjunction with the Forensic Network in relation to the pressures across the wider forensic estate.

He referred to the significant improvements now seen in the reduction of daytime confinement from November onwards, and the leadership of this through Ms McCaffrey and Professor Thomson, as well as the contribution made by the wider staff group. He also noted the appointment of a new Director (of Workforce who would commence employment in 1 March 2024.

Mr Jenkins provided an overview of the Annual Review, which had taken place on 29 November, led by Mr Stephen Gallagher, Director of Mental Health. This had provided positive feedback on the governance structures in place as well as the stable operational delivery throughout the Covid-19 pandemic and in the recovery period since. There had also been review of TSH performance in respect of the climate emergency and sustainability targets; and on key workforce metrics including wellbeing. The meeting had included briefings on the finalisation of the security projects; and on the progress made on the reduction of daytime confinement. A follow up letter to this meeting had just been received this week, in which Mr Gallagher thanked the Board, the Chief Executive and Executive Team as well as the staff at TSH for all of their efforts and commitment.

He also confirmed that the outcome had been received on the Network Information Systems audit, which had a very positive result, and offered thanks to Mr McNaught and the eHealth team for this achievement.

Mr Jenkins advised that in November, NHS Board Chief Executive had been focused mainly on the financial challenges facing NHSScotland, as well as the Support and Intervention Framework and the national performance and delivery framework. As referred to by the Chair, this had been underpinned by correspondence from the NHSScotland Director General and Chief Executive Officer that Boards bear down on any non-essential spend, and a grip on any spending above base budget. Within TSH, there would be a planning session on 15 January 2024, followed by a Board Development Session on 1 February focused on financial planning alongside development of the Annual Delivery Plan for the coming year.

Mr Currie commented on the development of the National Care Service in the context of the lived experience of patients which indicated a lack of consistency across different areas; and how a national service would take oversight of standards. In terms of workforce sustainability, he noted the experience across the wider public sector as well as NHS Scotland, The challenge may be making additional savings when workforce represented the biggest factor overall. He also referred to the potential of investing in the shorter term to bring change leading to savings in the longer term, but a lack of funding would make this challenging. He added that it would be important to continue to encourage staff despite the overall financial challenge. Mr Moore echoed this point, noting the need to include staff and communicate transparently. This would be discussed in detail as part of the next Board Development Session on 1 February, which was focused on the financial position and the way forward for the State Hospital.

The Board:

1. Noted the update from the Chief Executive.

7 PATIENT STORY: DAYTIME CONFINEMENT OR ROOM4U

Ms McCaffrey introduced this item for the Board, which related to patient feedback regarding experiences of daytime confinement as well as Room4U. Ms Garrity joined the meeting to lead the Board through the detail of the presentation. She outlined the routes through which patients regularly provide feedback, especially the Patient Partnership group (PPG) and focused events line What Matters To You?

Ms Garrity explained that patients did provide mixed feedback on daytime confinement, and that whilst some recognised the harms of this, others patients did continue to seek solitary time within their rooms. This was different to Room4U, when patients were able, with the support of their clinical team, to plan activity and spend time within their own bedrooms rather than in hub or Skye Centre. She highlighted the story that one patient had presented within the PPG about his own experiences. For him, he had at first accepted periods of confinement within his room during the day and had not thought that this was a hardship. He had not been clear in his own mind about the differences between Room4U and daytime confinement. Then within the PPG, he had heard other patients raising their concerns about it, and the impacts they had experienced. He found this had helped him to understand the situation more fully. He did now feel worried that he may not be able to progress through his recovery if he was not able to attend activities. He had come around to the idea that it may not always be helpful for his recovery if he was spending solitary time in his room. He was more open to being encouraged to participate in wider patients activities like crafts or attending the gym.

Ms Garrity then went on to outline some of the actions taken in response. These included a Lead Nurse led focus group with the PPG so that concerns could be addressed within this forum. The PPG had agreed to help promote clarity about the terminology used across the wider patient group, so try to support understanding of how daytime confinement differed from Room4U. It had also been recognised that further support should be provided to staff so that they were also clear about good practice, as well as the impact that daytime confinement was having on the patients. This was being led through senior nurses, through ward meetings as well as Service Leadership Teams.

Mr Moore thanked Ms Garrity for her presentation, and noted the importance of the patients' individual care plans to their care journeys. He also noted the importance of ensuring that the meaning around each term was clear. Professor Thomson picked up this point and noted the way in which therapeutic activity helps patients, and had been shown to decrease rates of aggression. Room4U was planned carefully and should be within the patient day. This would be twice a day at most following lunch and dinner, and was voluntary. This may be different within the transitions service, which was reviewing increased opportunity for Room4U, which may be appropriate for that patient cohort. She underlined the work being done to eliminate daytime confinement within TSH and the aim to reduce this to a non event by January 2024. It had occurred due to staffing pressures, with concrete action taken to reduce this significantly throughout the past six months.

Ms McCaffrey noted that it was encouraging to hear this patient's feedback and the way in which he had changed his own views about daytime confinement; and come to recognise the role of therapeutic activity in his own recovery. She went on to place this within the wider context of patients' experiences of Covid-19 with the necessary steps taken on isolation for infection prevention and control. For patients, it was essential to help build their understanding of the need for activity as a structured part of their care plans. She also thanked the PPG for their work on helping to raise awareness on the different terminology involved.

Mr Jenkins noted that given the success made towards the aim of eliminating daytime confinement by January 2024, the focus would be on the Patient Active Day to provide structured and meaningful activity for patients. This was recognised as a key strategic aim of the organisation going forward. Ms Fallon welcomed this point, and echoed the need to move on to focus on meaningful activity for patients.

Mr Moore summed up the discussion and welcomed the excellent progress made on daytime confinement; and that there was a need to ensure understanding for patients that Room4U was part of individual care plans. He asked Ms Garrity to feedback the Board's thanks to the patient who had taken the time to tell his story, as well as to the wider PPG for their very positive involvement. It was also noted that the full audio recording made would be shared with Non-Executive Directors.

Action: Ms McCaffrey

The Board:

1. The Board noted the content of the patient story and thanked the patient and PPG for their involvement.

8 PATIENT ADVOCACY SERVICE: 12 MONTH REPORT

Ms Rebecca Carr and Mr Michael Timmons joined the meeting in relation to the Patients Advocacy Service 12 Month Report (Paper No. 23/115).

Ms Carr described the key achievements made by the service, and highlighted the success made in meeting prescribed targets, with 83% of Key Performance Indicators having been met. She provided some further background on the areas where this had not been achieved. For example, it had not been possible for advisors to meet with all patients within prescribed timescales due to patient illness. She also highlighted the increased rate of attendance at Care Programme Approach (CPA) meetings; and the strong focus on Advanced Statements. Within the service, there was continued focus on training and development of the team; though recruitment in the current climate was challenging.

Mr Timmons provided some further background on the organisational and service development as well as areas for future development. This included engaging with patients on five consultation responses throughout the year, threading the patient voice through these. He also highlighted the increased response to the patient questionnaire; and noted the availability of ward drop in sessions which had proven to be supportive for patients.

He also advised that PAS were considering the availability of advocacy for patients who were being cared for temporarily within acute services external to TSH. This was an area of development, with it being recognised that although there would be advocacy services available in a local general hospital setting, these may not include the required level of experience to support TSH patients in this situation. The plan was to develop a protocol for this to fill this gap in the service. Mr Timmons noted that a key component of the following year for PAS would be the opening to tender for delivery of advocacy services within TSH, and confirmed planning was underway to prepare for this as the existing service provider.

Ms Fallon welcomed the very detailed report, and the positive initiative for supporting patients admitted into hospital external to TSH. She also noted that six complaints had been recorded as having been withdrawn due fear of negative consequences, and asked if this was a concern. Ms Carr noted the small number of complaints withdrawn and provided background to the way in which patients could change their minds through the process. Ms McCaffrey noted that any issue raised would always be followed up and any concerns would be acted upon. She also noted the supports in place for patients both through PAS and the Complaints Service to support patients positively to enable them to raise concerns.

Mr McConnell provided positive feedback on the report, particularly the patient feedback within it. He asked about the status of the volunteer programme. Ms Carr acknowledged that this had been difficult to support as the intention had been for the volunteer to have a similar role to the advocates but this would require a high level of training to deliver. The service was currently considering a slightly different focus for a volunteer service. Mr Timmons highlighted the importance of volunteer advocates, but that it was challenging to recruit into this role, and to support a meaningful induction and training programme for them. This was under review as to how to take this forward. Ms Radage asked whether about the

gender balance of advocates and the possibility of encouraging more male advocates. Ms Carr confirmed that PAS did previously have male volunteer advocates, and that positive action was planned within recruitment to encourage male applicants given the male population of the hospital.

Ms Fallon asked for clarification on income versus expenditure as reported; and Ms Carr advised that the service had made savings during Covid-19 so surplus was returned to TSH causing the anomaly indicated, but that income versus expenditure was currently on track for balanced yearend.

Mr Moore asked about how PAS demonstrated their independence as a service from TSH, noting the use of different coloured lanyards for PAS staff. Ms Carr said that she did not think it was a particular problem but nonetheless it was something that PAS staff would continue to highlight to make sure there was understanding of this across both staff and patients.

Mr Moore thanked both Ms Carr and Mr Timmons for their report and presentation, underlining the importance of independent advocacy for the hospital.

The Board:

1. The Board noted the content of the report.

9 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 23/116) from the Director of Security, Resilience and Estates, which provided an overview of the Corporate Risk Register including movement on risk gradings. Mr Walker confirmed that all the risk assessments were in date, and highlighted that three risks remained at a grading of 'high'.

The first of these was Risk ND71 (failure to assess and manage the risk of aggression and violence effectively) and Mr Walker asked the Board to note the update in this regard for a refreshed approach which would support a more informed assessment of risk. Reporting would return to the next session of the Board. The second risk was MD30 (failure to prevent/mitigate patient obesity) with an update provided on the multiple approaches being taken. Finally, ND70 (failure to utilise resources to optimise patient care) and reporting provided updates on the work being progressed on recruitment and retention as well as for e-rostering implementation.

Mr Walker also asked the Board to note the update on the continued development of the Corporate Risk Register, which would align this to the TSH Corporate Objectives.

On behalf of the Board, Mr Moore noted the report and agreement to it being an accurate statement of risk; as well as welcoming the ongoing work to continue to develop it.

The Board:

1. The Board reviewed the current Corporate Risk Register and approved it as an accurate statement of risk.
2. Noted that work would progress to develop the Corporate Risk Register so that it aligned to the TSH Corporate Objectives.

10 INFECTION PREVENTION AND CONTROL REPORT

The Board received a paper (Paper No. 23/117) 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 provided an overview of reporting, noting the key aspects. She highlighted the position on Covid-19 results with 12 patients testing positive during September to November, as well as the

vaccination uptake rate. This had decreased from last year and mirrored the experience found in the wider public community. Clinical teams had promoted positive messaging around vaccination to try to encourage uptake.

Ms Fallon asked about any changes made to the management of patients who tested for Covid-19 within the hospital; and Ms McCaffrey confirmed that the local Standard Operating Procedure had been reviewed appropriately with national guidance and found to provide an appropriate management plan. Therefore, this continued to be that symptomatic patients were isolated within their bedrooms and would re-join the ward once asymptomatic. There had been no negative impacts found from this practice which provided a good balance in managing outbreaks and with least restrictive practice.

The Board:

1. Noted the content of report.

11 BED CAPACITY REPORT

The Board received a paper (Paper No. 23/118) 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 summarised the content of the report, and noted that capacity across the forensic estate continued to be challenging. She noted that surge beds were available within THS but none was currently in use.

Mr Moore summed up for the Board, noting the assurance taken from the position outlined on bed capacity within TSH and the wider pressures in the forensic estate.

The Board:

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

12 CLINICAL MODEL

The Board received a paper (Paper No. 23/119) from the Director of Nursing and Operations and the Medical Director to provide an update on the work being taken forward by the Clinical Model Oversight Group (CMOG).

Professor Thomson asked the Board to note reporting which demonstrated the continuing progress being made; and Ms McCaffrey added that there was a positive link between the CMOG and the Activity Oversight Group which ensured that each workstream was working in tandem.

Ms Fallon asked if there had been any learning to date which indicated a need to make adjustment to the clinical model, and Professor Thomson responded in terms of how each service was developing and the guidance followed. There was a need for the CMOG as an oversight group whilst encouraging autonomy within each Service Leadership Team. However, there had not been any indication for fundamental change to the model itself, which remained a progression model for patients. Work was continuing to identify the way in which the transitions service could be differentiated to give a sense of progress for patients. Mr Jenkins added that the pressures recently experienced with daytime confinement may have provided less opportunity for development of services; and that it was expected that the benefits of the model would be built upon in the coming year.

In response to a question from Mr Moore about feedback from staff to date, Professor Thomson advised that the Service Leadership teams retained enthusiasm for the model, and were committed to delivery of it. Steps were in place to collect and evaluate wider staff feedback from a baseline position prior to implementation to measure any change in perspectives.

Mr Moore summed up for the Board, noting the continuing progress being made.

The Board:

1. Noted the content of this update.

13 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 23/120) which provided update reporting on progress made towards quality assurance and improvement activities. Ms Merson provided a summary overview of the content of the report, highlighting the hospital wide variance analysis undertaken, particularly the need to improve attendance at Care Programme Approach (CPA) meetings. She also updated the Board on the progress made within the Quality Forum in terms of training and development. The report also provided a case study from a QI project focused on the percentage of patients within the Intellectual Disability Service receiving a weekly one to one with their Key Worker. Finally she highlighted the work progressed through the Realistic Medicine workstream, and the quality assurance provided through the evidence for quality analysis.

Mr Moore asked about the variance analysis around CPA meetings which evidenced some improvements in reporting provided; but a drop in attendances to the meeting. He sought clarification as to whether a lack of attendance from one discipline would have an impact provided that reporting had been submitted. He also asked about whether all staff groups were asked to attend consistently. Professor Thomson responded by saying that the CPA meeting took a multi-disciplinary approach with a sharing of views so a lack of attendance could have an impact. She went on to say that, however, this did depend on the particular discipline involved. For example, it may not be the case that dietician staff would have a contribution to make at each meeting, beyond what they had reported. She also noted that there may be an issue in terms of the administration aspect of recording attendances. She offered the view that the attendance of the Key Worker should be considered essential at each meeting. She also noted that although it would be ideal to have the relevant Security Manager at each meeting, to support discussion between clinical and security disciplines, this was a small cohort of staff meaning that this was not always possible. Mr Walker added that this was a key area of focus within security, and that there had been an improvement in the last quarter. He provided assurance that there would be continued focus on this from the Head of Security.

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.

14 CLINICAL GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting, which had taken place on 10 August 2023; as well as a summary report (Paper No 23/121) of the key areas of reporting and discussion at the meeting which had taken place on 9 November 2023.

As Chair of the Committee, Ms Fallon highlighted reporting in terms of positive management of access for family contact. She also noted the review of administration of medication and that reporting would return to the Committee in this respect.

The Board:

1. Noted the content of the approved minutes CGC(M) 23/03.
2. Noted the content of reporting.

15 STAFF GOVERNANCE REPORT

The Board received a report from the Acting Director of Workforce (Paper No. 23/122) which summarised the key aspects of workforce performance across a range of metrics. Ms Nisbet led the Board through an overview of the report which focused in particular on attendance management, and the need to continue to target areas of high sickness absence through the Task and Finish Group set up in this regard, as well as usual governance. She noted the improvements made in the job evaluation process, as well as the work in progress to improve performance in the completion of Personal Development Planning and Reviews (PDPRs) across the whole organisation. She also underlined the re-fresh in the corporate induction process, held as an in-person event, and which had received positive feedback. Ms Nisbet also highlighted the range of wellbeing initiatives undertaken, and that the staff Long Service Awards event had been very positive and engaging for all involved.

Mr Currie noted the steady improvement overall in relation to sickness absence over time; and asked a question about the link between the wellbeing initiatives being funded and how the impact of these could be measured in terms of the impact on recruitment and retention of staff. He added that it would be essential for the Board to receive assurance on what could be shown to have most impact and should continue to be taken forward.

Ms Nisbet noted that in terms of attendance management, the intention was to embed good practice through usual governance in the longer term. She advised that an evaluation was going to be taken forward in the new year on the implementation of the Staff and Volunteer Wellbeing Strategy, and the related metrics. This should help to evidence which options did bring the most benefit. In this context, Mr McConnell asked whether the drop in the rate of footfall to the Wellbeing Centre during the reported period could give intelligence on the rate of use by front line staff. Ms Nisbet advised that there hadn't been a drop in use from any staff group in particular, and that it may be more likely related to the summer holiday period.

Ms Fallon asked whether the feedback from staff at the Long Service Awards had included any discussion on why some staff had felt content to remain at TSH for lengthy careers. Ms Nisbet confirmed that all the staff involved had an opportunity to speak and that there had been a range of views including the ability to make career progression and the positive impact on family life through working at a local organisation. Mr Moore added that feedback had been very positive with TSH seen as a positive working environment. He also asked about the opportunity presented for Healthcare Support Workers attending the Open University (OU) in terms of new roles, and whether there had been growth in the uptake of this.

Ms Nisbet advised that this was an area of development with the opportunity for non registrant staff to pursue a nursing degree through the OU and become a registered nurse, enabling them to apply for AfC Band 5 nursing positions within TSH. This was being reviewed as part of the Workforce Strategy. Ms McCaffrey added that this was part of a national workstream to encourage staff to consider a career in nursing. However, this had meant that there was competition for places at the OU to do this, and the Chief Nursing Officer (CNO) had indicated that that there was a need to explore opportunities at other institutions. Ms McCaffrey was keen for TSH to be part of any new initiatives going forward.

On behalf of the Board, Mr Moore noted the range of metrics reported as well as the continued focus on improvement in sickness absence rates.

<u>The Board:</u>

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. 23/123) which summarised the position on the implementation of the Health and Care Staffing (Scotland) Act 2019

(HCSA) and the adoption of e-rostering within TSH.

Ms McCaffrey presented the report and asked the Board to note the progress being made, with the establishment of the HCSA Compliance Group and the development of a Project Plan, which was

appendixed to the report. The Quarter 2 report had been submitted to Scottish Government, with a response awaited. A further engagement session had taken place with the CNO in December, which had been open to a range of staff across TSH. She provided assurance that implementation of e-Rostering was on track for 1 April 2024 deadline, with the benefit of additional functionality being recognised and under development. She asked for feedback from the Board on the high level overview of the Project Plan and whether any further reporting was required.

Mr Moore asked about staff feedback to date as this did represent an area of significant change, and whether more benefits could be identified as implementation was taken forward. Ms McCaffrey responded that clinical staff were supportive, and that it had helped to build understanding and knowledge of how rostering was managed within TSH. As the work progressed, more staff were becoming engaged with the project team. She noted the clear benefit of moving to digital rostering from manual processes, and that it was expected that additional improvement in managing rosters would be realised.

In answer to a query from Ms Fallon about funding of temporary posts within the project team, it was confirmed that these had been funded through existing budgets and that this was being carefully managed and under review as implementation progressed.

Mr Moore thanked Ms McCaffrey for the assurance provided to the Board.

The Board:

1. Noted the content of this update.

17 ORGANISATIONAL DEVELOPMENT UPDATE INCLUDING iMATTER SURVEY 2022/23

The Board received a paper (Paper No. 23/124) from the Acting Director of Workforce to provide an update to the Board on the Organisational Development (OD) Strategy, as well as a summary of the status of the I Matter 2022/23 within TSH. She summarised the content of the paper, and confirmed that the Staff Governance committee had taken detailed oversight of the results of the iMatter survey at its last meeting, with the national report then being published at the end of November. She confirmed that a new OD manager had commenced with the TSH this month and that the new strategy would help to give coherence across the organisation where a range of initiatives were underway.

Mr Moore summed up the Board discussion and underlined the importance of this workstream, and the need for this to be progressed.

The Board:

1. Noted the content of the report.

18 WHISTLEBLOWING QUARTER 2 REPORT

The Board received a paper from the Acting Director of Workforce (Paper No. 23/125) to report any developments during Quarter 2. Ms Nisbet confirmed that there had not been any new cases received, and that therefore there were no cases under review or outstanding. She also highlighted the activity within TSH to promote “Speak Up” week in October 2023.

Mr Moore provided a further update from the Independent National Whistleblowing Officer (INWO) in respect of the opportunity for NHS Boards to collaborate, especially on investigations. This was under development but it may be a helpful way to ensure the independence of investigations.

The Board:

1. Noted the content of the report.

19 STAFF GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting, which had taken place on 17 August 2023; as well as a summary report (Paper No 23/126) of the key areas of reporting and discussion at the meeting which had taken place on 16 November 2023.

As Chair of the Committee, Ms Radage asked the Board to note the range of reporting and workstreams developing, and the positive direction of travel. She raised the issue of PDPRs underlining the need for further progress especially in those departments who had not met the target of 80% over a lengthy period of time.

Mr Moore confirmed that the Board had taken note of this position and the need for improvement.

The Board:

1. Noted the content of the approved minutes SGC(M) 23/03.
2. Noted the content of reporting, and the need for improvement on compliance on PDPRs across all departments and most particularly in those departments which had not met the required target over a lengthy period of time.

20 PLANNING UPDATE – ANNUAL DELIVERY PLAN 2024/25

The Board received a paper (Paper No. 23/103) from the Head of Planning, Performance and Quality to provide an update on the requirement to develop an Annual Delivery Plan (ADP) for 2024/25. She confirmed that this should be delivered to government by 7 March 2024, with work having commenced in this respect across the organisation. An executive planning day had been scheduled for 15 January 2024, to help to produce a cohesive plan, a further update would be brought to the next Board Development Session on 1 February 2024.

Ms Merson confirmed that although Scottish Government had also commissioned Medium Term Plans from NHS Boards, it had been agreed that TSH would no longer be required to do so at the present time.

The Board:

1. Noted the content of the report, and that further reporting would be presented at the next Board Development Session.

21 FINANCE REPORT TO 31 October 2023 (MONTH 7)

The Board received a paper (Paper No. 23/128) from the Finance and eHealth Director, which presented the financial position as at 31 October 2023.

Mr McNaught provided a summary of the key aspects, especially that a breakeven position was expected for the Board at yearend. To achieve this, there was continued focus on the remaining savings required to be achieved this year. At the same time, work had commenced on budgetary savings targets for 2024/25. The capital allocation was being fully utilised in the current year.

Mr Currie noted that a breakeven for this year should be recognised as a considerable achievement. He commented on the difficulty for TSH in being able to achieve further savings in the next financial year given the unique nature of the service providing essential care. He commented on the need for all staff

across the organisation to understand the financial pressures expected going forward. Further that staff should be commended for the efforts they had made to date which had helped the Board to date in progress towards breakeven in the current year. Ms Fallon echoed these comments, and asked if the corporate training plan would be under review in terms of budget. Mr McNaught confirmed that this would necessarily be the case.

Ms Radage referred to the data presented on vacancies compared to the use of overtime spend within nursing, comparing this to the workforce reporting considered earlier in the meeting. Mr McNaught confirmed that this was due to the timing of the reporting, and the periods under review with the workforce report providing more recent data. Mr McConnell asked if reporting now showed all national pay uplifts for 2023/24, and Mr McNaught confirmed that this was the case – and as a recurring allocation going forward in the year.

Mr Moore summarised for the Board, noting the expectation of a breakeven for yearend; and the challenging financial position for 2024/25.

The Board:

2. Noted the content of the report.

22 NETWORK AND INFORMATION SYTEMS (NIS) REPORT

The Board received a paper (Paper No. 23/129) from the Finance and eHealth Director, to confirm the outcome of the audit of Network and Information Systems within TSH. The Board had been receiving an update as a standing item at each of its meetings until the end of the process in October 2023.

A session had been led by Cyber Security Scotland on 6 December, attended by both Executive Leads as well as Non-Executive Directors, and a draft outcome report had been shared. This had given an overall assessment of compliance with a rating of 76%, and TSH was described as a strongly performing Board in this area.

This had been very positive with a key message that huge progress had been achieved by a small team, and that this had been impressive. The review team had complimented both the eHealth team as well as staff involved across the organisation in delivering the evidence required for compliance. The review team also underlined the contribution made at an executive level, and the involvement and support of the Chief Executive. Mr McNaught confirmed that work was underway to plan the way forward for the areas of development for 2024. It was also confirmed that the final report would be published, once it was available.

Ms Fallon noted the work of all involved, and Mr Moore echoed this point. He thanked all staff involved for their hard work and focus on this, which had produced an exceptional outcome.

The Board:

1. Noted the content of the report.
2. Thanked all staff for their contribution to this workstream, producing an excellent outcome.

23 PERFORMANCE REPORT QUARTER 2

The Board received a paper (Paper No. 23/130) from the Head of Planning and Performance to provide a high-level summary of organisational performance for Quarter 2. Ms Merson presented the report to the Board highlighting that there were five key performance indicators (KPIs) which were off target for this period.

Ms Merson provided more detail in each of these areas, beginning with the performance for review of care and treatment plans at six-month intervals. This remained at amber through there had been some

improvement, with the administration aspects remaining a contributory factor. Similarly, patients undertaking 150 minutes of exercise each week had seen a slight increase in performance but remained at amber. The Activity Oversight Group were taking detailed oversight in this area to focus on further improvement. The performance rating for patient BMI remained in the red zone, as did the performance on sickness absence. For the latter target, there had been some improvement seen in Quarter 3.

The final performance target highlighted was for patients to have their clinical risk assessment reviewed annually, which was rated at amber. Ms Merson advised that she had interrogated the data on this further, and could confirm that those that were out of date at the end of September, had been completed in October. Further, there had been a recording issue with risk assessments being carried out but not uploaded timeously. On this point, Professor Thomson also added that there had been further recruitment within psychological services, but that in the period under review the team had focused on completion of risk assessments. She provided assurance to the Board that risk assessments had been completed as required.

Mr Moore commented on the very positive improvement made in the indicator for engagement in psychological therapies, which was rated as green. He also added that it may be helpful to re-visit the way in which the performance target for a healthy BMI was evaluated given the range of workstreams underway in this area. Mr Jenkins underlined this point and the innovative work being progressed through the Supporting Healthy Choices workstream for patients in a high secure environment. He also commented that these metrics were for the most part set by TSH, as targets to achieve, rather than being part of a national target framework. Mr Moore also noted that in the Annual Review process, the Mental Health Directorate had asked for further updates on the target for patient care and treatment plans, as well as for engagement in psychological therapies.

The Board was content to note this detailed update and the information provided as part of reporting.

The Board:

1. Noted the content of the report.

24 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report from the Director of Security, Resilience and Estates (Paper No. 23/131) detailing the update of the Perimeter Security and Enhanced Internal Security Systems re-fresh project.

Mr Walker highlighted the key points of the report, and further that revision 54 was now under consideration which indicated that completion may not be possible by April 2024.

The Board noted that a further update would be presented in a private session of the Board, given the security and commercial sensitivities of reporting.

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 BOARD WORKPLAN

The Board received a report (Paper No. 23/132) from the Head of Corporate Governance to present the draft workplan for the Board for 2024, outlining reporting across each scheduled meeting to ensure that the Board received the appropriate level of assurance throughout the year.

Ms Smith presented the report, acknowledging that although the plan was intended to be comprehensive, there also would need to be an element of fluidity to take into account any future

developments. She outlined some the key areas of expected reporting including the evaluation of the revised clinical model implemented during 2023, as well as for continued regular reporting of the Supporting Healthy Choices workstream given the continued priority of patient physical health. She also noted that it was planned for the Board to continue to be able to hear directly from patients and carers through being to tell their own stories. It was planned for twice yearly updates from the Communications Service, including annual reporting. Finally for reporting on the Corporate Governance Improvement Plan to be developed as part of the Blueprint for Good Governance.

Mr Moore noted the position on the Clinical Forum which was currently paused, and Ms Smith confirmed that there had been difficulty in engagement in the Clinical Forum as well as the related professional advisory committee structure. This was related to staff resourcing as well as the challenge of supporting a fully independent advisory structure separate to the management reporting structure in a small NHS Board. This would return to the Board, as part of the corporate governance improvement workstream, with options as to how to make progress in this area.

The Board also considered the Organisational Development Strategy, which was part of the ADP 2023/24 and had been scheduled to come to the Board in February 2024. Given developments in this area, it was agreed that this would be better placed in April 2024.

The Board:

1. Approved the updated workplan for 2024.

26 ANY OTHER BUSINESS

The Chair took the opportunity to thank everyone for their contributions throughout the year, extending this to all staff in the organisation for all of their work and positive contributions made to place the Board in such a positive position for the coming year.

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 22 February 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 12.45pm

ADOPTED BY THE BOARD _____

CHAIR _____

DATE _____

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	August 23	Central visiting / family centre	Update on fencing – when installed and gardens available	D Walker	February 24	**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. **Update December 23:** Install date w/c 15 January confirmed and action closed. **CLOSED**
3	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. **CLOSED**
4	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. **CLOSED**
5	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. **CLOSED**
6	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. Further discussion at meeting to confirm attend anywhere switch on in wards in Jan 24, health centre looking at virtual appoints where possible, an further audit on Emergency Department appoints with results to CMT in Jan 24. Further update will be routed to Board /Committees. Added to CGC agenda Feb 24. **CLOSED**
7	December 23	Patient Story: "Daytime Confinement or Room4U"	Patient story – audio recording	K McCaffrey	Immediate	Share patient story to non-execs **Update January 24:** patient story shared to non-execs 31/01/2024. **CLOSED**

Last updated – 01.02.24 L. Kirk

Paper No. 24/02

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 February 2024
Agenda Reference:	Item No: 7
Sponsoring Director:	Director of Security, Estates and Resilience
Author(s):	Risk Manager
Title of Report:	Corporate Risk Register Update
Purpose of Report:	For Decision

1 SITUATION

A corporate risk is a potential or actual event that:

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

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

2 BACKGROUND

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

3 ASSESSMENT

3.1 Current Corporate Risk Register - See appendix 1.

3.2 Out of Date Risks

All risks are in date.

3.3 Update on Proposed Risks for inclusion on Corporate Risk Register

HRD113 Job Evaluation - HR have developed a risk assessment relating to the impact of delays within the job evaluation process and the potential impact this may have on services. The risk assessment details the control measures in place to minimise the impact of this process as well as ongoing work that is underway to mitigate the risk further. The risk has been added to the Corporate Risk Register after approval at CMT and is currently graded at Moderate x Possible giving an overall rating of Medium. Full risk assessment is available in Appendix 2.

3.4 Corporate Risk Register Updates

ND71 – Serious Injury or Death as a Result of Violence and Aggression (previously ND71 - Failure to assess and manage the risk of aggression and violence effectively)

ND71 Risk has been updated to better reflect the risk of violence and aggression within TSH. All current control measures and latest incident data were considered when developing the risk assessment. It now focuses on serious injury from violence and aggression incidents, a change from the previous focus of all violent incidents. The assessment highlights that the majority of incidents are managed without issue or injury and therefor the risk to staff and other patients should reflect this. After analysing the data the risk has been reduced from High to Medium (Moderate x Possible) and will be monitored regularly. Full risk assessment is available in Appendix 3.

3.5 High and Very High Risk – Monthly Update

The State Hospital currently has **2** 'High' graded risks:

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

Monthly Update:
100 Patients total (Patient number correct at time of data collection), overweight and obesity in Feb 24 was 86%, a slight increase from 85.4% in January. Declined/no data accounts for 5% of patient population which is a decrease from 7.8% declined/no data. There are multiple approaches in place across the organisation to address this issue, these include the following:

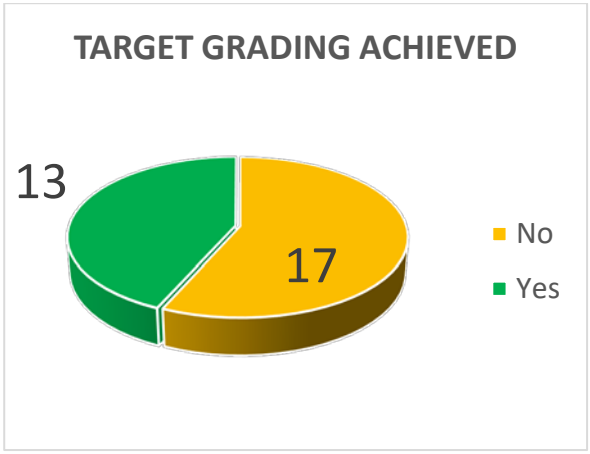
- Weight management group, Healthy Living Group should run again early 2024, Slim & Trim (will be re-named) and health psychology along with dietetics will look at different ways of delivering this (discussions in progress).
- Continued offer of pharmacological adjunct therapies where appropriate such as metformin, orlistat and pathways agreed 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.
- Skye Centre Activity staff provide beneficial support as part of their remit, to support patient's activities and walks.
- Hub areas open now offering more activity to patients off ward, support from Occupational Therapists and clinical staff allow this to take place when staffing resource permits.
- Increased remit of health psychologist work with hard to reach patients.
- Weight management pathway updated to incorporate diet management framework needs and will be updated again with changes and practice needs now that clinical model has been implemented

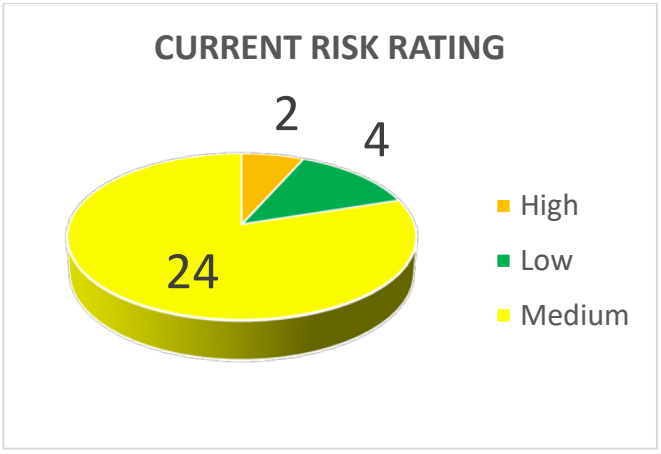
Nursing Director: ND70: Failure to utilise our resources to optimise excellent patient care and experience.

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 of long term sickness levels and the return of staff to work. This continued work has had a positive impact on staffing.
- Risk register and risk assessment also completed. Numbers of incidents are reducing overall after a small spike over the festive period, full closure incidents have decreased significantly.
- Risk assessment to be fully reviewed with a view to utilise live activity data

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 High to Medium after a review of the risk (ND71 detailed above).

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 Manager by ensuring 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 was 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 Strategic Objectives. Work is ongoing within the Risk and Resilience Team to identify the first areas to be reviewed.

Current Progress:

- Nursing Directorate review is 50% complete with ND71 having been fully reviewed and positive feedback received about new format. The other ND risks are currently being reviewed and will be shared with relevant groups when complete.
- Exploration of Datix Incident Management System underway in preparation for transfer of Corporate Risk Records. The Risk Manager has identified areas that require some modification prior to use, a department will be identified to test the system before full roll out across the hospital is considered.
- The appointment of the Risk and Resilience Support Officer has allowed the team to focus on the Local Risk Register. Work is currently underway to update all records, schedule in reviews and look to begin preparation required to move Local Risk Assessments to the Datix System.
- Security Directorate CRR review will begin in the coming weeks following the completion of the Nursing Directorate Risks.

4 RECOMMENDATION

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

Paper No. 24/02
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 and Audit Committee
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. 24/02

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	27/02/24	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	27/02/24	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	16/04/24	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	16/04/24	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	16/04/24	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	08/05/24	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	08/05/24	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	08/05/24	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	08/05/24	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	08/05/24	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	08/05/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate ND 71	Health & Safety	Serious Injury or Death as a Result of Violence and Aggression	Extreme x Almost Certain	Moderate x Possible	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	10/04/24	Clinical Governance Committee	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	16/04/24	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	16/04/24	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	16/04/24	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	12/08/24	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	27/07/24	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	16/07/24	Clinical Governance Group	6 Monthly	-

Appendix 2

Risk to Operational Services – Job Evaluation

Ref: HRD113

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

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

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

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

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

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

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

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

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

Risk Rating Refer to the QIS Matrix and descriptors (appendix 1) to assess the likelihood of the	**Impact/Consequence** (use descriptor relevant to proposal and select level of impact)	**Likelihood** (use descriptor relevant to proposal	**Rating** R=I/C x L

risk occurring and the impact it would have and determine the overall level of the risk.		and select level of impact)	
Initial Risk Rating Risk grading without controls	Major	Possible	Medium
Target Movement Movement since last review	-	-	-
Target Risk Rating	Neglible	Unlikely	Low
Current Risk Rating	Moderate	Possible	Medium

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

Assurances and KPIs	What assurances are there that current controls are effective? (Internal and external)
Progress and status is now reported monthly in the workforce paper which is presented at Workforce Governance, OMT, CMT,	

HR & Wellbeing, Partnership Forum & quarterly to Staff Governance.
6 monthly report on status will be completed to Workforce Governance and CMT (due January 2024).

Local timeline indicates 14 week from receipt to outcome given.

Update: 16th January 2024
Job Evaluation panels continue to be scheduled 3 per month. In November and December 2023 some could be 'stood down' as there was sufficient capacity to consider all job descriptions submitted.
Progress is being made as follows:

Posts given outcome	Within 14 weeks	Compliance with 14 week target
5	3	60%
3	3	100%
4	4	100%

At end December there are 3 posts which remain active, and there is sufficient resource to progress these at the earliest opportunity within the 14 weeks' timescale (NB: one will breach due to being longstanding JAQ but is progressing now at pace).

The risk remains around being reliant on key individuals and succession planning is an action for the Job Evaluation Leads.

Detail any existing KPIs that would link to risk and show performance against risk

Date Added	29/09/2023
Completed by	Laura Nisbet, Head of HR
Date Reviewed	16/01/2024
Next Review	16/04/2024

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

Appendix 3

Serious Injury or Death as a Result of Violence and Aggression Ref: ND71

Corporate Objective	Better Care	Risk Owner	Director of Nursing & Operations	Action Officer	Director of Nursing & Operations

Risk	Complete the relevant details of the operation/ activity giving risk to the risk
There is a risk of serious injury or Death to Staff, Patients, Carers and other colleagues working with patients (Volunteers, Contractors etc.) as a result of patient violence and aggression if not managed effectively. Serious Injury is defined as: • Injury resulting in absence of more than 7 days • Injury resulting in specified injury (refer to HSE list of specified injuries) • For patients – Injuries that meet the Duty of Candour criteria	

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

Hazards	Details the hazards associated with this risk, i.e. the effect. Impact of this risk if realised
The State Hospital (TSH) provides assessment, treatment and care in conditions of special security for individuals with mental disorder who, because of their dangerous, violent or criminal propensities, cannot be cared for in any other setting. There is an increased risk of violence and aggression related incidents at The State Hospital due to the nature of the patients within the care setting. Hazards at TSH: • Risk of serious injury to staff as a result of an assault • Risk of serious injury to staff as a result of applying PMVA techniques • Risk of injury to other contractors, volunteers, carers, other patients and anyone else who may come into contact with patients as part of their role as a result of an assault.	

• Mental trauma to anyone involved in or witnessing an incident There are many factors that can be attributed to violence and aggression incidents such as: • Patients current mental state • Relationships with staff, carers and other patients • Frustrations regarding access to services, activities and other freedoms		
Individuals or group exposed	Staff, Carers, Volunteers, Visitors, other Patients and anyone who may come into contact with Patients.	Highlight those who would be affected by risk

Benefits	Detail any benefits associated with this risk being mitigated. (e.g. cost savings)
• Contributes towards a safe environment for all • Improved care community in a safe and secure environment • Improved reputation • Improved care for patients when violence and aggression is managed appropriately. • Improved staff / patient safety experience • Improved reputational engagement for new staff • Reduced levels of staff absence as a result of injuries from violence and aggression incidents	

Existing Control Measures	List any existing measures in place to mitigate this risk.
See • Monitoring of all violence and aggression incidents through Datix reported through the Clinical Governance Committee. Where any incident of violence or aggression is classed as major, a Cat 1/2 Review takes place – and the results of the CIR help to inform future practice. • Observe and report patient behaviour using clinical notes, Security Assessments, Disassociations and issues • Physical structure of wards e.g. good sight lines, access, seclusion suite, observation panel etc. • Security CCTV infrastructure gives us overall vision of hospital to review or oversee incidents and to monitor movement of patients. Think • De-escalation techniques can be used to assist • Medication reviews can assist in mitigation • Clinical Care Policy and implementation. This refers to observation levels and VRAMP to assist and mitigate • Prevention and Managing of Violence and Aggression (PMVA) policies are in place to cover issues such as hands on restraint and seclusion.	

- Following any incident De-briefs are carried out to gain valuable learning and reflective practice.
- Incidents are monitored and analysed to look for patterns and trends. Repeated aggressors are highlighted for closer monitoring to clinical teams
- Incidents are overseen by several governance groups to ensure that they are closely monitored and areas of concern are highlighted
- Patient Safety Group – Provide an overview in governance of PMVA activity
- Interaction with patient group via PPG to establish any issues or frustrations early in order to intervene.
- SPSP activities focused on reduction of impact, such as post incident de-briefs.
- Risk assessments are carried out at all venues where patients may visit externally to reduce risk to staff and others.
- Security arrangements take place prior to any patient movement to ensure the security requirements (handcuffs etc.) and staffing requirements are accurate
- Skill and gender risk assessments allow us to ensure the correct staffing compliment is in place in line with the risk
- Number of staff have completed negotiator training and staff are on call and available 24/7
- Number of staff are Level 3 Trained and on call 24/7 should situation escalate to that level
- Wards separated in to ID, Treatment and Recovery, Admission and Transition to allow for better management of patients and staff resources.

Act

- All staff are trained in appropriate risk assessment tools.
- All training and compliance is monitored.
- All patients have individual risk assessments and management plan which involves staff assessing the risk of violence from patients to devise effective plans to mitigate and manage the risk of aggression. Overall, this process captures the risks and devises a care and treatment plan. Each patient's plan is regularly reviewed and updated at patient case reviews.
- Patient dynamic and association are reviewed prior to admission and regularly throughout stay within hospital and also following any incident.
- Staff training in PMVA is regularly refreshed and is delivered by fully accredited trainers. Compliance with training completion is monitored.

Disassociation policy ensures that patients who cannot mix are managed separately but still have opportunity and access to activities

- The physical security infrastructure at the State Hospital (fence, CCTV, personal attack alarms, lock system) all contribute towards managing the risk of aggression.

- The patient environment both personal and physical are maintained to a high standard and monitored daily by staff.

Assurances and KPIs Incidents where physical intervention was required to be used as a result of violence and aggression are included in the figures below. Any RIDDORs reported were as a result of these incidents. Impact – Current impact meets the Moderate criteria, which is incidents that result in agency reportable incidents and/or significant injury requiring treatment. No incidents in the last 3 years have resulted in major or long term injuries or death, either of these would meet the Major or Extreme categories. Likelihood – Current likelihood meets the Possible criteria, significant injuries have occurred in 1 in 24 incidents. Duty of Candour Incidents: There have been 0 Duty of Candour Incidents recorded relating to violence and aggression in the last year.	What assurances are there that current controls are effective? (Internal and external) Detail any existing KPIs that would link to risk and show performance against risk

Year	2020	2021	2022	2023 (to Nov)
Physical Intervention Incidents	171	111	157	146
RIDDORs related to V&A	5	3	0	6
%	2.9%	2.7%	0%	4.1%

Rare	Unlikely	Possible	Likely	Almost Certain
1/1000	1/100	1/20	1/7	1/1

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

Rare	Low	Low	Low	Medium	Medium

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

Further Control Measures Required	Include any additional controls identified to eliminate or reduce the risk further.
- Further analysis of data, specific to ward functions and make changes based on actual data. - Ensure staff have access to all data and can use it inform current practice. - Implement changes when an incident results in significant harm	

Date Added	06/09/2023
Completed by	Karen McCaffrey/Stewart Dick
Date Reviewed	10/01/2024
Next Review	10/04/2024

Risk Register	Corporate Risk Register
Directorate	Nursing, AHP and Operations
Group/Committee Monitoring Risk	Clinical Governance Committee

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 February 2024
Agenda Reference:	Item No: 8
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 31 January 2024
Purpose of Report:	To note 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.

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 £45.797m 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 1 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 excluded TSH's allocations at this stage, we remain aware and alert that such options are potentially being considered across NHS Scotland.
A further letter was issued on 12 December advising the national position to be further pressured.

The January accounts show an underspend to date of £0.372m, with an in-month adverse movement of £0.160m – arising mainly in connection with ward nursing pressures.

The year to date underspend is primarily attributable to additional Medical recharges and Psychology vacancies.

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 been paid.) This was accrued in 2022 and 2023, and the matter remains ongoing.

In the previous year, some costs of the project works started re eRostering *(see para 3.2)*, M365 licences, and related pressures were accrued to fund an element of anticipated future costs, and any unutilised elements continue to be carried forward.

3.2 Key financial pressures / potential benefits.

Revenue (RRL): -
Covid-19
Some posts have been reviewed for permanency, and a schedule of such posts is collated for review and consideration and is being addressed.

eRostering Project
While provision was noted for the contractual implementation costs of the eRostering project in 2022/23, this project is now rescheduled nationally by NSS to implement across 2023/24 and 2024/25. Two additional project posts (fixed term) are required in order to manage this implementation. Funding has been secured in 23/24 from RRL and accruals.

Clinical Model review update
Current indications are that the budget for overtime should remain in place, while savings targets are set against anticipation of leavers at higher points in the bands' scales being replaced with starters at lower points. Further analysis on the volume of 'Boarding out' and 'offsite' activity has been undertaken. A paper will be presented to CMT to assess the cost of baselining this activity.

Energy and inflation increases
The rising costs of energy supplies and the knock-on effect on other supply chain deliverables will continue to be closely monitored as it is expected that there could be significant pressure in 2023/24 – previously estimated at an increase of £300k (accrued March '23), this has now been revised to £550k. £325k has been released to date for current year pressure.

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.

Medical
The budget for pay inceases was realigned in November, on receipt of SG budget.
Additional income for backdated recharges has masked the pressure created by the appointment of the new consultants, with the additional recharges giving rise to a net underspend.

Clinical Psychology
There is an underspend as a result of significant vacancies across psychology. An opportunity to look at different skill mixes or developing our own staff may need to be considered to enable recruitment.

3.3 2023/24 Budget

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

Energy cost increases are anticipated in the coming period 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 were notified and confirmed through CMT – also noting that additional project funding would 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	YTD Variance (budget less actuals) for period 10	Budget WTE	Actual WTE
Nursing And Ahp's	24,113	20,300	20,507	(207)	403.08	409.13
Security And Facilities	6,725	5,623	5,710	(87)	123.82	115.46
Utilities	732	610	617	(7)		
Medical	3,457	2,901	2,666	235	22.75	16.52
Chief Exec	2,368	1,977	1,900	77	26.07	22.35
Human Resources Directorate	1,091	910	909	1	16.30	17.66
Finance	3,122	2,615	2,609	6	29.18	31.71
Cap Charges	2,868	2,390	2,394	(5)	0.00	
Misc Income	(200)	(167)	(215)	48	0.00	0.00
Central Reserves	1,522	648	339	310	0.00	0.00
	45,797	**37,808**	**37,437**	**372**	**621**	**613**

Nursing & AHPs
- Budgets have been reviewed in year for Ward Nursing to recognise in-year cost pressures through to the year-end, including boarding out pressures.
- Unutilised central reserves have been phased to enable offset of earlier Nursing overspend.
- Large numbers of vacancies means that backfill of these posts is being covered by overtime.
- The level of staff usage in excess of establishment is due mainly to boarding out.
- Psychology vacancies continue, which helps offset some of the ward nursing overspend.
- PAIAW and overtime reserves are released monthly agaionst spend.

Security & Facilities
- Accruals brought forward are contributing to funding the electricity and biomass pressures.
- 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

- More Consultant time is being recharged for external work; post base budget setting, giving rise to a considerable favourable variance. New Consultants costs are offset with this.

CE

- The benefit is arising from vacancy management.

HR

- Corporate training is noted as having very little spend to date, with forecast underway to confirm utilisation to year-end.

Finance

- eHealth strategic RRL has been released for support of fixed-term staffing pressures; with further contract pressures now funded non-recurringly and under review.

Capital Charges

- The budget was adjusted in 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, hence the currently large balance will reduce proportionately as year progresses.

4 ASSESSMENT – SAVINGS

Savings targets 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)	586	146
Human Resources	(25)		(25)
Medical	(65)		(65)
Security & Facilities	(140)	80	(60)
Total	**(766)**	**666**	**(100)**

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. Savings are overachieved to date mainly in connection with Psychology vacancies.

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 remained at £0.220m, and now reflected in the base allocation for 2023/24.

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation is £0.269m, which is anticipated to be fully utilised with capital projects planned and agreed through the Capital Group. Certain projects at times may require requests on a project-by-project basis to SG for additional funding, for which availability going forward is now known to be extremely pressured nationally.

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, with plan updated in table below.

CAPITAL CRL 2023/2024 AS AT JANUARY 2024	ANNUAL PLAN £'k	YTD SPEND £'k
SECURITAS TECHNOLOGY LTD (v Stanley)		73
THOMSON GRAY LTD		186
TSH STAFFING		137
BRICK & STEEL		51
PERIMETER SECURITY TOTAL	**557**	**448**
IM&T		58
CAPITAL CRL	**269**	**58**
Fleet Decarbonisation / other	**46**	**4**
Total CRL	**872**	**509**

6 RECOMMENDATION

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

Revenue
The year to date position is an underspend of £0.372m. Forecast for the year remains for a breakeven position to be achieved.

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.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 February 2024
Agenda Reference:	Item No: 9
Sponsoring Director:	Director of Nursing and Operations
Author(s):	Senior Nurse for Infection Control
Title of Report:	Infection Prevention & Control Report
Purpose of Report:	For noting

1. SITUATION

This report will provide the Board with Infection Prevention and Control (IPC) Activity on a bimonthly basis as requested.

2. BACKGROUND

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

3. ASSESSMENT

The Senior Nurse for Infection Control will present IPC activity under the headings outlined in the HIS Infection Control Standards (2022).

Standard 1: Leadership and Governance

The organisation demonstrates effective leadership and governance in IPC.

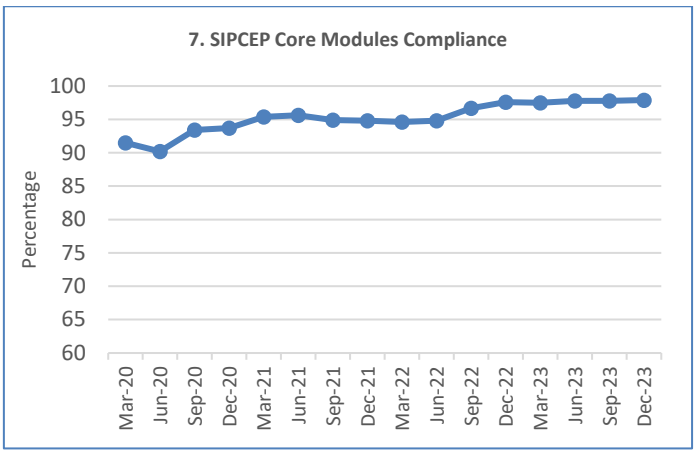
The Infection Prevention and Control Group met in December and February (January was cancelled due to public holiday)

The Infection Control Committee met in December 2023 and will meet again in March 2024.

There are no areas which have required escalation.

Standard 2: Education and Training

Staff are supported to undertake IPC education and training, appropriate to their role, responsibilities and workplace setting, to enable them to minimise infection risks in care settings.



Going forward information will be presented on discipline compliance and the length of time it takes for the modules to be completed. Core modules are to be completed within 3 months of commencing employment and role specific modules are to be completed within 6 months of commencing employment.

No areas requiring escalation

Standard 3: Communication

The organisation implements robust communication systems and processes to enable person-centred decision making, continuity of care and effective IPC throughout a person's care experience.

The Senior Nurse for Infection Control attends the PPG bimonthly. There were no issues raised at the December meeting.

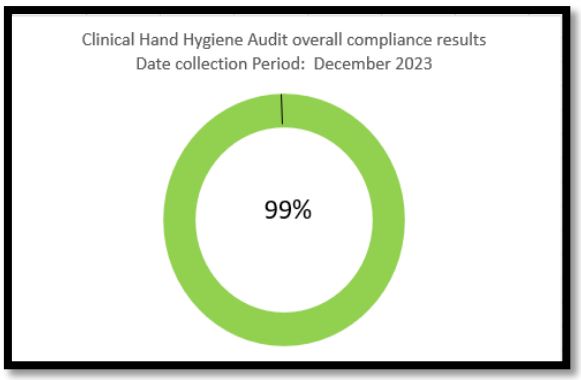
Regular communication via the Staff Bulletin and the Patient bulletins continue.

100% of patients were offered the Covid and Flu vaccines in autumn 2023, additional letters were sent to patients (January 2024) who initially refused the vaccines. However, the uptake remains unchanged.

No escalation required.

Standard 4: Assurance and monitoring systems

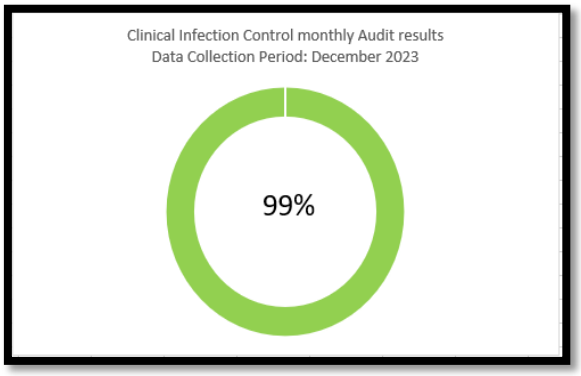
The organisation uses robust assurance and monitoring systems to ensure there is a co-ordinated and rapid response to reduce the risk of infections and to drive continuous quality improvement in IPC.



Hand Hygiene Monthly Summary:

- 100% (16 clinical areas) returned the completed audit tool between 1st – 20th December 2024

- Overall compliance, remains in RAG Green
- 99% (15 clinical areas) observed a 100% compliance.
- Areas where the five key moments were not observed to be followed:
    - Arran 1- 1 x member of security staff observed not to utilise hand hygiene techniques after contact with patients.

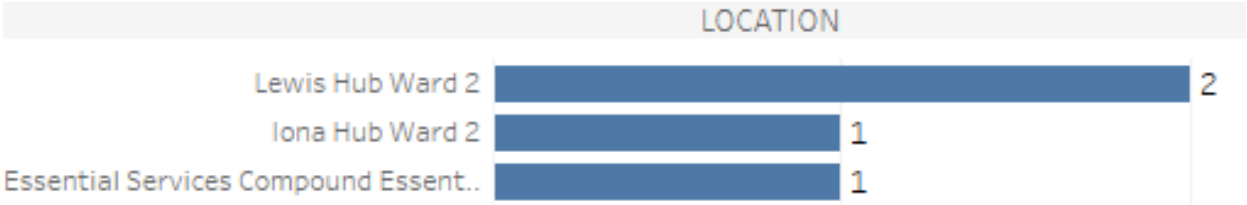


Infection Control Monthy Audit Summary:

- 100% (16 clinical areas) returned the completed audit tool
- The overall percentage remains green
- 99% (15 clinical areas) observed a 100% compliance
- Area where infection control processes were not followed:
    - Mull 2 – Soap/Gel dispensers not working. This was reported to Estates following the audit

Datix Incident monthly audit summary

- The total number of datix reports for November is 4. This equates to 1% of the overall total of laundry bags received by the laundry department.



CATEGORY	
Clinical Waste	3
Exposure to Bodily Fluids	1

SUB CATEGORY	
Laundry Packed Incorrectly	3
Urine	1

Continue to monitor with no escalation required.

<u>Standard 5: Optimising antimicrobial use.</u>
The organisation demonstrates reliable systems and processes for antimicrobial stewardship to support optimal antimicrobial use.

Antibiotic spend and usage remains comparatively low:

- £280 total spend - reduces to £185 when Hipprex cost (£95) for one client is subtracted
- Relatively low spend but higher than previous usage
- 11 antibiotic agents used over the quarter

Antimicrobial usage is reviewed by the antimicrobial pharmacist and reported to the Infection Control Committee (ICC) quarterly.
Continue to monitor with no escalation required.

Standard 6: Infection Prevention and Control Policies, procedures and guidance.
The organisation uses evidence-based IPC policies, procedures and guidance.

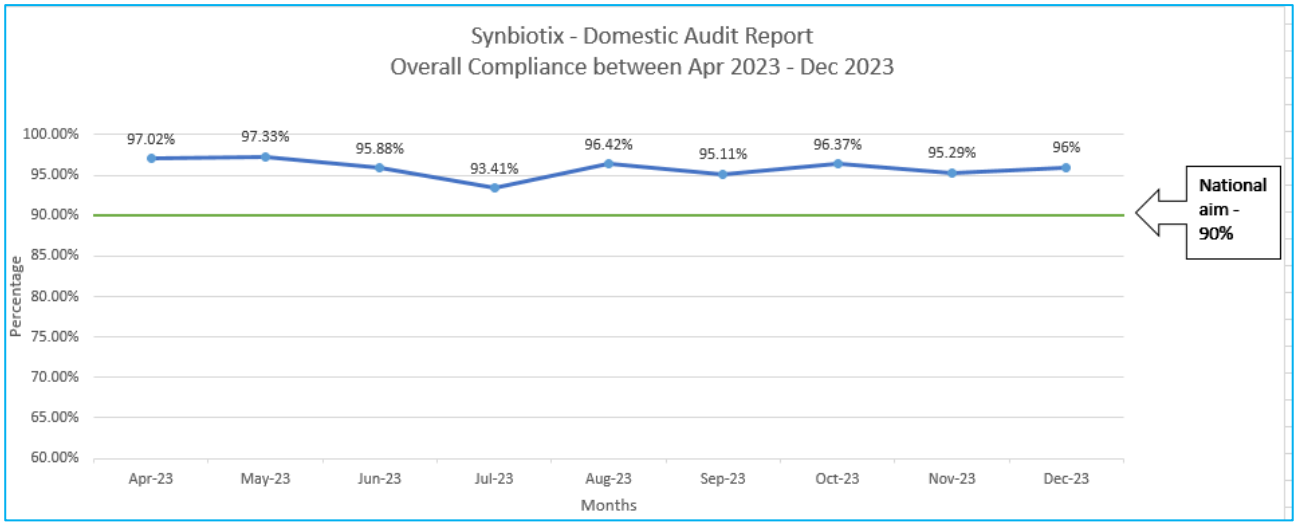
2 policies have been reviewed by the Infection Prevention and Control Group (IPCG) and will be presented to the ICC in March prior to submission to the Policy approval group.

Standard 7: Clean and Safe Care Equipment
The organisation ensures that care equipment is cleaned, maintained and safe for use.

Continue to monitor with no escalation required.

Standard 8: The Built Environment
The organisation ensures that infection risks associated with the health and care built environment are minimised.

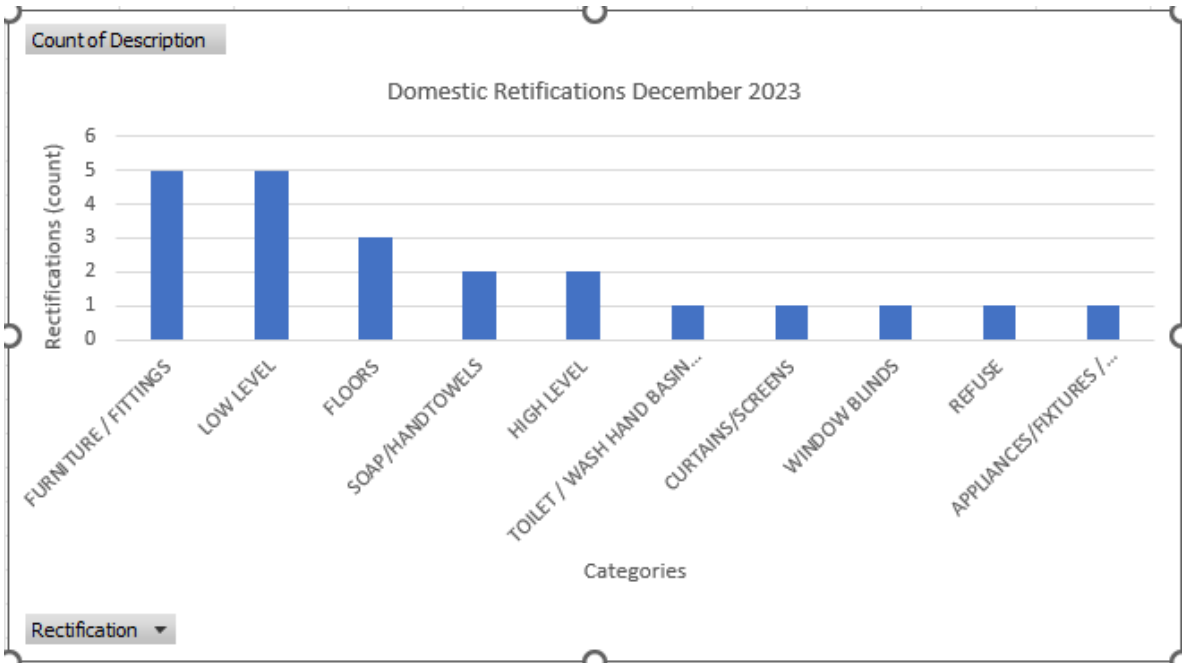
The Cleanliness and fabric of the hospital is monitored by the housekeeping supervisors and reported through the Facilities Monitoring Tool (FMT) Synbiotix. In 2024/25 members of the IPCG will undertake assurance audits.



Summary

- Overall score remains above the national aim of 90%. Total scoring has increased slightly to 96 % in December from 95.29% in November, this is increased just over 0.8%.
- For December, 7 areas were selected to be audited as part of the national monitoring tool. 4 clinical areas. The clinical areas monitored were Iona 3, Mull 1 & 2 and Skye Centre Vocational Corridor.

  The areas of non-compliance (rectifications required) are identified in the chart below.



- The mains areas where non-compliance was identified were and continue to remain the main areas since November are:
    - Furniture / Fitting – has remained at 5.
    - Low level has decreased from 7 to 5.
    - Soap/Hand Towels have decreased from 4 to 2.
    - High Levels has decreased from 11 to 1.

Continue to monitor with no escalation required.

Information on estates issues will be presented going forward.

Standard 9: Acquisition and provision of equipment
The organisation demonstrates the acquisition and provision of equipment that is safe for use in health and social care settings.

No patient care products have been purchased during the reporting period.

4. RECOMMENDATION

The Board is invited to:

1. Note the content of this report.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 February 2024
Agenda Reference:	Item No: 10
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 December 2023 until 31 January 2024.

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	16	47	22	12 + 3 surge	100
Admissions	3 (external) 0 (internal)	0 (external) 4 (internal)	0 (external) 3 (internal)	0 (external) 0 (internal)	3 (external) 7 (internal)
Discharges/Transfers	3 (external) 4 (internal)	3 (external) 2 (internal)	0 (external) 1 (internal)	0 (external) 0 (internal)	6 (external) 7 (internal)
Bed occupancy as at 31/01/2024	66.7%	97.9%	91.6%	62.5% (all beds) 125% (ID beds)	83.3% (available beds)

					71.4% (all beds)

Please note that in total there were 100 patients as of 31st January 2024, within this number 15 patients are under the care of the Intellectual Disability Service (the service is currently 3 patients in excess of their 12 patient allocation).

18 patients have been identified for transfer from TSH and 7 have been fully accepted for transfer. Of these 1 has been waiting longer than 8 months. 2 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 no patients have 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.

Future reports will also include the number of patients discharged across the forensic estate.

FN Capacity - Dec-Feb 2024.xlsx

3 ASSESSMENT

The current bed situation within TSH is manageable. The new clinical model is working and there is patient movement between services. The discharge of patients from treatment and recovery wards rather than transitions is being explored. 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 /ADP / 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. 24/06

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 February 2024
Agenda Reference:	Item No: 11
Sponsoring Director:	Medical Director
Author(s):	SHC Improvement Programme Leadership
Title of Report:	Supporting Healthy Choices Improvement Programme (SHCIP)
Purpose of Report:	For Noting

1. SITUATION

The Supporting Healthy Choices Improvement Programme (SHCIP) focus is to support The State Hospital to improve patient health and wellbeing and to reduce high levels of obesity. The current proportion of patients is 82.9% (median) who have a BMI in overweight and obese categories, with the risk of associated comorbidities and known increased risk of morbidity and mortality. 10.2% (median) of patients maintain a healthy BMI and there are no underweight patients. The remaining proportion is made up of a gap in data, which consists of patient refusals, errors and gaps in reporting, which will all be addressed as improvements.

2 BACKGROUND

SHCIP has been asked to develop a vision and remit of work that supports TSH aim of creating an environment that best supports the opportunity, capability and motivation of our patients to engage in behaviours that support their physical health and weight. Building on initial work in 2015 and 2021 SHCIP was tasked with taking forward actions and progressing with the remit of the SHC group including applying an existing Public Health England practice guidance 'Managing a healthy weight in secure settings' (PHE, 2021) for TSH. This practice guidance emphasises the crucial role that services play in supporting patients' health and weight, which viewed through a biopsychosocial lens is complex with many interlinked drivers.

3 ASSESSMENT

SHCIP has developed best practice guidance: Moving towards a Healthier State Hospital: A whole system approach. Its origins are in the Public Health England Guidance on weight management within secure settings and the new TSH guidance has been sent to Public Health Scotland for a view. It was agreed that the next step is to have a clear plan for publication, communication and implementation. This will describe short, medium and long term plans and consider productive engagement/involvement and testing of ideas by teams/patients/carer's during all stages of the clinical model.

ITEM_4.2 Moving Towards a Healthier S

The best practice guidance links directly to the driver diagram and the overall aim of the programme is:

"*To engage all TSH staff in improving the overall health and well-being of all patients, and involve all patients to address the social and environmental factors influencing patients' motivation, capability and opportunity to achieve and maintain their healthy weight"* The complexity of initiatives and approaches to meet this will mean that the timeline is extended.

20230919 Driver Diagram SHCIP V0.2.p

A measurement plan has been developed which sets out outcomes and KPI's for BMI and Physical Activity, with considerations for Food Fluid and Nutrition, provision and purchase on site.

Priority has been given to prevention of weight gain in new admissions. Work with staff in the Admission and Assessment Team is underway.

SHCIP meets weekly and is building momentum. A wider extended membership to address hospital wide improvements started on the 19th of January with a first monthly engagement session, involving members from across the site, the plan to set up workstreams that will impact on the plan of actions that are being set out to meet the best practice recommendations.

4 RECOMMENDATION

The Board is asked to note the current progress and best practice guidance which will be formalised

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP / Corporate Objectives	Supporting Healthy Choices initiative
Workforce Implications	Nil
Financial Implications	Nil
Route to Board Which groups were involved in contributing to the paper and recommendations.	Physical Health Steering Group
Risk Assessment (Outline any significant risks and associated mitigation)	Nil
Assessment of Impact on Stakeholder Experience	Nil
Equality Impact Assessment	Nil
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One There are no privacy implications.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 February 2024
Agenda Reference:	Item No: 12
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 December 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.

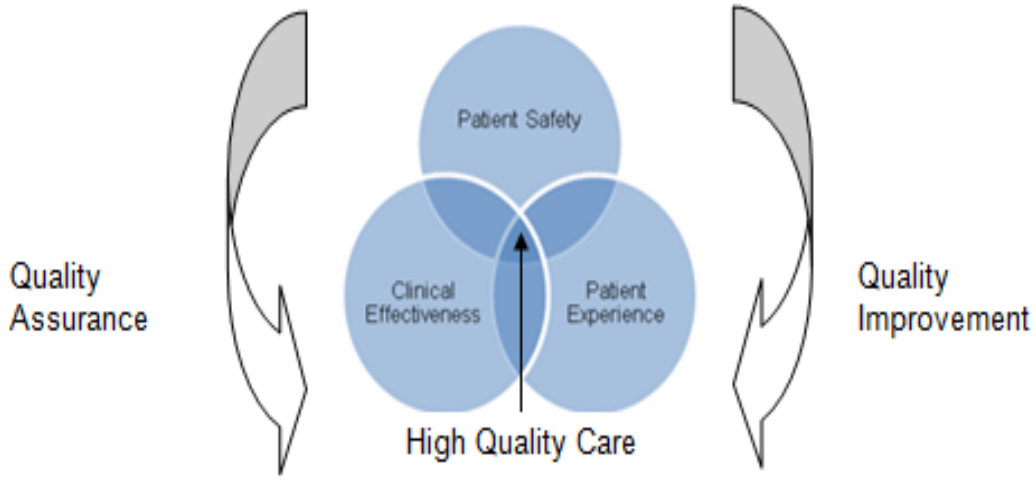
2. BACKGROUND

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 2024 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
  - Report from the analysis of variance analysis tools.
- 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

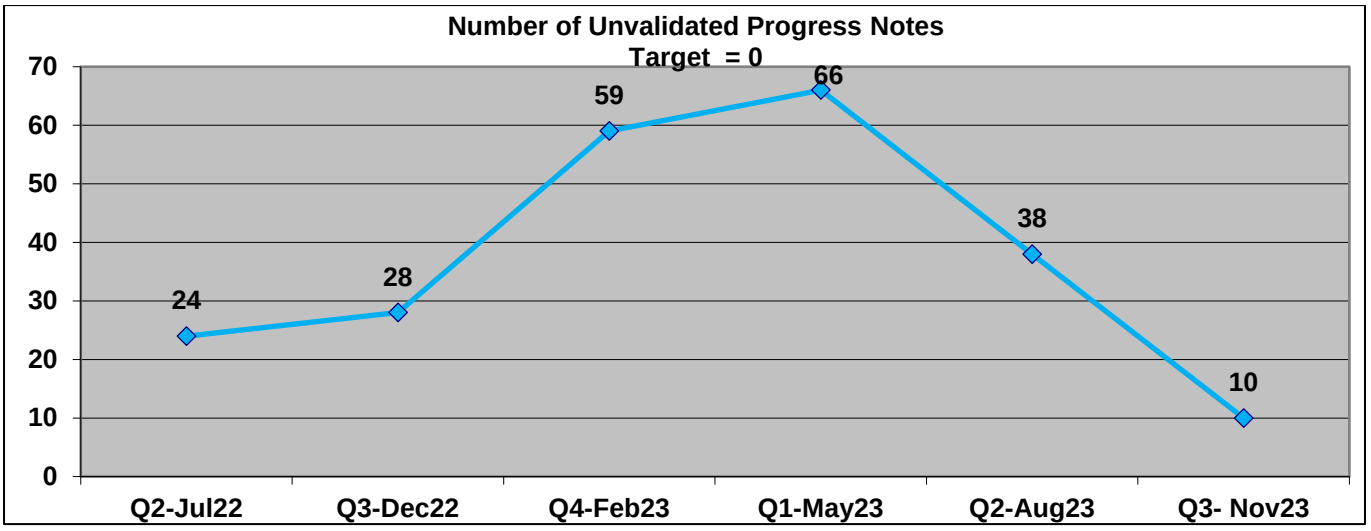
The Clinical Quality Department carries out a range of planned audits. Over the course of a year there are usually 25 – 28 audits carried out. These aim to provide feedback and assurance to a range of stakeholders that clinical policies are being adhered to. All clinical audit reports contain recommendations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

There have been 2 audits completed and actioned during this reporting period. A further 2 have been completed but await approval at their commissioning group:

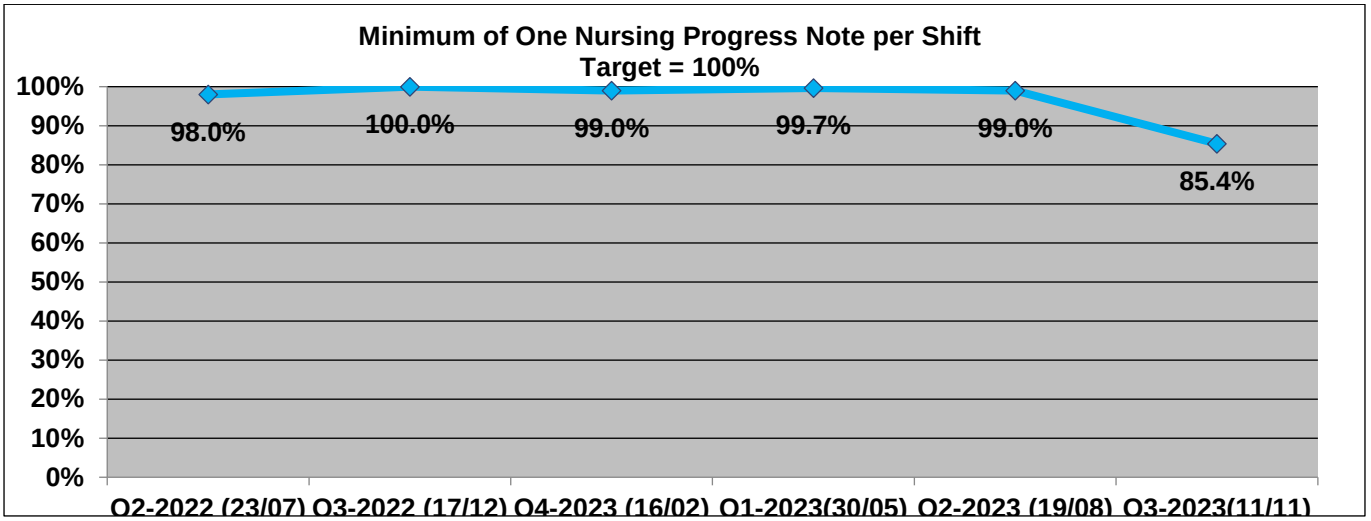
- Record keeping audit – unvalidated progress notes and nursing progress note per shift
- RMO Record keeping audit

Record Keeping Audit

Excellent improvements have been seen in this data over the last 2 audits with only 10 unvalidated entries within RiO across all disciplines. It should be noted that the number of progress notes made within a full month will be in excess of 10,000:



One nursing progress note per shift has fallen slightly with 85.4% compliance. 14 out of 15 were from night shift and the majority related to one ward. This has been fed back to the Senior Charge Nurse:



RMO Record Keeping:
Excellent compliance with all RMOs and medical staff meeting the standard of meeting with the patient at least once per month.

Variance Analysis Tool (VAT) – Flash Reports

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

HOSPITAL WIDE VARIANCE ANALYSIS FLASH REPORT

Date: Oct-Dec 2023

Overview and areas of good practice

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

The quarterly VAT report is split as follows:

Oct-Dec 23	Annual	Intermediate	Total	VAT completion	Overll MDT attendance
Admission	4	2	6	99%	69%
Arran T & R	4	6	10	98%	64%
Lewis T & R	7	4	11	100%	73%
ID	6	2	8	99%	82%
Transition	3	5	8	96%	72%

Overall VAT form completion continues to be good at 99%

Medical – increase in provision of Physical Health Report from 79% to 84% and increase in discussing report with patient prior ro review from 70 to 75%.

Occupational Therapy – increase in all Ocuupational Therapy interventions over the quarter

Skye Activity Centre –provision of the Skye Centre report has been 100% over the last 2 quarters.

Pharmacy – increase in Pharmacy attendance to 63% - highest since the start of the new Cliical Model

Psychology – improvement in all Psychology interventions

Security – provision of report at 96%

Social Work – cosistently good results with all Child Protections and Social Work reports completed since the start of the new clinical model

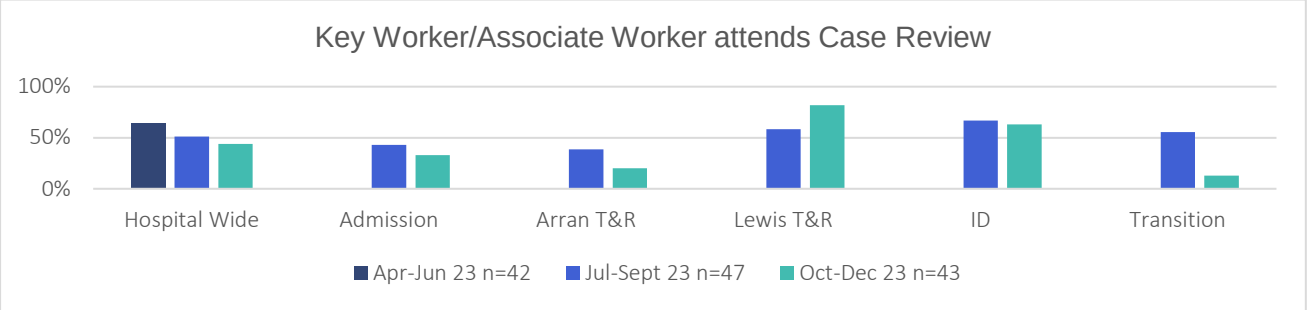
Carer – Carer attendance has increased from 28% to 44% this quarter

Advocacy attended all Annual and Intermediate reviews during the quarter

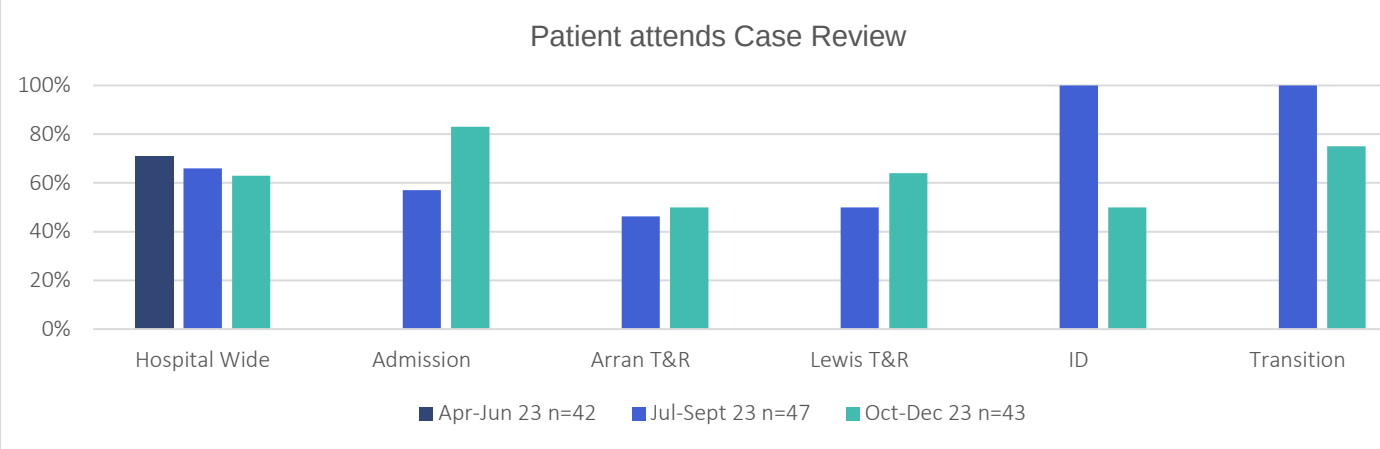
Areas of concern

Medical – third consecutive quarter on decrease for PANSS completion which is now sitting at 11%. The Mental State Review has been sitting around 80% since the start of the new cliical model – consideration to be given if this is "good enough".

Nursing – there has been a decrease in the majority of nursing interventions over the quarter – it should however be noted that we have seen increases in the December data. KW/AW attendance continues to fall and showed no improvement in December.



We may also not want to lose sight of the decrease in patient attendance over the last 3 quarters.



Any challenges with the systems that are being addressed

Improvement

Going forward the VAT data will have to be collected from RiO due to the risks to the organisation in using the current system. The new process pulls data from specific sub-headings in RiO. The first stage of this is to run a pilot in nursing where the following data is collected using both the exisiting VAT process and the new RiO process we are starting to see improvement in this:

- discussing the nursing report with the patient prior to the review
- discussing the review with the patient after the review

	Aug 23		Sept 23		Oct 23		Nov 23		Dec 23	
	VAT forms	RiO –sub headings	VAT forms	RiO –sub headings	VAT forms	RiO –sub headings	VAT forms	RiO –sub headings	VAT forms	RiO –sub headings

Pre CPA – Nursing Patient Discussion – progress note sub heading	77%	35%	69%	31%	57%	43%	62%	29%	100%	75%
Post CPA – Nursing Patient Discussion – progress note sub heading	77%	59%	75%	75%	86%	50%	86%	52%	100%	87.5%

Ongoing VAT review looking into obtaining assurance data direct from RiO. Meetings have taken place with individual professions to identify how VAT interventions will be pulled from RiO. Currently progress has been made with Social Work, Occupational Therapy and Pharmacy and meetings are arranged in January for Nursing, Skye Activity Centre and Security.

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. Over this quarter there is currently a total of 17 QI projects being undertaken.

QI Capacity Building

QI Essential Training has been delivered in Oct/Dec to TSH staff. Projects are progressing with a project feedback session planned in the Q4.

Three TSH staff completed the Scottish Improvement Leadership Training (ScIL) in December 2023 with final posters submitted in February 2024. A further 2 TSH staff have been successful in gaining places on the current cohort of ScIL which commenced in December 2023.

The Scottish Coaching and Leading for Improvement Programme (SCLIP) is currently in the recruiting stages with shortlisting carried in Februaury for the 1 place on this cohort.

QI Case Study – Embedding Reflective Practice into Lewis 2 Culture

The Case Study detailed in **Appendix 1** is a QI project, from the QI Essentials Training in June. Its focus was to support nursing staff by improving their wellbeing. The paper details the QI methodology used and highlights how fostering a culture within Lewis 2 where reflective practice is embedded to build within the team and increase staff morale. The conclusion from this QI Project within Lewis 2 was that 88% staff engaged in at least two reflective practice sessions over a three month period, 80% increase in staff having a clinical supervisor allocated and a culture shift around attending the staff wellbeing center for team debriefing which was the most popular choice identified by staff for reflective practice

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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 2023/24 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. Scottish Government have requested the Realistic Medicine Action Plan for 2024/25 be submitted by 15th March

A new Project Manager has been appointed and will take up post in February. Interim support continues 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 December 2023 to 31 January 2024, 24 guidance documents have been reviewed. There were 20 documents which were considered to be either not relevant to TSH or were overridden by Scottish guidance and 4 documents which were recorded for information and awareness purposes; one of which is pending review by MHPSG.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
Mental Welfare Commission (MWC)	3	2 (+1 awaiting decision)	0
SIGN	1	0	0
Healthcare Improvement Scotland (HIS)	1	1	0

National Institute for Health & Care Excellence (NICE)	19	0	0

There are currently 4 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, 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 early 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.

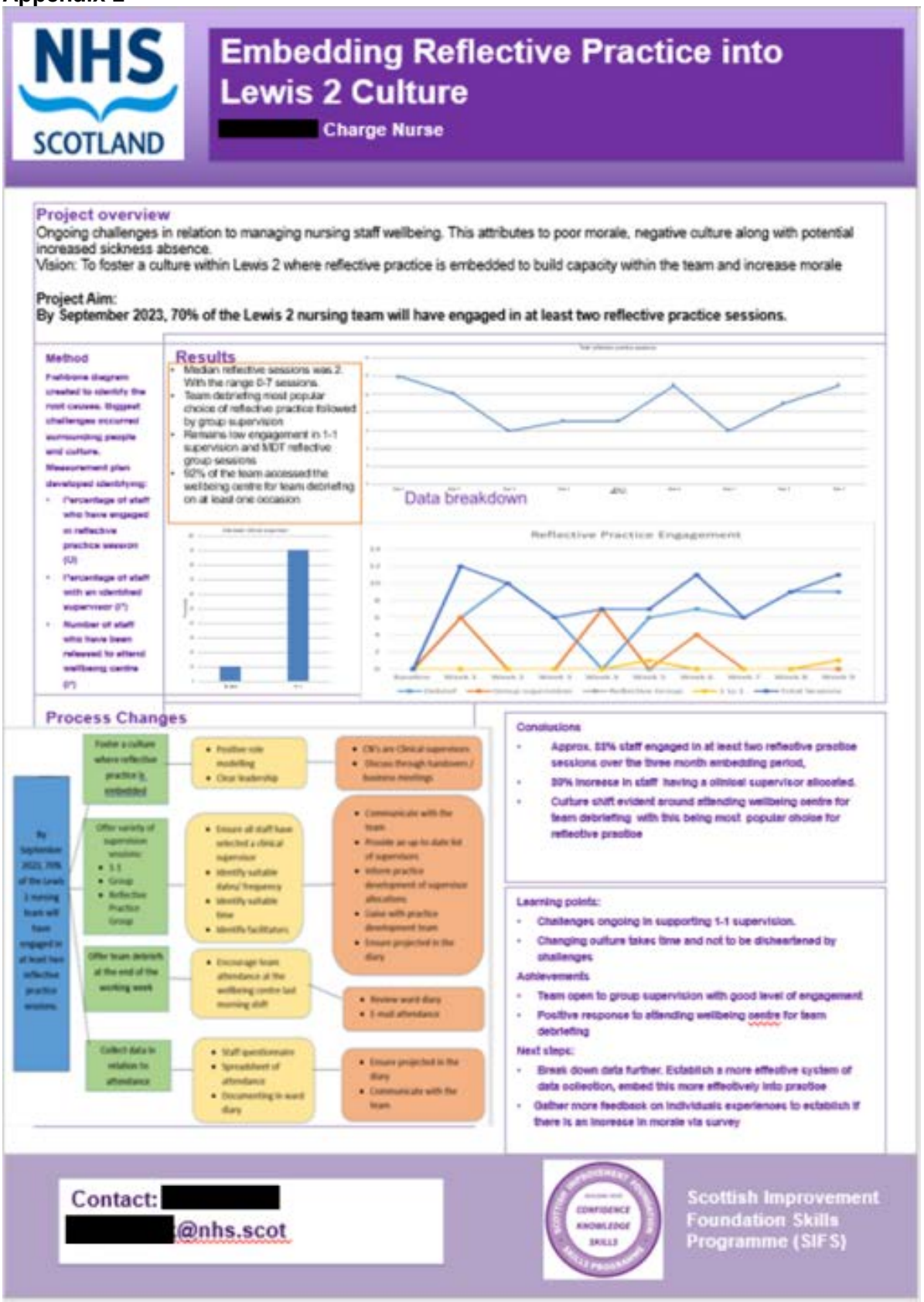
The evaluation matrix for SIGN national guideline for stroke was delayed due to prioritizing of numerous guideline reviews by the practice nurse and GP. Psychology are anticipated to complete their review by the end of next week and thereafter an adapted evaluation matrix will be compiled for review 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	Mar 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 changes linked to Clinical Care Policy.	Oct 2019	Mar 2024
NICE	Multiple sclerosis in adults: Management UPDATED	PHSG	Previously reviewed in Oct 2014 when recorded for information purposes only. Given that TSH had no patients with an MS diagnosis PHSG agreed that should this change, the guideline would be used. Current 2022 situation was same however there is now 1 possible diagnosis pending with patient on waiting list for further investigation (week 53 of 66). Completion of matrix placed on hold until outcome of referral.	June 2022	2024 Awaiting outcome from specialist referral (March 2023)

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
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. Member of Psychology now identified to review content and feedback anticipated w/c 5th Feb 2024. Once received, document will be collated and review meeting will be arranged involving all disciplines for final completion.	April 2023	Feb 2024

Appendix 1


NHS SCOTLAND
Embedding Reflective Practice into Lewis 2 Culture
[redacted] Charge Nurse
Project overview
Ongoing challenges in relation to managing nursing staff wellbeing. This attributes to poor morale, negative culture along with potential increased sickness absence.
Vision: To foster a culture within Lewis 2 where reflective practice is embedded to build capacity within the team and increase morale
Project Aim:
By September 2023, 70% of the Lewis 2 nursing team will have engaged in at least two reflective practice sessions.
Method
Fishbone diagram created to identify the root causes. Biggest challenges occurred surrounding people and culture.
Measurement plan developed identifying:
Results
Median reflective sessions was 2. With the range 0-7 sessions.
Team debriefing most popular choice of reflective practice followed by group supervision
Remains low engagement in 1-1 supervision and MDT reflective group sessions
92% of the team accessed the wellbeing centre for team debriefing on at least one occasion
Data breakdown
Reflective Practice Engagement
Process Changes
Conclusions
Approx. 81% staff engaged in at least two reflective practice sessions over the three month embedding period,
30% increase in staff having a clinical supervisor allocated.
Culture shift evident around attending wellbeing centre for team debriefing with this being most popular choice for reflective practice
Learning points:
Challenges ongoing in supporting 1-1 supervision.
Changing culture takes time and not to be disheartened by challenges
Achievements
Team open to group supervision with good level of engagement
Positive response to attending wellbeing centre for team debriefing
Next steps:
Break down data further. Establish a more effective system of data collection, embed this more effectively into practice
Gather more feedback on individuals experiences to establish if there is an increase in morale via survey
Contact: [redacted]
[redacted]@nhs.scot
CONFIDENCE KNOWLEDGE SKILLS
Scottish Improvement Foundation Skills Programme (SIFS)

THE STATE HOSPITALS BOARD FOR SCOTLAND **CGC(M) 23/04**

Clinical Governance Committee

Approved Minutes of the meeting of the Clinical Governance Committee held on Thursday 9 November 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:	
Lead Professional Nurse Advisor	Josie Clark (for item 7)
Social Work Mental Health Manager	David Hamilton (for items 11 & 12)
Skye Centre Manager	Jacqueline Garrity (for item 14)
Chief Executive	Gary Jenkins
Consultant Forensic Psychiatrist	Dr Khuram Khan
Director of Nursing & Operations	Karen McCaffrey
Director of eHealth and Finance	Robin McNaught
Head of Planning and Performance	Monica Merson
Board Chair	Brian Moore
Head of Corporate Governance	Margaret Smith
Head of Clinical Quality	Sheila Smith
Medical Director	Professor Lindsay Thomson
Personal Assistant to CEO / Chair	Lindsay Kirk (minutes)

1 APOLOGIES AND INTRODUCTORY REMARKS

The Chair welcomed everyone to the meeting. Apologies were received from Mr David Walker, Director of Security, Estates and Resilience, and Ms Shalinay Raghavan, Non-Executive Director.

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 10 AUGUST 2023

The Minutes of the previous meeting held on 10 August 2023 were noted to be an accurate record of the meeting following two minor changes.

The Committee:

1. Approved the minute of the meeting held on 10 August 2023.

4 MATTERS ARISING

Mr Moore asked for an update on The State Hospital's (TSH) Trauma Champion status. Professor Thomson confirmed that the hospital's Trauma Champion was Sandra Dunlop, Head of OD and Learning. She also advised that Dr Amelia Cooper, Clinical Psychologist was the Trauma Practice Implementation Coordinator. This provided the hospital with both management and clinician

involvement. The Committee requested a paper be presented at next meeting regarding the Trauma Champion role and status in this area.

Action: Professor Lindsay Thomson

Mr Moore noted a reference to the Staff Safety Survey however there was no paper / update regarding this on the agenda. Mr Jenkins clarified that this was in relation to the outcome of the Scottish Patient Safety Programme rather than the Staff Safety survey.

5 PROGRESS ON ACTION NOTES

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

In relation to Item 4 – water leaks in the Skye Centre – the Committee noted that this remained an issue and asked for a formal update in this respect prior to the next meeting of the Committee. This was also requested in relation to Item 9 – installation of fencing in the garden area of the visiting centre.

Action – David Walker

The Committee discussed Item 10 – relating to staff resourcing and Ms McCaffrey provided confirmation that the positive movement in resourcing underpinned by successful recruitment, and a decrease in sickness absences had led to a drop in Datix reporting.

The Committee also received an update in relation to Item 11 relating to the completion of patient risk assessment by the Psychological Therapies Service. Ms Flynn provided assurance that the risk assessments were being prioritised by the service given the importance of these; and also that the service had successfully recruited two new psychologists and also work was progressing for recruitment of link nurses into the department.

The Committee:

1. Noted the updated action list, and the progress being made in this regard.
2. Requested a report relating to Items 4 and 9 on the Action list, to be circulated prior to the next meeting.

6 CORPORATE RISK REGISTER – CLINICAL RISKS

Members received and noted the Corporate Risk Register clinical report, which related to clinical risks on the Corporate Risk Register. Professor Thomson presented a summary outline with specific updates on the main points from the report. This included an improvement relating to Risk HRD112 (Compliance with Level 2 Refresher training) meaning that the risk grading had returned to low. She noted that Risk ND71 (Failure to assess and manage the risk of aggression and violence effectively) had also been reviewed to give a more accurate picture of the risk, and the grading had been reduced to medium. Professor Thomson noted the work being progressed by the Supporting Healthy Choices group, and how this linked to Risk MD30 (Failure to prevent or mitigate obesity).

Mr Jenkins added his assurance for the Committee on the movement of risk gradings reported, which were regularly reviewed by the Corporate Management Team.

Ms Fallon thanked Professor Thomson for her report and noted good progress in terms of PMVA achievement.

The Committee:

1. Noted the reviewed current clinical Corporate Risk Register.

2. Accepted it as an accurate statement of risk.

7 CLINICAL MODEL PROGRESS UPDATE

The Committee received a report outlining progress on the work being led by the Clinical Model Oversight Group. Ms Clark, Lead Professional Nurse Advisor joined the meeting and presented the paper. It was noted that since the last Clinical Governance Committee in August, there had been three meetings and some key themes were highlighted which the group would continue to monitor.

Ms Clark noted the key issues discussed by the group over recent meetings, which included patient flow through each of the services and the referral process for this, including possible improvement to give more constancy. The group had also considered the impact of daytime confinement for patient across each of the services, and the work continuing in this respect to eliminate it as soon as possible. Finally, Ms Clark advised that the group were developing key performance indicators, which would help to set a baseline for the key aspects of service delivery.

Ms Clark also noted work was ongoing to ensure consistency throughout the services and this had been added as a standing agenda item, with reporting from the Service Leadership Teams, which could then be reviewed and escalated as appropriate.

The Committee Chair thanked Ms Clark for her detailed report and noted the work being progressed for a centralised referral process and Key Performance Indicator reporting, which would be very helpful.

The Committee:

1. Noted the Clinical Model update Report.

8 INCIDENT REPORTING AND PATIENT RESTRICTIONS REPORT

Members received and noted the Incidents and Patient Restrictions report covering the period from 1 July – 30 September 2023 (Quarter 2). Professor Thomson provided the Committee with a high level summary of the content of the paper, which included reporting on episodes of physical restraint and use of soft restraint kits, as well as health and safety incidents.

Ms Fallon noted the helpfulness of the report level of information contained therein, including comparative data over a 12 month period.

Mr McConnell asked if there was an underlying factor in the increase of incidents from Quarter 1 to Quarter 2 and if there was reason behind the movement in dip in Quarter 1 compared to the previous year. Professor Thomson advised the Quarter 1 report had been reviewed in detail with the Risk Department, regarding the increase in assaults. She confirmed that there was no pattern found and advised that it tended to be one unwell patient having a period of disturbance. Ward closures and modified working were also reviewed and no correlation was found.

Mr Currie commented on staff resources, efficiencies, finance, and the consequences of these alongside the high number of patient incidents. He further commented that it was worth remembering that when you lose staff, you lose the experience of that staff member rather than just the number. Ms McCaffrey advised that part of the oversight in relation to the management of staff resources was widened within the group to include a number of different disciplines, including Charge Nurses, to ensure inclusion in decision-making.

The Chair referred to page 12 where it was stated that an investigation would be prepared in terms of a medication incident. Professor Thomson advised that a Category One Investigation was ongoing in relation to this and the outcome would be shared with the Committee once available.

Action: Professor Lindsay Thomson

The Chair noted her disappointment at the increase of Clinical Waste incidents reported in Q2.

The Committee:

1. Noted the Incidents and Patient Restrictions report.

9 PATIENT MOVEMENT REPORT

Members received and noted the Patient Movement report dated 1 April – 30 September 2023, presented by Professor Thomson. The Committee were asked to note reporting of patient flow throughout this period including admissions and discharges from the hospital. Further that as of 30 September, 18 patients were on the transfer list. Eight were fully approved and awaiting transfer.

Mr McConnell asked for clarity around three month / twelve week timescale regarding appeals against excessive security, and Professor Thomson confirmed that responsibility in each case lay with the patient's health board of origin in terms of provision of onward care, once they had been approved for transfer. If the patient did not have a home address, then the default NHS Board would be NHS Lanarkshire. She also provided a brief explanation on how patients can appeal against excessive security, and the framework of criminal responsibility in place.

Ms Fallon thanked Professor Thomson for the report and additional information regarding appeals.

The Committee:

1. Noted the Patient Movement report.

10 PHYSICAL HEALTH STEERING GROUP REPORT

The Committee received the 12 month report from the Physical Health Steering Group, for the period 1 April 2022 until 31 March 2023. Dr Khan presented the report, in his role as the group's chair, providing a summary overview of the key points.

He asked the Committee to note in particular a slight decrease in patients accepting flu vaccinations from 74.4% to 62.2%, and that there were 32 patients who fell into the additional "at risk" group, of this 24 (75%) patients consented to the flu vaccination. He also summarised the pilot being progressed for patients' nutritional care plans. Ms S Smith provided additional information on the Nutrition and Physical Healthcare checklist following a recent audit. She noted that within the checklist side effects would be included and also recorded on RiO to gain additional structure.

Mr Currie commented on media coverage relating to drugs approved within the UK that provide benefit to weight loss and asked about this in the context of patients within TSH. Dr Khan advised that the Medicine Committee, GP, Dietician and Pharmacy were reviewing this, however, at the moment focus remained on increased activity and nutrition. Professor Thomson advised that this would be considered if clinically appropriate for a patient.

Mr Moore wished to acknowledge the assurance that this report provided regarding the physical health of patients. He also welcomed the work being done in regards to health improvement. He asked about the use of virtual technology like Near Me, to enable patients to attend external hospital appointments, and it was confirmed that this was being progressed, and may help support attendance. Further detail on this would be included in future reporting.

Ms Fallon also asked for an update on the use of symbiotics to be added to the Rolling Actions List, so that this would come back to the Committee.

Action: Secretariat/ Dr Khuram Khan

The Committee:

1. Noted the Physical Health Steering Group report.
2. Requested an update on the use of symbiotics.

11 CHILD AND ADULT PROTECTION ANNUAL REPORT

The Committee received reporting relating to child and adult protection activity and Mr Hamilton, Social Work Mental Health Manager joined the meeting to present the paper, which covered the period 1 October 2022 to 30 September 2023. He provided an overview of the key performance headlines and achievements over the past twelve months.

Mr Currie thanked Mr Hamilton for a very positive report. He noted that human rights were at the centre of this especially relating to access for family contact. He was pleased to see this and the consistent monitoring. He asked whether virtual visiting helped to support this given that some families would live at a distance from the hospital. Mr Hamilton noted the importance of the right to a family life in accordance with the Human Rights Acts, as well as the broader responsibilities under the UN Convention on the Rights of the Child. In relation to virtual visits, he noted that this was an area where improvement could be made to streamline processes and the expected move to a new provider would assist with this.

Mr McConnell provided positive feedback on the Storybook Dad initiative and queried how reporting in respect of child protection referrals and near misses would be reported to the Committee, as there were none in the report presented today. Mr Hamilton confirmed that there had been none to report within this period and that going forward, it would be made clear if there were no near misses or referrals to report.

Ms McCaffrey thanked Mr Hamilton for his report and the proactive approach his team were taking to engage with families and the importance in relation to support recoveries and how patients moved on in their care journey.

Ms Fallon noted the good practice evidenced in the report in respect of the family friendly visits, and the positive atmosphere generated for these.

The Committee:

1. Noted the Child and Adult Protection Annual report.

12 CPA TRANSFER/ MAPPA REPORT

Members received and noted the Transfer Care Programme Approach (CPA) report covering activity from the period 1 October 2022 to 30 September 2023. Mr Hamilton presented a summary of the key highlights from the report. Professor Thomson noted the achievement of five years of 100% of all discharges and transfers to be managed by the CPA process.

Mr McConnell thanked Mr Hamilton for the report. He queried the reason for the reduction in CPA meetings taking place compared to the previous reporting period. Mr Hamilton advised that this was due to the pressures on patient transfers from the hospital to other services.

Ms Fallon thanked Mr Hamilton for both reports presented today and the positive nature of the inter agency work taking place across the hospital. Further, that the workplan provided was helpful and proactive.

The Committee:

1. Noted the report.

13 UPDATE TO TELEPHONE SYSTEM

Members received and noted the update to telephone system report presented by Professor Thomson. This outlined the options available for a telephone system with increased capability to record and randomly sample all calls.

The report confirmed the available options and decision-making by the Corporate Management Team in this respect, which had been to replace the current hardware and software systems. This would give increased functionality, at a lesser cost than a completely new system. It was noted that the costs involved for this would be within the remit of the Capital Group, and would not need formal Board approval. It would be included in routine reporting to the Board in respect of capital spend.

Ms Fallon thanked Professor Thomson for the report.

The Committee:

1. Noted the update on the patient telephone system.

14 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 1 June – 30 September 2023.

Ms Garrity joined the meeting and provided members with a summary of the report and highlighted the main areas of feedback shared during this time. This included delays regarding access to the garden area during visiting times, as well as compliments about extended visits and being able to engage in meaningful activity during these visits. Patient feedback had also been received in relation to concerns about grounds access, and also for occasions when visiting had been less than an hour. Patients had provided positive feedback on the engagement sessions held in relation to the digital inclusion workstream. Ms Garrity also passed on thanks from the Patient Partnership Group (PPG) to Non-Executive Directors for their attendance at the meetings.

Ms McCaffrey added that it was good to see the positive feedback in relation to extended visits, and the benefits being seen as a result.

Ms Fallon noted patient feedback concerning witnessing physical restraints, and it was noted that it was likely that most if not all patients would witness a restraint taking place at some point during their stay at the hospital. The Committee noted that supportive work was being taken forward for patient debriefs following incidents, and the possible impacts on patients when witnessing the restraint of a peer.

Ms Fallon thanked Ms Garrity for her report and noted it was good to see both positive and negative feedback.

The Committee:

1. Noted the Learning from Feedback Report.

15 LEARNING FROM COMPLAINTS

Members received and noted the Learning from Complaints report for Quarter 2 of the current year. Ms M Smith provided an overview of the report and the learning taken from complaints within this quarter.

She highlighted the continued progress in the delivery of the complaints service, with increased visibility of the Complaints Officer in patient areas as well as the availability of a direct patient telephone line. She noted that investigations were being carried out at ward level by a senior nurse from another area, to help support impartiality and patient confidence in the process. In terms of ensuring learning, complaint outcomes had been added to quarterly directorate

performance meetings, led by the Chief Executive, to ensure that there would be a focus on quality improvement. Ms Smith also reported that the Complaints Team had linked with complaints services in high secure hospitals within NHS England, and regular meetings would be set up in 2024 for information sharing and learning.

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

Finally, the Chair noted the need for continued monitoring of meal distribution, given some concerns raised in this area.

The Committee:

1. Noted the Learning from Complaints Report.

16 DISCUSSION ITEM: DAYTME CONFINEMENT

Professor Thomson, Ms McCaffrey and Ms S Smith led the committee on the daytime confinement discussion.

Professor Thomson detailed the background and current position and the improvements made in data collection to help inform this workstream. There had been considerable progress made to date to eliminate this practice, chiefly in terms of recruitment. The other major issues were sickness absence and staffing for external outings and internal visits and tribunals. Ms S Smith provided the Committee with information on the layout of the dashboards on the patient electronic records system (RiO). Ms McCaffrey advised Committee that the following four workstreams were described as follows:

1. Maximise efficiency and effectiveness of patients boarding out.
2. Fully understanding the extent of the use of daytime confinement.
3. Implement tailored approaches to risk assessment and management.
4. Develop a culture based upon trust, connectivity and 'one team' that motivates and engages all staff.

Each workstream provided a flash report to the Daytime Confinement Short Life Working Group at its monthly meeting.

The Committee Chair opened up the agenda item for discussion.

Mr Jenkins advised that the core solution to this was to get recruitment to where it needed to be and reducing sickness absence. He noted that another component would be culture, especially building the confidence of front line staff, which was an ongoing organisational development piece. He noted that significant improvement had taken place in the last few weeks, with strides being made to end daytime confinement altogether by January 2024.

Mr Currie commented that context is important in relation to this. He noted that the hospital does not have the same flexibility compared to the other health boards in relation to staffing resource, given the unique nature of the service being delivered. Mr Currie added that communication was key and it was important that both patients and staff were aware of the intended direction of travel. Mr McConnell echoed Mr Currie's comments. He agreed that recruitment and subsequent retention of staff were key to this.

Mr Moore advised that the Board has received assurance that this was a key issue and it was good to see senior leaders within the hospital having a tight grip on this, to ensure that daytime confinement became a never event.

Professor Thomson noted the link to staff governance as well, and the culture of the organisation and links to staff wellbeing. The Committee agreed that consideration should be given as to how

this could feed into the Staff Governance Committee. Mr Jenkins noted that it would be helpful to link this to the annual review of the three-year Workforce Plan. This would be noted within Item 19 on today's agenda.

Ms Fallon summed up the discussion and emphasised the commitment to the organisation to make daytime confinement a never event.

The Committee:

1. Noted the update and discussion on daytime confinement.

17 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

The following areas of good practice were suggested

- Positive atmosphere within the Family Centre for visiting.
- Transfer CPA report being at 100% complete as was detailed in the CPA Annual Report.
- Increased visibility of the Complaints Officer and access to telephone line.

The Committee:

1. Agreed with these additions to the Areas of Good Practice.

18 COMMITTEE WORKPLAN 2023/24

The Committee reviewed and agreed that a change would be made so that the Supporting Healthy Choices report at the May 2024 meeting would be on an interim basis and that the annual update would be presented in November 2024. Members also agreed that an update on daytime confinement would be presented at the February 2024 meeting.

Action: Secretariat

The Committee:

1. Agreed the Committee Workplan for 2024.

19 ANY ISSUES ARISING TO BE SHARED AMONGST GOVERNANCE COMMITTEES

The Chair advised she would provide an update to Pam Radage, Non-Executive Director in relation to daytime confinement and consideration of this in terms of culture and staff wellbeing.

20 ANY OTHER BUSINESS

Members raised no other items of other business.

21 DATE OF THE NEXT MEETING

The next meeting would be held on Thursday 8 February 2024 at 0945 hours via Microsoft Teams.

The meeting concluded at 12.49 hours.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 February 2024
Agenda Reference:	Item No: 13
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 8 February 2024.

1	Corporate Risk Register	The Committee reviewed the clinical risks within the Corporate Risk Register, and confirmed these to be an accurate statement of risk.
2	Incident Reporting and Patient restrictions	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 Committee welcomed the refreshed format of reporting as this enabled focus on clinical incidents. More general security incidents such as management of staff and visitors entering the secure site would be reported through the Audit and Risk Committee. The outcome of the serious adverse event review underway in relation to administration of medicines will be reported to the next meeting.
4	Clinical Governance Group 12 Monthly Report	The Committee welcomed this report as a comprehensive summary of the activities of the group, and as a means of assurance on the structured nature of clinical governance. The Chair thanked those involved for their work across the wide range of workstreams. It was agreed that it would be helpful to have further reporting in respect of the Excellence in Care framework; and how this was evaluated across the hospital.
5	Psychological Therapies 12 Monthly Report	The Committee received and noted reporting to capture clinical activity within the service across. There was particular focus on the experience within quarter 3, during which there had been some pressure on capacity in the context of resourcing; assurance was given around focus on core activity for CPA and Risk Assessments, and acknowledgment that this meant some impact on delivery of group therapies. The position had been resolved, and the service was working positively. The Committee noted assurance from reporting, and thanked the service lead for their

		significant contribution.
6	Nurse Resourcing	The Committee noted the position on nurse staffing with an improvement overall during the last 12 months, and active recruitment ongoing for both registered and non-registered staff. The Committee noted the continuing challenge in relation to sickness absence especially during the winter period. This reporting was linked to the much improved situation on daytime confinement which had reduced to a nil return, with one exception over the seasonal period. The SLWG in this respect would continue to ensure actions taken were firmly embedded, and reporting would return to the next meeting. The impact of the implementation of the non-pay aspects of the AfC pay award for 2023/24 were also discussed, especially the 36 hour week and protected learning time, with assurance that scoping work had been completed across the organisation.
7	Person Centered Improvement Service 12 Monthly Report	The Committee received an noted a report summarising the key activities of the service, and that a change in leadership and focus had taken place during this time, continuing to strengthen patient engagement.
9	Learning from feedback	Reporting highlighted the way on which the different needs of patients were being accommodated. There was assurance around communicating with patients in situations whereby it may be challenging to meet expectations, not only to inform patients but to help them understand and feel included. The good work by the Catering Team was noted, in engaging with patients on menu choices in a tailored and imaginative way.
10	Learning from complaints	Reporting highlighted the detailed nature of investigation and the willingness of the organisation to uphold/ partially uphold complaints when appropriate. The Committee noted the longitudinal data provided which helped the organisation to take learning. The importance of including complaints awareness within inductions as well as an ongoing training opportunity was noted, and linked to how we lead to NHS Values overall.
10	Trauma Champion	Reporting provided an overview of the Trauma Champion role within the hospital, focused on building capacity as well as supporting staff wellbeing, as well as the planned future development of this remit. This was welcomed by the Committee, as an important area and would be shared with the Staff Governance Committee.
11	Patient Activity	The Committee received and noted the Activity Oversight Group summary report, and this was used as a basis for discussion on patient activity. The comprehensive nature of the information provided and the key areas of focus and development were welcomed. In particular the progress on data reporting as this provided a strengthened evidence base from which decision-making could be taken.

12	Areas of good practice/concerns	The Committee noted the excellent work of the catering team, as evidence in the Learning From Feedback Report. The good work on patient engagement and management of concerns was noted through both the Learning and Feedback and Learning From Complaints report. This helped to build confidence from patients that their views would be listened to, and responded to. The good work from the Clinical Quality Team and from eHealth in the development of data collection and the better quality reporting this enabled was also noted.

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:	22 February 2024
Agenda Reference:	Item No: 14
Sponsoring Director:	Acting Workforce Director
Author(s):	Acting 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.

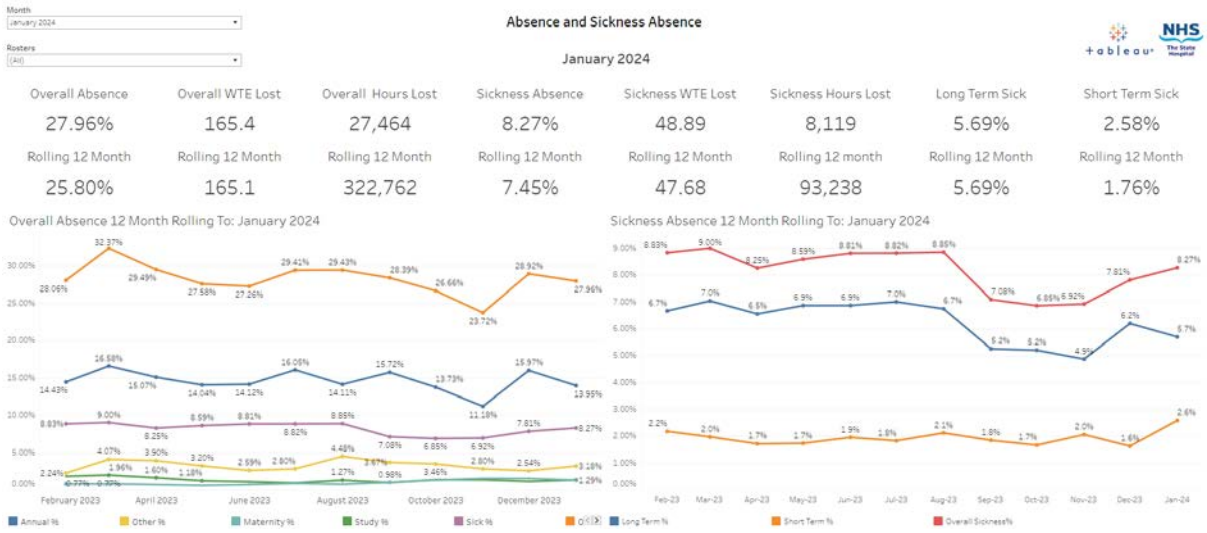
3. ASSESSMENT

Attendance Management including Task & Finish Group

Current sickness absence analysis

In December 2023 and January 2024 there has been a slight increase in sickness absence as described in graph 1 below (from 6.92% in Nov to 8.27% in Jan).

Graph 1



This is disappointing given the significant efforts to reduce sickness absence in 2023 however, there are important contextual points to note.

Long term absence has reduced again supporting the overall downward trend of long term absence in the last 12 months. Additionally, when undertaking a more detailed analysis of the number of individuals on long term sickness, the number has significantly reduced (at times this was over 40 headcount and at present is just over 20) with actions agreed or a return to work planned for all individuals.

In January, we have experienced a notable increase in short term absence (from 1.6% to 2.6%) which is directly correlated to an increase in the 'cough cold flu influenza' reason for absence which is usually the 4th or 5th most common reason for absence but was the 2nd most common reason in January. A total of 813 hours were lost for this reason in January which is an increase in 281 hours compared to the month before.

This increase in respiratory conditions within the community was predicted previously by Public Health Scotland and then later reported as an 'actual' within week 3 of January that 'moderate or High activity levels was observed among all age groups'.

It is interesting to note that if the 'cough, cold, flu influenza' reason had remained static as in previous months, the overall organisation sickness absence would only have increased by a slight 0.17%.

Lastly, in terms of context, if we look back over previous years there is a general trend of increase in sickness absence in winter months which again might be expected due to factors out with the Board's control regarding the effects of the season. However, it is encouraging to note that the starting position in 2024 is much better than in previous years for example January 2023 the overall absence rate was 10.36% compared to a 8.27% this year.

Task & Finish Group

Notwithstanding all of the above considerations, it is essential that the organisation responds to this seasonal, upward trend.

The Task and Finish group continues to meet fortnightly and review data, by department, in relation to percentages and wte absence trends. There remains four key area of focus at this point, the areas under specific focus are: Ward Nursing, Skye Centre, Security and Housekeeping. The group continue to consider any changes in data and trends to respond appropriately to any other departments which may need specific focus, however, at present it is believed that the correct departments are represented in the group.

Several actions are underway within these areas:

- Focus on 'return to work' meeting compliance levels
- Review of supportive measures for staff to returning to work, including reasonable adjustments guidance and temporary placement guidance for employees who may require an alternative role, support plans
- Establishment of weekly meetings (in some focus areas) between partnership and managerial teams
- Discussion with Occupational Health on targeted support to specific areas and the management referral process for employees.
- Reestablishment of regular review meeting with Occupational Health and Lead Nurses
- Development of 'assistance prompt' questions for first in line managers undertaking absence interviews an receiving calls from people who absent from work
- Monitoring the use and compliance with the absence policy trigger stages, noting that there is an increase in formal stage meetings in 23/24 compared to last year
- Training for frontline managers and enhanced HR support. 30 sessions have taken place to date with further sessions scheduled in December
- Consideration of the 'wellbeing offer' for staff to ensure organisational support enables employee to optimise their attendance
- Line managers requested to evidence that reflective conversations are taking place with people who absented over the festive period, to identify any trends and agree actions as appropriate in response to this
- Detailed review of initial driver diagram which was developed at the outset of the Task & Finish group.
- Development of further communications across the hospital in relation to the increase in absence over the winter months

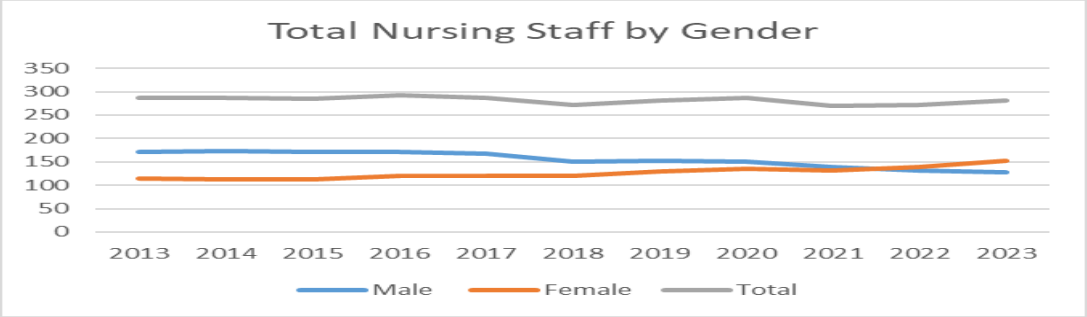
Sustainability of a long term attendance management culture is essential to reduce sickness absence and maintain acceptable levels of absence from work. The Task & Finish group will also consider what governance structures are already well placed within the organisation to monitor, respond and act in relation to sickness absence in the long term.

Recruitment – Nursing

There was a commitment made in the 3 year workforce plan to "Project ahead, regular recruitment will be required to maintain the nursing staffing levels each year" in response to the well documented challenges around recruitment to the nursing profession. Also taking cognisance of the significant induction and training The State Hospital requires to undertake before a member of the nursing workforce can commence in the wards.

Within the workforce plan there is also acknowledgement of the shifting gender profile within the nursing profession as a whole and at the end of 2023, the opportunity was taken to refresh this data and consider the option of a targeted recruitment campaign.

Graph 2



As illustrated in Graph 2, in 2013 there were 171 male members of staff working in a nursing role at the hospital compared to the current 128. Taking into consideration the 10 ward environments, this decrease of 43 equates to a loss of approximately four male members of staff for per ward.

This is in a context of the national position where, in addition to the noted attrition in numbers wishing to take up nursing as a career choice there has also been longstanding concern about the relatively small numbers of men who enter the profession. The reasons for this are varied and well documented.

Therefore, in January of 2024, after detailed consideration of the requirements of the Equality Act in respect of positive discrimination versus positive action, with agreement from the Workforce Governance Group, a targeted recruitment campaign was launched to attract male registered nurses and male HCSWs for the reasons outlined above. This is aligned to the current vacancies and predicted / planned turnover in 2024. This was supported by the Communications Team and included a social media campaign featuring current male colleagues 'why I like to work at The State Hospital'.

An up to date position in respect of the success of this can be provided verbally to the board.

Job Evaluation

The table below demonstrates continued performance against the 14 week target, from receipt of the job description to the provision of a final outcome. In November and December 2023, all 7 posts which were given outcomes, were given these within the 14 week target.

Additionally, the 4 posts which remain active at the end of January, all have dates arranged to progress.

Further actions are committed by the Job Evaluation to ensure sustainability of this performance which includes development of a practitioner succession plan to ensure that there are enough trained practitioners to undertake the various roles required of this process locally. Secondly, the Steering Group have agreed a training resource for managers to utilise as required on the TURAS platform to aid development of job descriptions and provide oversight of the process. Lastly consideration of a 'stretch' target will be considered, reducing this from 14 weeks.

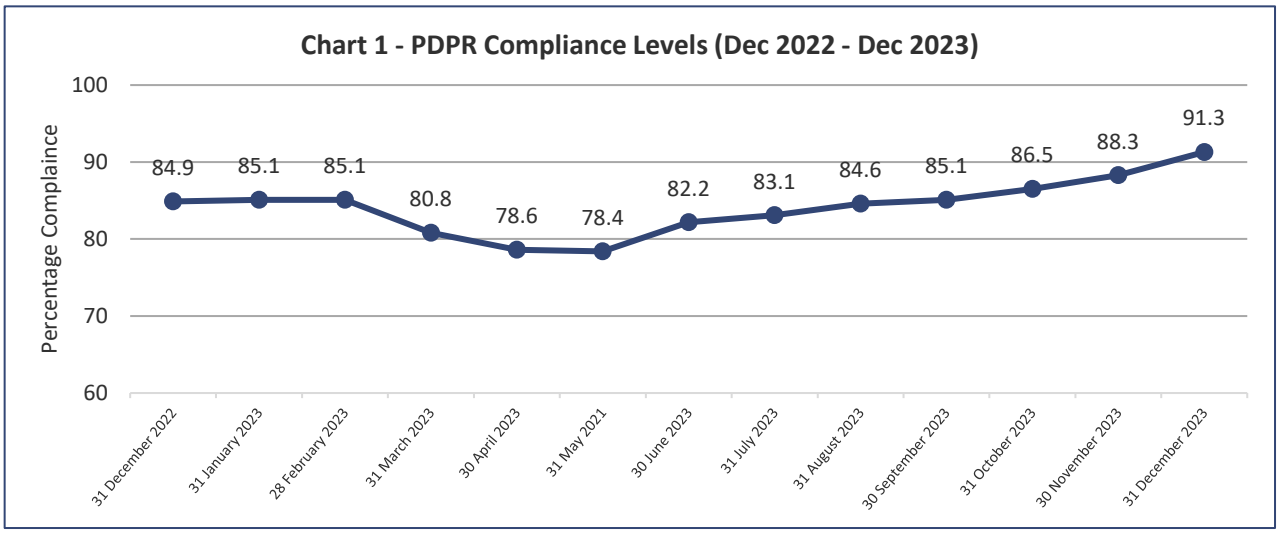
		June	July	Aug	Sept	Oct	Nov	Dec	Jan
ACTIVITY	*Carried from last month*	12	10	14	15	9	5	3	3
	New JDs received	3	6	4	0	1	1	4	0
	Reviews requested	1	-	-	-	**1*** same post	-	-	1*
	Outcomes given	6	2	3	5	5	3	4	0
	Outcomes given in >14 weeks +	0	0	0	4	2	-	-	-
	Outcomes given in <14 weeks	6	2	3	1	3	3	4	-
WAITING LIST	*Post Still Active by end of month*	10	14	15	9 (as one post was withdrawn)	5(as one post withdrawn)	3	3	4
	received < 1month ago	3	4	4	0	2	-	2	1
	1-3 months ago	3	2	1	4	2	2	-	2
	3-6 months ago	1	4	6	4	0	-	-	-
	6+months ago	3	4	4	1	1	1	1	1
SHARING PROTOCOL	*JDs requested - Job Sharing Protocol*	-	2	2	1	3	3	1	1
	Outcomes given - Job Sharing Protocol	-	2	1	-	2	2	1	-
	JDs still active - Job Sharing Protocol	-	-	-	1	3	1	2	1
	progressed < 1month		2	1		1	2	2	2
	progressed 1-3 months					1			
	3 months +								

Organisational Development & Learning Update

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. The national Turas Appraisal online system is used for recording details of PDPR meetings and completed annual reviews. As at 31 December 2023:

- 565 (91.3%) – had a current (i.e. live) review
- 47 staff (7.6%) had an overdue review
- 7 staff (1.1%) had not yet had a review meeting (These are staff who have not had the initial set-up review meeting that should take place at the end of their 3-month induction period)

Chart 1 shows the trend in organisational PDPR compliance levels from December 2022 to December 2023 and highlights incremental improvements in compliance over the last 6 months.



Progress reports continue to be provided to all departmental managers on a monthly basis, and PDPR compliance levels are monitored and reviewed quarterly by the Organisational 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 31st December 2023 are noted below – with high levels of compliance for both statutory and mandatory training being effectively maintained.

Statutory Training	Mandatory Training
93.7% compliance	***87.5% compliance***

Corporate Induction Refresh

Refresh of the corporate induction is ongoing. To-date, two 'face-to-face' corporate induction events have taken place, with a total of 24 attendees. Delegate feedback with regards the 'usefulness' and 'relevance' of the corporate induction content has been positive, and the OD Advisor continues to work with session facilitators and other key stakeholders to support further refinements to the event content and session delivery methods in response to the feedback received. Future corporate induction events are scheduled to take place at bi-monthly intervals throughout the year.

Coaching Provision

There are currently 3 accredited internal coaches who provide coaching for State Hospital staff, and to staff in other Boards as part of a collaborative coaching network across the West of Scotland. A further 2 managers from the State Hospital are currently undertaking the Advanced Certificate in Coaching Practice (ACCP). As of 31 December 2023:

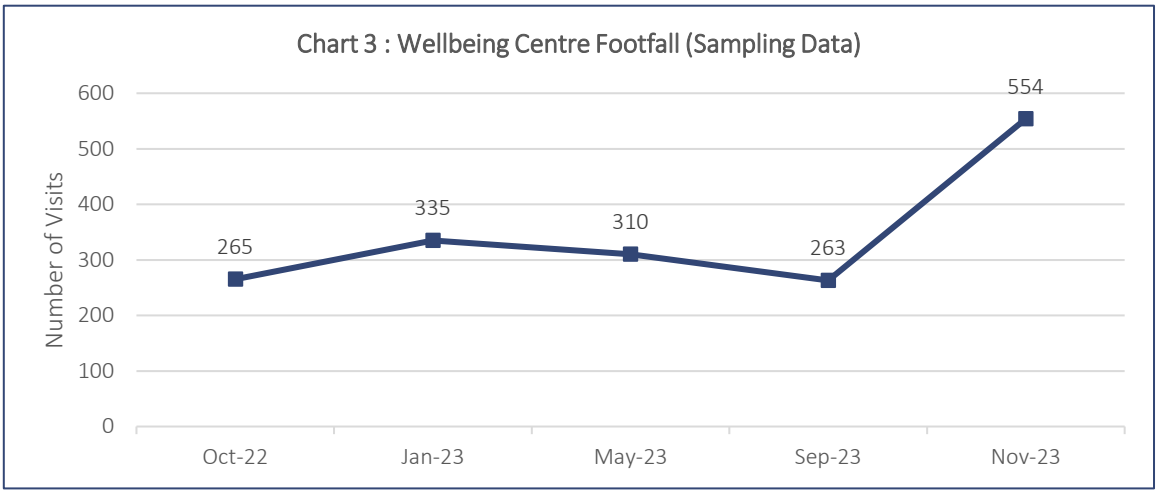
- 4 members of TSH staff are being coached by TSH coaches
- 3 members of TSH staff are being coached by an NHS Lanarkshire coach
- 3 members of TSH staff are waiting to be matched with a NHS Lanarkshire coach
- 1 external staff member is being coached by a TSH coach

In addition, a total of 22 managers attended the 'Coaching Skills for Managers' training that was delivered in Quarter 3.

Wellbeing

The Wellbeing Centre continues to be available for all staff to access 24/7 (including before, during or after shifts). There is dedicated support available within the Centre Monday–Friday, 9am-5pm, and a summary of wellbeing activities undertaken during November-December 2023 is provided for information in Appendix 1.

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 554 people were recorded as accessing the Wellbeing Centre in November 2023 and a comparison with footfall levels in previous quarters is provided for information in Chart 3.



The increase in footfall in November 2023 was due in part to a 'Health Check' event that took place within the Centre on 15 November 2023 (which was attended by 85 staff). There has also been an increase in the number of ward nursing staff accessing the Centre, and 3 wards have arrangements

in place to facilitate the release of staff and provide opportunities for nursing staff to utilise the wellbeing resources and participate in reflective practice.

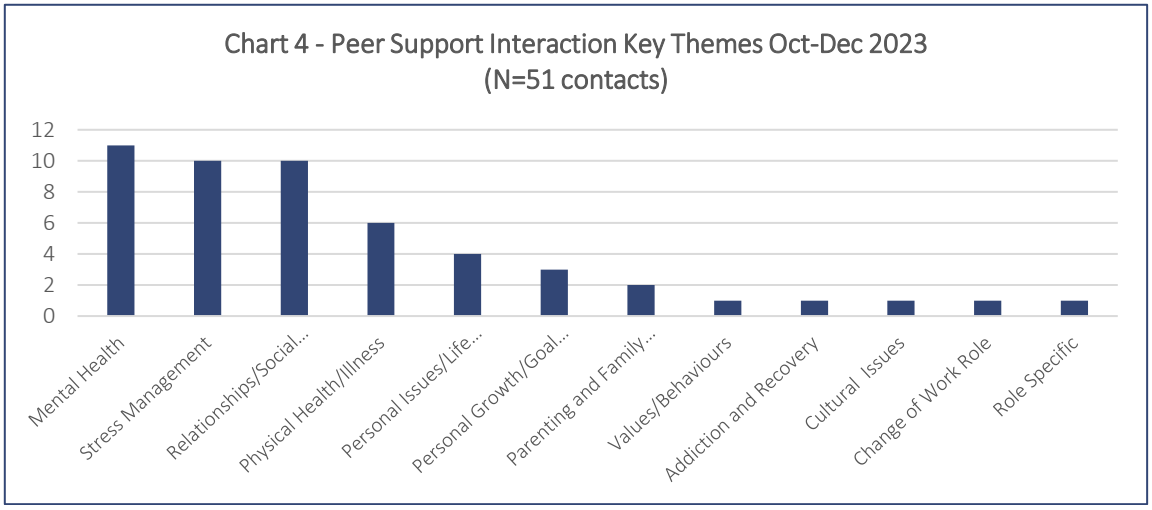
In addition to the above, 128 staff visited the Wellbeing Centre to participate in events that were delivered as part of the 'Wellbeing Week' initiative that took place from 11-15 December 2023.

Staff Care Specialist Service

The Staff Care Specialist Service remains in place and is delivered via a service level agreement with NHS Lanarkshire (NHSL). Two temporary Staff Care Specialists (Graeme Bell and Patricia Johnston) were each providing support for one day per week up to 31 December 2023. A new Staff Care Specialists (Lorna Tutty) commenced in post on 8 January 2024 and is based within the Centre two days per week (Tuesday and Thursday). There were 6 self-referrals in November-December 2023. In addition to accessing the support provided on-site, the 24hr helpline provided as part of the SLA was also utilised by 1 member of staff in December 2023.

Peer Support Network

Since launch of the Peer Support Network in September 2023, Peer Supporters have provided support to 51 staff (9 in October, 27 in November and 15 in December). Staff are engaging with Peer Supports for support on a broad range of issues, and an overview of key themes reported by the Peer Supporters is provided for information in Chart 4.



Wellbeing Strategy Evaluation

The Staff & Volunteer Wellbeing Strategy was implemented in the State Hospital in April 2022. An evaluation of the strategy, and associated wellbeing offerings/interventions, is currently being undertaken to assess the outputs and impact of the strategy to-date. Results of the evaluation will be used to refine the strategy where required, and to inform and guide priorities for staff wellbeing interventions for 2024/25.

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 retain 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:	22 February 2024
Agenda Reference:	Item No: 15
Sponsoring Director:	Director of Nursing and Operations / Director of Workforce
Author(s):	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. Statutory Guidance Chapters have been developed in conjunction with Health Improvement Scotland (HIS) and are currently being tested out across Scotland and, enactment of the legislation is anticipated to take place in April 2024. Ten Chapters in total are developed (1, 3, 4, 5, 6, 7, 8a, 8b, 9 and 13).

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

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

2 BACKGROUND

The aim of the Health and Care (Staffing) (Scotland) Act is to provide a statutory basis for the provision of appropriate staffing in health and care service settings, enabling safe and high quality care and improve 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 support the wellbeing of staff.

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

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

3 ASSESSMENT

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

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

Reporting

The State Hospital's Quarter 2 report was submitted to the Scottish Government in November 2023. A formal response providing feedback on this submission is still awaited. However, informal feedback has been received from SG providing reassurance we are working positively towards our preparedness for enactment in April 2024. The final Q3 report is due to be submitted in March 2024, thereafter our first annual report to SG on compliance of the legislation will be in April 2025. Copies of previous submissions to SG are available on request. Alongside the implementation of eRostering, a short life working group has been established to monitor the organisations compliance with the duties of the act and the evolution of eRostering which is now being referred to as 'Optima' and associated products. This meeting meets monthly and is chaired by the Director of Nursing & Operations.

Progress to date HCSA

- The Senior Nurse Workforce Planning continues to work closely with Health Improvement Scotland (HIS) and the testing oversight members from SG to ensure the board is kept connected and up to date.
- SG delivered a 2nd engagement session in December 2023 which was open to all staff to attend. The Senior Nurse delivered a presentation providing our progress so far and the next steps going forward. 35 members attended and were asked to provide an evaluation to SG. The outcome of the evaluation has still to be shared.

- A project Plan has been agreed to map timescales to ensure compliance by March 2025. Leads have been identified for each of the duties within the project plan which will be confirmed at the next HCSA compliance meeting in February.
- Presentation delivered to HIS in December 2023 mapping the progress being made as well as learning from other boards.
- We have been working with Senior Programme Advisors and Analysts from HIS to develop interim workload task sheets for the Mental Health Learning Disability Workload Tool named in the HCSA. The original task sheets did not reflect the complexities of our clinical acuity and associated workload, therefore the outputs were unreliable. We have commenced a test of change within 2 ward areas and have completed a 4 week recording period. This data has now been sent back to the analyst for comments and feedback. All being well we will complete a 2 week test run in March 2024.
- Multi disciplinary engagement sessions have been delivered in one hub covering the legislation and what that means for them, how to contribute to the submission to SG and the final session in February will cover the use of the Multi Disciplinary professional judgement tool
- Training has been delivered to Charge Nurses and Senior Charge Nurses on the use of the Real Time Staffing Resource Template.
- Training delivered to AHP's on the MD Professional Judgement Tool with a further session being arranged to include Psychology.

Progress to date eRostering

1. **Health Roster**

There are 42 roster locations in total and of that, 41 are now live with rostering. For each roster location, the budgeted establishment is set therefore; Managers are now able to see a comparison of what the budget is versus what is required.

All nursing wards are now creating their rosters to ensure they are entering all leave, training staff moves or swaps of shifts and overtime are recorded. All ward-based staff have access to Employee Online in order to view and check their shifts.

As part of the roll out, the Project team have provided additional training to roster creators as a number of staff had not been using the system since their initial training. With the support from two recently redeployed clinical staff, this additional resource has been crucial to meet the target of all the wards being live with the system before 31 March 2024.

Areas of risk currently identified for ward roster locations:

- No link with SSTS (payroll) which requires manual input, double keying
- No link with eESS (HR management tool) also requires manual updating
- Running a quadruple system to manage safe staffing for wards onsite (SSTS, Hospital wide composite sheet, ward composite sheet and Health Roster)
- Demand set within the system versus shifts actually needed at roster build causing issues
- Auto rostering functionality versus manually rostering, fixed shift patterns
- Lines not balancing to reflect the demand
- Training not in
- If some staff were on annual leave, changes lines up to even out
- Too many highs and lows across the 6 weeks, rather than an equal balance

Areas of risk currently identified for non-ward roster locations:

- No link with SSTS (payroll) which requires manual input
- No link with eESS (HR management tool)

Next Steps

The Project team will determine the cause of the risks identified and look to mitigate these to improve rostering practice. The Project team are currently working with keys staff to review the areas of risk identified within the ward rosters.

Establish and agree good rostering practice for Charge Nurses and Senior Charge Nurses.

Review current funded establishment in each ward area, considering registered non registered, gender split, redeployed staff and shift patterns to ensure equity across all ward areas.

All ward rosters to have skills identified and uploaded.

Annual Leave entitlement to be uploaded.

2024/25 Budgets to be uploaded to all rosters.

Educate and train staff to understand the roster analyzer functions.

Develop a process to move from a centralization management of resourcing.

1. **Safecare 1**

Allocate SafeCare helps organisations embrace a real-time staff deployment. It provides live visibility of staffing levels and matches this with patient clinical acuity. It can highlight areas where the demand is not met and is designed to enable a review of daily staffing issues at both roster level and across the entire organisation, providing an instant view of whether the actual staffing levels are deemed safe to meet the clinical demand.

At present, The State Hospital have trained all roster approvers the ability to update attendance only in Safecare which allows the organisation to see which staff are on site from all rosters within the organisation. There are some issues with ward rosters due to the number of staffing changes throughout the day.

Work is ongoing with the Project team and RLD in the preparedness for the other functions within Safecare to comply with the Healthcare Staffing Act legislation from 1 April 2024.

Next Steps

RL Datix providing a suite of educational sessions to all relevant stakeholders on the functionality of Safe Care 1 and 2.

Develop a project plan for the implementation of Safe Care across all relevant rosters.

Employee Online

Employee Online enables rostered staff to view all published rosters, manage all leave to improve a work-life balance. Employee online will be replaced by a version a Loop approved by The State Hospital.

All ward based staff use employee online to view their published rota which is available for a 12 weeks period. In addition other roster locations are using employee online to request annual leave. The Implementation of loop should be completed by March 2024. This is when RLD will remove the current support to employee online from this time.

Next Steps

The Project team are currently engaging with expert staff from within the organization as well as guidance from RLD and NSS.

Educate and train the workforce on the agreed Loop version.

Develop protocols/policies

eJob Plan

e-JobPlan, is another product available to us and is designed to help facilitate the process of job planning, allowing users to populate, review and sign off of job plans all in one place. Initial set up has been provided to Medics and they are in the process of implementation.

Next Steps

The Project team require to have oversight of this project ensuring their rosters are maintained. eJob Plan will require to be included within the BAU roadmap for The State Hospital.

4 RECOMMENDATION

The state Hospital's Board for Scotland is invited to note the content and the ongoing work on progress of work to date.

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 Committee Which groups were involved in contributing to the paper and recommendations.	Board Staff Governance Workforce Governance Group
Risk Assessment (Outline any significant risks and associated mitigation)	Unknown currently
Assessment of Impact on Stakeholder Experience	As detailed within Paper
Equality Impact Assessment	
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick (✓) One; ✓ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 February 2024
Agenda Reference:	Item No: 16
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 provided to the Board regarding 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 3 update is for 1 October 2023 to 31 December 2023. **No formal Whistleblowing cases** were raised during this quarter direct with The State Hospital.

Nationally, colleagues from the INWO office have been in touch with the HR Directors group requesting an update meeting to consider what is currently working well in relation to the standards, what is working less well and any suggested improvements.

Further updates will be provided on any national developments when available.

4 RECOMMENDATION

The Board are invited to note the Quarterly 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 Committee
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) 23/04**

STAFF GOVERNANCE COMMITTEE

Approved Minutes of the meeting of the Staff Governance Committee held on Thursday 16 November 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 Therapist and BOAT / Unison Representative	Chelsea Burnside
Lead Professional Nurse Advisor	Josie Clark (for item 14)
Head of Organisational Development & Learning	Sandra Dunlop
Corporate Services Business Manager	Anne Donnelly
Chief Executive	Gary Jenkins
Director of Nursing and Operations	Karen McCaffrey (for items 11 & 13)
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 Burt (Minutes)
Organisational Development Manager	Brian Young (for items 15 & 16)

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Ms Radage welcomed everyone to the meeting, and apologies were noted from Mr Garry McKendrick, POA 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 17 AUGUST 2023

The Committee approved the Minutes of the previous meeting held on 17 August 2023 subject to the following amendments;

On page one, insert ‘Sandra Dunlop, Training and Professional Development Manager’, as in attendance at the meeting.

On page three, fifth paragraph down, first sentence should read “staff may be wary”, not weary.

On page four, second last paragraph from the bottom, last sentence should read “the expected timescale was ten weeks”, not 14.

On page nine, under formal dismissal hearings heading, should read “This had not been required at the State Hospital and support and guidance would be provided”.

The Committee:

1. Approved the minute of the meeting held on 17 August 2023 following the amendments noted above.

4 MATTERS ARISING

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

In addition to the action list, Members requested that a six monthly review update on the Occupational Health service be provided at the next meeting in February 2024 to ensure Committee oversight.

It was noted that an update would be provided on comparative workforce data to other high secure hospitals in NHS England would be presented during item 8 on today’s agenda. Further, that a paper would come to the May 2024 meeting of the Committee relating to evaluation of the framework for development of Once for Scotland policies within the State Hospital (TSH).

Action: Laura Nisbit

The Committee:

1. Noted the updated action list.

2. Agreed that a six monthly review update on the Occupational Health Service be provided at the next meeting in February 2024.

3. Agreed that a paper would be presented to the Committee in May 2024 relating to the evaluation of the framework for development of Once for Scotland policies within the State Hospital.

6 CORPORATE RISK REGISTER – STAFF GOVERNANCE RISK QUARTERLY UPDATE

The Committee received and noted the Corporate Risk Register - Staff Governance quarterly update, which detailed the current positon on risks that sit under the Workforce Directorate. Ms Nisbet provided an overview of the four risks i.e. HRD111 – Deliberate Leak of Information, HRD122 – Compliance with Mandatory Level 2 PMVA Training, HRD110 – Failure to Implement and Develop the Workforce Plan, and HRD113 – Job Evaluation and impact on services.

Ms Radage commented that it was good to see the progress made, in such a short space of time, particularly in terms of HRD113.

A further update would be provided at the next Committee meeting in February 2024 as part of the standing items on the agenda.

The Committee:

1. Agreed that the Corporate Risk Register – Staff Governance update represented an accurate statement of risk.

7 STAFF GOVERNANCE MONITORING RETURN

Members received and noted the Staff Governance Monitoring Return 2022/23 for review and final approval prior to its submission to the Scottish Government on 4 December 2023. Members recognised that as part of the approval process, this was previously circulated to the Partnership Forum and the Corporate Management Team for approval prior to today's meeting.

A minor error was noted on page two, under 'Assessment' heading, which should read as 2022/23, rather than 2021/22.

Ms Fallon noted that a plan was in place to conduct an evaluation of the Staff & Volunteer Health and Wellbeing Strategy, which aimed to determine the impact of the hospital's Wellbeing Centre activities, inform future direction, and contribute to creating a positive workplace culture. The field work was planned to take place from February 2024. The Committee therefore agreed that it would be beneficial to be sighted on a paper around May 2024 following this evaluation.

Action: Ms Laura Nisbet

Mr Connor queried the meaning of the narrative the "five employees were re-appointed to *the Board*, taking the opportunity to retire and return". Ms Nisbet confirmed this response was in relation to a question from the Scottish Government where the terminology reflected the 'organisation' rather than The State Hospital's Board. She agreed to ensure the narrative was changed in future reporting.

Mr Currie commented that the report read well, was positive around staff wellbeing and that staff should aim to keep up the high-level detail of work. He further added that it would be beneficial to consider linking recruitment and retention in terms of resources.

Members approved the Staff Governance Monitoring Return 2022/23.

The Committee:

1. Approved the Staff Governance Monitoring Return 2022/23.

8 WORKFORCE REPORT

Members received and noted the Workforce Report, which provided an update on overall workforce performance up to 31 October 2023. Ms Nisbet highlighted key areas from the report and summarised the information under subjects such as attendance management, nursing recruitment, job evaluation and equality networks opportunity for staff from minority groups. She highlighted the focus on on-boarding, quality local inductions and initial PDPR conversations which was hoped to drive improvements in each of these areas. Also, the downward trajectory of sickness absence, particularly within the nursing cohort.

Ms Nisbet summarised the data around the Board's ask for analysis around any comparison of potential working days lost due to long / short term sickness absence in comparison to lengths of service. It was noted that the graphs showed that there are no instances of long-term absence for employees with less than 4 years' service, and thereafter, there was no obvious conclusion to be drawn as the instances were quite evenly spread through the years. The scale of sick pay entitlements in accordance with the Agenda for Change Terms and Conditions in the first five years of service may explain this. In relation to short-term absence, there was a higher instance of short-term absences in the first three years of employment and then there was no obvious pattern. The

new ‘in person’ induction programme contained presentations and sources of information in relation to wellbeing, attendance at work and support from occupational health. Again, a focus on on-boarding, quality local inductions and initial PDPR conversations should drive an improvement in this area.

Mr Jenkins advised that in relation to short term absences, it may be beneficial to highlight the organisation’s expectations at the induction process. Ms Radage echoed this point especially in relation to the impacts and costs of sickness absence on other colleagues and on the delivery of care.

Ms Merson queried whether the long-term sickness absence data was instances or days, to which Ms Nisbet confirmed was hours.

Ms Fallon asked when the update would be available around comparative workforce data in relation to other high secure hospitals. Ms McCaffrey advised that The State Hospital had provided the information, however not all services had supplied the information therefore the data was not available. Mr Jenkins suggested that a commitment be made to ensure a paper was submitted for the next Committee meeting in February 2024 detailing this information.

Action: Ms Karen McCaffrey

Members welcomed the positive and newly refined report.

The Committee:

1. Noted the Workforce Report.

2. Agreed that an update paper on comparative workforce data in relation to other high secure hospitals be submitted to the meeting in February 2024.

9 GUIDANCE ON DISMISSAL APPEALS

The Committee received and noted the update on panel composition at appeals against dismissal hearings following the communication received previously from the NHS Scotland ‘Once for Scotland’ Workforce Policies Programme. Ms Nisbet provided an overview of the paper and reiterated that Non-Executive Directors would be supported by the Human Resources Department in any such case.

Mr Currie commented that from his experience within the Scottish Ambulance Service, two important points were raised and worthy of mentioning; MS Teams meetings were set up in a timely fashion in order to comply with strict timescales, and appropriate breaks were included within the hearings.

Mr Jenkins welcomed the update and that this now added a positive layer of assurance given Non-Executive Director input to the process overall.

Mr Moore advised he felt the guidance was very helpful and asked if it was aligned and reflected to the relevant policy. Ms Nisbet confirmed the guidance was aligned to policy within the Once for Scotland Policy suite and was not in conflict nationally. She further advised that Non-Executive Directors would be approached for any hearings in terms of their individual impartiality and experience for a fair process.

The Committee:

1. Noted the Guidance for Appeals Against Dismissals update.

10 WHISTLEBLOWING UPDATE

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 Two and took assurance of the compliance with the National Whistleblowing Standards.

Ms Nisbet and Ms Raghavan thanked the Communications Department for their extensive efforts in helping to organise and facilitate the "Speak Up" week, during October 2023.

In the context of the small number of whistleblowing cases, Mr Jenkins advised that he recently met with Rosemary Agnew, Independent National Whistleblowing Officer for the NHS in Scotland, who advised that there had been a total of 66 cases across NHS Scotland in 2023, therefore it was not a large number in comparison.

Mr Currie noted that the terminology of "whistleblowing" may have an impact in not encouraging people to raise concerns, and also noted that this could not be done anonymously within the standards.

Ms Raghavan advised that work was ongoing in relation to Speak Up Champions, and positively advised of the layers available to staff to speak up, prior to a whistleblowing case being raised. Ms Nisbet added that as part of business as usual practice, there was a range of routes through which staff could raise concerns e.g. peer support and wellbeing contacts.

The Committee:

1. Noted the Whistleblowing Update Report for Quarter Two.

11 TASK AND FINISH GROUP – ATTENDANCE MANAGEMENT

The Committee received and noted the Task and Finish Group update on Attendance Management which provided an overview of the changes made since the last report. Updates included a reworked paper and a more workable group with additional accountability. It was recognised that there remained challenges although the sickness absence trend was reducing. Members noted that several actions were underway within specific areas of focus i.e. Ward Nursing, Skye Centre, Security and Housekeeping. These actions included;

- Focus on 'return to work' meeting compliance levels.
- Review of supportive measures for staff to returning to work, including reasonable adjustments guidance and temporary placement guidance for employees who may require an alternative role.
- Weekly meetings (in some focus areas) between partnership and managerial teams.
- Discussion with Occupational Health on targeted support to specific areas and the management referral process for employees.
- Development of 'assistance prompt' questions for first in line managers undertaking absence interviews.
- Monitoring the use and compliance with the absence policy trigger stages.
- Training for frontline managers and enhanced HR support. 30 sessions have taken place to date with further sessions scheduled in December 2023.
- Consideration of the 'wellbeing offer' for staff to ensure organisational support enables employee to optimise their attendance.

In addition to the report, Ms McCaffrey advised that she met with each Senior Charge Nurse (SCN) to ensure their understanding of the process and the importance of their role as a line manager. This allowed her to obtain an understanding of their expertise as a SCN and to develop the knowledge and skills of the individual.

Mr Jenkins referred to the potential of an increase in sickness absence around the winter months in relation to flu, colds and coronavirus. Therefore, it would be helpful to think about how to develop data and add modeling scenarios to give a risk analysis and means of predicting absence rates. He also referred to the detailed review of the position on daytime confinement within the State Hospital at the last Clinical Governance Committee meeting, and the correlation to attendance management as well as recruitment. Ms Fallon picked up on this point and agreed it would be helpful to link reporting across each area. She welcomed this as a very helpful report and commented on the poster campaign launch. Additionally, Ms Radage thanked staff for the detailed report and acknowledged that it was good to take a proactive approach to sickness absence where possible.

The Committee:

1. Noted the Task and Finish Group update in relation to attendance management.

12 WORKFORCE GOVERNANCE GROUP UPDATE

Members received and noted the Workforce Governance Group update report and Ms Nisbet provided members with a summary of the content, which included an update of the last three meetings held during September, October and November 2023.

The Committee were content to note the report.

The Committee:

1. Noted the Workforce Governance Group Report.

13 HEALTH AND CARE STAFFING SCOTLAND UPDATE

Members received and noted the Implementation for Health and Care Staffing Act and eRostering update 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. Ms McCaffrey advised that The State Hospital's Quarter One report was submitted to the Scottish Government (SG) in July 2023. A response was received from SG providing reassurance that the hospital were working positively towards the preparedness for enactment in April 2024. The report also gave areas to be considered which would be included in the newly revised Quarter Two report which is due to be submitted in November 2023. A copy of this submission would be available at the next Committee meeting in February 2024. 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.

Ms Fallon welcomed the report and flagged that it would be beneficial and useful to the Clinical Governance Committee also. There was further discussion around the crossover of accountabilities between the two committees, and agreement that there should be further consideration as to how reporting was route to each to ensure oversight. Ms Radage also asked for clearer reporting to include forward planning and milestones to be added to reporting going forward.

Action: Ms Karen McCaffrey

The Committee:

1. Noted the Implementation for Health and Care Staffing Act and eRostering Update.

2. Noted the crossover of accountabilities and need to route reporting appropriately with the Clinical Governance Committee.

3. Agreed that reporting should be refreshed to include forward planning and milestones to give assurance that the State Hospital would be ready for implementation.

14 PRACTICE DEVELOPMENT UPDATE

The Committee received and noted the Nursing Practice Development (NPD) report which provided an update on the key priorities identified for the service throughout 2023. The six identified priorities were as follows;

1. To recruit to vacant Practice Education Facilitator post.
2. Embed the new clinical care policy into practice and ensure its alignment with the revised clinical model structure.
3. Work with colleagues from NHS Education Scotland to undertake a pathfinding project to explore and develop a framework for the delivery of a sustainable model for the delivery of nursing clinical supervision.
4. Development of a peer support network that would consist of both clinical and non-clinical peer support workers throughout the organization.
5. Review the current nursing induction process (including secondary induction) with the dual aim of streamlining processes whilst also increasing the number of inductions carried out each year
6. Work to increase Delivery of nursing assessment and care planning.

Ms Clark gave a summary update on each of the above areas, as well as the planned work over the next six-month period, which would mainly focus on supporting the successful implementation of the new Clinical Care policy and evaluate its impact on practice. This would be in addition to ongoing delivery of already existing work streams supporting ongoing bedding in of the new Clinical Model service structures.

Members acknowledged that an annual update detailing the work carried out by the NPD Team in early 2024 would be provided for the next Staff Governance Committee meeting.

Action: Ms Josie Clark

Ms Fallon commented on the high number of student nurses coming to The State Hospital and queried whether there was a comparison to other hospitals available to look in to in future. Ms Clark did not have this information at the time of the meeting though agreed to look in to and feed back at a later date.

Action: Ms Josie Clark

Mr Connor commented on the narrative within the report around clinical supervision amongst nurses had been challenging both within The State Hospital and across the NHS nursing workforce more widely, and queried what information this was based upon. Ms Clark advised the feedback during a pilot had reported that types of supervision lines were perhaps blurred at times, e.g. restorative and clinical supervision. It was hoped to improve this through clear explanation and building an understanding within future training sessions. In addition, Ms Merson advised that the Clinical Quality Department take forward the number of clinical supervision sessions from a local quality perspective. Although the hard data was not known at the time of the meeting, assurance was taken that focus was there and remained at ward level.

Mr Connor asked that of the 22 nurses trained in the delivery of clinical supervision during 2023, how many 1:1 sessions had taken place. Ms Clark agreed to seek and provide this information following the meeting.

Action: Ms Josie Clark

Lastly, Mr Connor noted that 13 staff had received BEST and PECC training over 2023, though asked how many were outstanding and for which training. Ms Clark advised there were 14 staff who had not completed the training though future reports would show an increase with compliance in this area.

Mr Moore asked if the hospital actively targeted first year students for employment, to which Ms Clark confirmed was the case and that proactive actions were taken to reach out to this cohort. Mr Moore expressed the view that he felt the content of the Core Induction was positive.

The Committee:

1. Noted the Nursing Practice Development update.

2. Acknowledged that a further update report would be submitted to the next Committee in February 2024.

15 ORGANISATIONAL DEVELOPMENT, LEARNING AND WELLBEING REPORT

The Committee received and noted the Organisational Development, Learning and Wellbeing Report which provide an update on these key workstreams and associated activities within the State Hospital (TSH) such as PDPR completions, statutory and mandatory training compliance, and staff wellbeing activities.

In addition to the report, the Committee were advised that at a recent Learning and Development Leads meeting, the TSH were recognized to be second from top in terms of compliance scores of PDPR's, in relation to other NHS Boards in Scotland.

Ms Dunlop and Mr Young provided reassurance of the overall positive picture given the wealth of data contained within the report. Both attendees and their teams were thanked for the extensive list of initiatives, alongside the impact on organisational development culture and values. Ms Merson also noted that as part of the Annual Delivery Plan, an organisational development strategy was due to be developed in the next quarter.

Members also welcomed the new streamlined report, which would be continued going forward.

The Committee:

1. Noted the Organisational Development, Learning and Wellbeing Report.

16 IMATTER REPORT – STATE HOSPTIAL SURVEY

The Committee received and noted the iMatter report which provided a brief analysis of the findings as they related to the State Hospital. In addition, it was noted that the national report had not yet been compiled, therefore national comparisons were not possible at the time of the meeting.

Mr Young provided an overview of the report, and the committee discussed areas of strength and positive responses and further areas for improvement. Ms Fallon suggested that the survey showed a need for more focus on staff involvement on decision-making. Mr Young noted that team action plans may help to do this. Mr Moore noted the data in relation to staff feeling confident to raise concerns, and linked this to the changes being made in local leadership development which may impact over time. Mr Jenkins also noted the various different methods of obtaining staff feedback underway, including the staff questionnaire released in May 2024 relating to the revised clinical model, on boarding surveys. It would be helpful to draw these together to get a fuller picture of staff feedback. Mr Young noted that as the State Hospital was a small organisation, it may be more helpful to carry out staff survey like this every second year.

Mr Currie also noted the helpfulness of local discussions e.g. PDPRs which may draw feedback from staff in a way that was difficult to achieve in surveys. Ms Radage noted that there could be risk of staff thinking of feedback surveys as being iterative process, bit that nothing concrete ever changed as a result.

Mr Moore noted that a staff bulletin would be issued detailing the results for staff, and this could be linked to the Organisational Development Strategy being developed for 2024/25, which would come to the Committee in February 2024.

Ms Smith asked members, in terms of the local report received by the Staff Governance Committee, then the full report being submitted to the Board meeting in December, whether they wished to follow this pattern of reporting or utilise this opportunity to change. Members agreed they wished to review the Organisational Development Strategy and link this to the iMatter data at the same time as a useful pause and way to consider the way forward. It was agreed that a paper would be presented to the Board meeting in December 2023 to summarise the discussion at today's meeting, and outlining this way forward.

Action: Ms Laura Nisbet

The Committee:

1. Noted the iMatter Report – State Hospital Survey.

2. Requested reporting to the Board at December Meeting linking the iMatter results to the forthcoming Organisational Development strategy.

17 ONCE FOR SCOTLAND POLICIES – EVALUATION FRAMEWORK

The Committee received and noted the Once for Scotland Policies – Supporting Work Life Balance update which provided a final update on the local implementation.

Ms Nisbet provided assurance on the implementation of the suite of national policies, in accordance with the locally agreed action plan. An outline evaluation framework was presented noting that the policies were effective from 1st November and therefore, not enough time had passed to carry out an evaluation. Members agreed that the timescale be reviewed on the rolling action list and amended to May 2024 whereby an evaluation report on the suite of policies would be provided.

Action: Ms Julie Burt (completed) / Ms Laura Nisbet

The Committee:

1. Noted the Once for Scotland Policies – Evaluation Framework update.

18 INTERNAL AUDIT PAYROLL REPORT

The Committee received and noted the Internal Audit Payroll Report reference 5.22/23 which was an ask of the June 2023 Audit and Risk Committee to share for information.

Ms Fallon asked if over payments would be detailed within the report as it made reference to under payments though not over payments. Ms Nisbet advised that this would be the case and that there was previously a minor over payment, which was a low occurrence and resolved within a month.

Members acknowledged a generally positive response particularly within the complex area of payroll administration.

The Committee:

1. Noted the Internal Audit Payroll Report dated June 2023.

19 COMMITTEE WORKPLAN FOR 2024

The Committee received and noted the draft Committee Workplan for 2024. Members reviewed and agreed that 'Review of new Occupational Health Service' and the OD strategy be added to the February agenda. Evaluation of the Staff & Volunteer Health and Wellbeing Strategy should be added to each meeting.

Action: Secretariat

The Committee:

1. Approved the Committee Workplan for 2024 following the updates noted above.

20 PARTNERSHIP FORUM APPROVED MINUTES FROM JUNE TO AUGUST 2023

Members received and noted the approved Partnership Forum minutes dated 27 June, 25 July and 22 August 2023. Ms Fallon welcomed the update on the Credit Union. She sought clarity in terms of whether the option of a running track for patients and the plan to address the temperature in the wards during the hotter months had been pulled in to the Capital plan funding as Mr Jenkins previously suggested in the minutes dated 25 July 2023, in order to consider improving ventilation onsite. Mr Jenkins agreed to confirm this out with the meeting and advise Ms Fallon.

Action: Mr Gary Jenkins / Robin McNaught

The Committee:

1. Noted the approved minutes of the Partnership Forum held on 27 June, 25 July and 22 August 2023.

21 HR AND WELLBEING GROUP UPDATE

Ms Nisbet provided a verbal update from the HR and Wellbeing Group and advised that a meeting had not taken place in November as a review and reflection would be undertaken in relation to the groups remit, alongside the monthly Workforce Governance Group. A future update would be provided to the Committee in February 2024.

Action: Ms Laura Nisbet

The Committee:

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

2. Agreed that an update on progress would be submitted to the Committee in February 2024.

22 AREAS OF GOOD PRACTICE

Ms Radage took the opportunity to have an open discussion around views on the more streamlined reports. Members welcomed the changes made. Mr Currie suggested that a 'summary narrative' would be useful to be included following graphs, and that the quality of reports resulted in less questions from Non-Executive Directors, given that the information was detailed within the reports. Members also felt the streamlined reports were more readable in terms of scrutiny.

Ms Fallon commented that the structure of today's papers showed linkage to the Clinical Governance Committee and thanked staff for the detailed level of data provided.

The Committee:

1. Noted the update.

23 ANY ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTIEES

Mr Jenkins commented that in terms of the pillar aspects across all Board Committees, there was a requirement to highlight interlinked components, therefore would keep reviewing papers submitted to each Committee to ensure effective information was provided.

The Committee:

1. Noted the update.

24 ANY OTHER BUSINESS

There was no other business raised.

25 DATE AND TIME OF NEXT MEETING

The next meeting will take place at 9.30am on Thursday 15 February 2024.

Meeting concluded 1240 hours.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	15 February 2024
Agenda Reference:	Item No: 17
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 15 February 2024.

1	Corporate Risk Register Quarterly Update	The Committee received the quarterly report regarding the corporate risks assigned to the Workforce Directorate. The Committee agreed that this as a statement of risk and noted the mitigations in place, with no proposed changes.
2	Occupational Health Service	The Committee reviewed the delivery of the service, following a change in provider this year. Reporting included key activities, focused on supporting staff and providing a range of interventions. There was a review of the provision of the early intervention, and agreement that this should change to an opt in service through line managers; and that there would be evaluation of the effectiveness of this as a more targeted approach. The service also outlined the other work being taken forward, and the inked approach with Infection Prevention and Control, particularly on hand hygiene practice.
3	Workforce Report	Reporting outlined the wide range of metrics across workforce data. The Committee noted that although here had been an increase in sickness absence levels during January, this was related to short term illness through winter virus, and noted the positive trend continuing in lowering long term absences.
4	Employee Relations	The Committee received a presentation describing the main themes found in employee relations cases, and lessons learned. It was agreed that the aim of shortened timeline to complete and resolve cases would be a positive development, being mindful of the impacts on staff.
5	Implementation of Health and Care (Staffing) Scotland	Reporting provided assurance that each part of this implementation was progressing well, and was on track for 1 April 2024, with no concerns for delivery. The Committee noted that there was active

	Act: and e-rostering	consideration of the post implementation period, and how this work would be managed into the next financial year.
6	Workforce Governance Update	The Committee received an update on the activity within the monthly Workforce Governance Group, and noted the good progress being made especially on development of succession planning and a policy to support staff experiencing the menopause. Further, the scoping work had been carried out on the impact of a 36 hour week, as part of last year's Agenda for Change pay settlement. The Committee also noted the change in organisational governance with a delivery group focused particularly around staff wellbeing.
7	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. The improvement in PDPR compliance was commended, and assurance was given on access to the Wellbeing Centre and Staff Care Specialist for shift workers.
8	iMatter Report Survey	Reporting provided benchmarking of the results of the survey for the State Hospital to the national results. The Committee discussed the intelligence this report provided and placed with within the wider context of OD, and the activity underway to develop a dedicated strategy in this respect including a refresh in communication to take a more targeted approach.
9	Practice Development Update	An update as provided in respect of the Practice Education Facilitator post, progress on embedding the new clinical care policy, nursing clinical supervision, the peer support network and nurse induction and ongoing support including a first year support programme.
10	Whistleblowing	Quarterly update report, with no new cases reported.
11	Areas of good practice	The steady progress being made in respect of long term sickness absence, and PDPR compliance. Further the Peer Support Network and first year nursing support programme. The Committee also welcomed the refreshed approach to OD, and the strengthened focus in this area.

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

Paper No. 24/13

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 February 2024
Agenda Reference:	Item No: 18
Sponsoring Director:	Chief Executive Officer
Author(s):	Head of Corporate Governance
Title of Report:	Corporate Objectives 2024 - 25
Purpose of Report:	For Decision

1 SITUATION

The State Hospitals Board for Scotland undertakes a review of its corporate objectives annually to provide a high level statement of strategic goals for the following year. This brings together the priorities for the Board across each strand of governance. This document sets out the draft Corporate Objectives for The State Hospital (TSH) for the period 1 April 2024 until 31 March 2025.

2 BACKGROUND

The intention of the corporate objectives is to set out the strategic priorities for the organisation transparently, and to support its key aims and mission.

The Corporate Objectives should align with the operational business model for TSH through the Annual Delivery Plan and related Delivery Plan template submitted quarterly to Scottish Government. Therefore, it has at its centre the aim of delivering safe and secure patient care, within a sustainable financial plan; as well as reflecting the organisational aim for a sustainable workforce, who feel supported in the workplace.

3 ASSESSMENT

The draft Corporate Objectives are attached (**Appendix A)** and group the key aims around the themes of Better Care, Better Health, Better Values and Better Workplace.

- Improve the quality of care for patients by targeting investment and focus at improving services with the high security environment and for providing the most effective support for all. **(Better Care)**

- Improve health and wellbeing by promoting and supporting healthier lives and choices, addressing inequality and adopting an approach based on recovery, care and treatment. **(Better Health)**

- Increase the value from, and financial sustainability of, care by making the most effective use of available resources through efficient and effective service delivery **(Best Value)**

- Improve the engagement of staff and opportunity for development through effective values based leadership resulting in a culture of quality and accountability **(Better Workplace)**

The performance management framework underpinning delivery of these objectives is through:

Annual Review

Scottish Ministers hold the Board to account through an annual review of performance, and this was last undertaken formally on 29 November 2023, with the outcome provided through the Director of Mental Health on 20 December 2023. This was supportive of the work progressed by the Board through the period April 2021 to March 2023, with no significant concerns raised, and is published on the TSH website.

Further oversight of performance will continue through the quarterly sponsor meetings held Between the Executive leadership and the Scottish Government colleagues, supported by the quarterly update of the Delivery Plan. It is expected that the Annual Review for 2023/24 will be scheduled for autumn 2024 and will be led by the Minister for Social Care, Mental Wellbeing and Sport.

TSH Board

The Board and its committee structure holds the Executive Team accountable through a wide range of assurance reporting, as well as audit reporting. The Board undertook a self-assessment exercise recently, and will review the outcome of that through a structured development session on 7 March, led by the Board Development Team from NHS Education for Scotland. This will enable the development of a corporate governance improvement plan for 2024/25. This will also support the Board's aim of linking its Corporate Objectives to the Corporate Risk Register, taking cognisance of performance and risk together.

Executive Leadership

The Corporate Objectives form the basis for setting the individual objectives for each of the Corporate Directors, with detailed oversight of performance then taken by the Remuneration Committee within the structure of the NHSScotland National Performance Monitoring Committee. The Remuneration Committee takes active consideration of the way in which it seeks assurance and related evidence base for its consideration of individual performance.

This process underpinned by structured directorate performance meetings, led by the Chief Executive. These provide a conduit through which each directorate can highlight areas of excellence or any potential area of concern; to build engagement toward improvement where necessary.

The Board is also asked to note that the Corporate Objectives have been drafted for 2024/25 within the context of review of the national framework for delivery of forensic mental health services in NHS Scotland, led by Scottish Minsters. At the time of reporting, national guidance is pending, and may impact the strategic direction for the organisation.

4 RECOMMENDATION

The Executive Team was asked to review and contribute to the draft Corporate Objectives for 2024/25, with approval from the wider Corporate Management Team. The Board is asked to recommend any changes required before providing approval of these objectives for 2024/25.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP / Corporate Objectives	To present the draft corporate objectives to the Board for their consideration and approval.
Workforce Implications	The Corporate Objectives detail our key strategic aims for a better workplace; providing a framework through which impacts on the workforce can be considered through any strategic planning for the year.
Financial Implications	To underpin the key aim of better value for the organisation, stating the intent that this will underpin strategic planning and financial management.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Requested as part of the Board's workplan, and reviewed by the Corporate Management Team.
Risk Assessment (Outline any significant risks and associated mitigation)	No specific risk assessment made, this supports the organisational delivery of key objectives.
Assessment of Impact on Stakeholder Experience	Key stakeholders and the need to align the corporate objectives to these is outlined in the paper.
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No issues identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

The State Hospitals Board for Scotland

Corporate Objectives 2024/25 **Appendix A**

Better Care	▪ Implement the Annual Delivery Plan, aligning the organisational aims and direction to the health priorities set out in Scottish Government Policy. ▪ Tailor the Clinical Model to better reflect the graduated clinical and security steps for patient progression on their care and treatment pathway. ▪ Eliminate the use of Day Time Confinement to all but very exceptional circumstances. ▪ Safe delivery of care within the context of least restrictive practice resilience and the ability to identify and respond to risk ▪ Ensure the principles of the rehabilitative care are applied optimising opportunities for patient activities, educational development and occupational development across all service areas ▪ Ensure organisational resilience and ability to respond to any increase in risk to care delivery within expected systems pressures and any unexpected events. ▪ Learn locally and nationally from adverse events to make service improvements that enhance the safety of our care system ▪ Deliver a programme of Infection Control related activity in line with all national policy objectives ▪ Monitor the use and recording of seclusion practice in accordance with the definitions published by the Mental Welfare Commission ▪ Be accessible to patients, their family and visitors ensuring their views and experiences are reflected in service improvements. ▪ Work with stakeholders and Scottish Government representatives to enhance the reputation and healthcare 'profile' of The State Hospital ▪ Collaborate with the Forensic Network in the delivery of quality care guidance and standards applicable to the Forensic Mental Health Environment ▪ Take forward national collaboration and interface work with the Health in Custody Network ▪ Support the development of a national framework for collaborative working in the delivery of forensic mental health services across NHS Scotland

Better Health	▪ Tackle and address the challenge of obesity, through delivery of the Supporting Healthy Choices programme ▪ Improve the physical health opportunities for patients ▪ Ensure the delivery of tailored mental health and treatment plans individualised to the specific needs of each patient ▪ Address the overall social wellbeing issues for patients undergoing treatment ▪ Utilise connections with other health care systems to ensure patients receive a full range of healthcare support ▪ Ensure that patients have a seamless transition from the State Hospital to other care providers as part of their care pathway when clinically appropriate. This will align with the aims and ambitions of medium secure provision and other treatment pathways ▪ Ensure the organisation is aligned to the values and objectives of the wider mental health strategy and framework for NHS Scotland
Better Value	▪ Meet the key finance targets set for the organisation and in line with Standard Financial Instructions ▪ Develop a sustainable finance model within the available finance allocation that supports the sustainability and growth of the organization ▪ Deliver all Scottish Government financial budget and resource reporting and monitoring requirements for NHSScotland national matters, through Board Chief Executive, Director of Finance and Human Resource Director groups ▪ Work collaboratively across public sector bodies to ensure that best value is achieved in service planning, design and delivery, including through National Board collaboration and the Anchors Strategy ▪ Deliver programme of sustainable working and progress to net zero recognising the impacts of climate change and financial constraints

	▪ Enhance and strengthen digital innovation for the organisation; and the digital inclusion programme ▪ Ensure delivery of a cohesive approach to information governance and records management standards, including delivery of the newly formulated Records Management function. ▪ Deliver the actions identified by the NIS audit, to maintain cyber security and resilience. ▪ Complete the security upgrade and move towards the development of the core security quality indicators. ▪ Strengthen corporate governance to ensure transparency and clear direction, both within and external to the organisation in line with the Blueprint for Good Governance. ▪ Support quality improvement approaches, embedding a cohesive approach ▪ Ensure the continued delivery and development of the organisation's performance management framework
Better Workforce	▪ Continue with the development and delivery of the 3-Year Workforce Plan within the context of the planning framework and guidance from Scottish Government. ▪ Continue to support and build partnership working so that this is embedded across the organisation ▪ Implement the Health and Care (Staffing) (Scotland) Bill (2019) across TSH, following national rollout, and in conjunction with the local delivery of the national e-rostering programme, through the Workforce Governance Group. ▪ Maximise workforce sustainability through delivery of the TSH Recruitment and Retention Strategy, through modern, inclusive recruitment practice and continued development of a supplementary workforce. ▪ Promote and deliver a framework of wellbeing within the framework of a Staff and Volunteer Wellbeing Strategy ▪ Develop an Organisational Development Strategy, and implementation plan. ▪ Building on i-matter and staff governance principles to deliver an inclusive staff engagement programme in partnership to support

	the wellbeing of all employees ▪ Sustain a safe working environment for staff with a focus on risk management across all aspects of the organisation ▪ Implement the 'Once for Scotland' suite of Human Resources policy, aligning with the national rollout ▪ Ensure accessibility and support internal and external services for staff who require them, including a cohesive Occupational Health Service. ▪ Review and action absence related issues and prioritise support mechanisms and staff wellbeing to provide staff and line managers with the support required; and where absence is required, support staff to return to work at the earliest opportunity. ▪ Continue to support training and development for all staff at every level across the organisation. ▪ Support the Independent National Whistleblowing Standards, and support this workstream locally including promoting awareness for staff. ▪ Maintain an appropriate Health and Safety governance framework that demonstrates continual improvements and a commitment to fulfil our compliance obligations.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 February 2024
Agenda Reference:	Item No: 19
Sponsoring Director:	Chief Executive
Author(s):	Head of Corporate Planning and Business Support Clinical Quality Facilitator
Title of Report:	Q3 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 Q3: October to December 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 Q3 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 be engaged in psychological treatment
- 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%)

Performance Indicator	Target	RAG Q4 22/23	RAG Q1 23/24	RAG Q2 23/24	RAG Q3 23/24	Actual	Comment
Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	A	A	R	84.4%	This indicator moves in to the red zone.
Patients will be engaged in psychological treatment	85%	G	A	G	R	74%	This indicator has decreased to Red for Q3
Patients will be engaged in off-hub activity centers	90%	G	G	G	G	95.0%	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				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	R	58%	Achievement has decreased and moves to Red for this quarter
Patients will have a healthier BMI	25%	R	R	R	R	11%	This indicator remains in the red zone
Sickness absence rate (National HEAT standard is 4%)	** 5%	R	R	R	R	6.79%	October's figure was 6.7%. November's figure was 6.3%. December's figure was 7.4%.
Staff have an approved PDR	*80%	G	G	G	G	88.7%	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%	A	G	G	G	100%	As at the end of December 2023, there were no instances of any patient waiting beyond the specified wait time
Patients have their clinical risk assessment reviewed annually.	100%	A	G	A	G	96%	As at the end of December , 3 patients had an out of date / no risk assessment
Attendance at CPA Reviews							

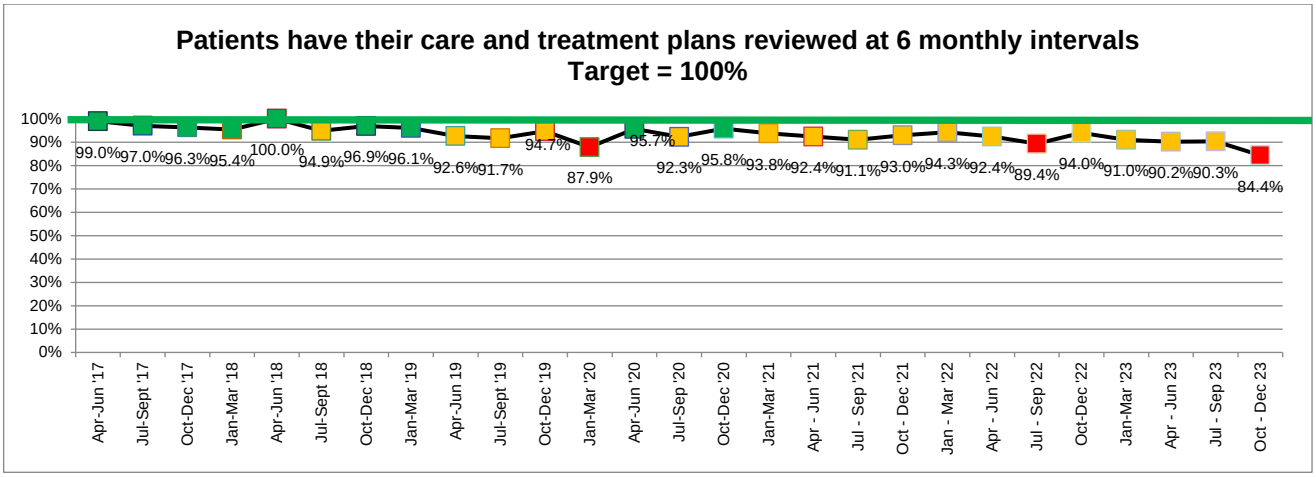
Definitions for red, amber and green zone:

- 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: 84.4%
Performance Zone: Red

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 October 2023 the compliance was 83.7%, November was 87.2% and in December 2023 compliance was 82.4% giving a quarterly compliance of 84.4%, which is a decrease from last quarter's figure. This indicator moves to the red zone.

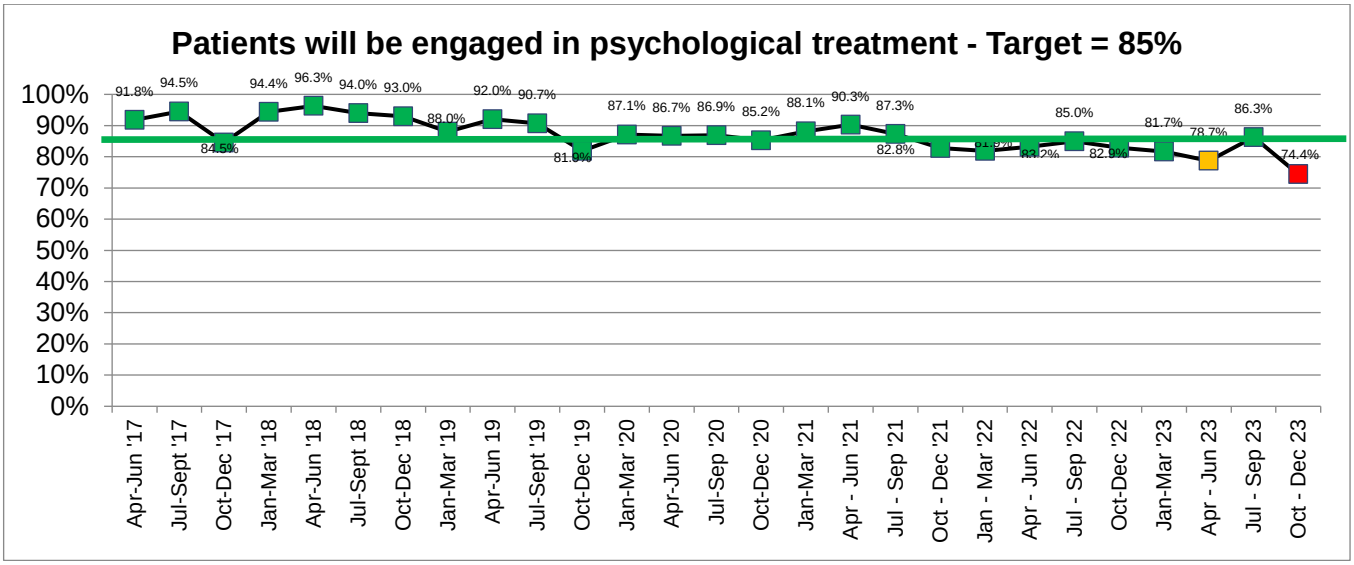
On 31 December 2023 there were 103 patients in the hospital. Twelve of these patients were in the admission phase. Fifteen CPA documents had not been reviewed and available within the 6-month period, or within the agreed admission phase. All of these CPAs have been held with no documents being uploaded 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: 74%
Performance Zone: Red

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 October 2023, the compliance was 75.2%, November 2023 was 71% and December 2023 was 77% giving a quarterly compliance of 74.4%, which is a decrease from the Q2 2023/24 figure of 86%. This indicator moves into the red zone.

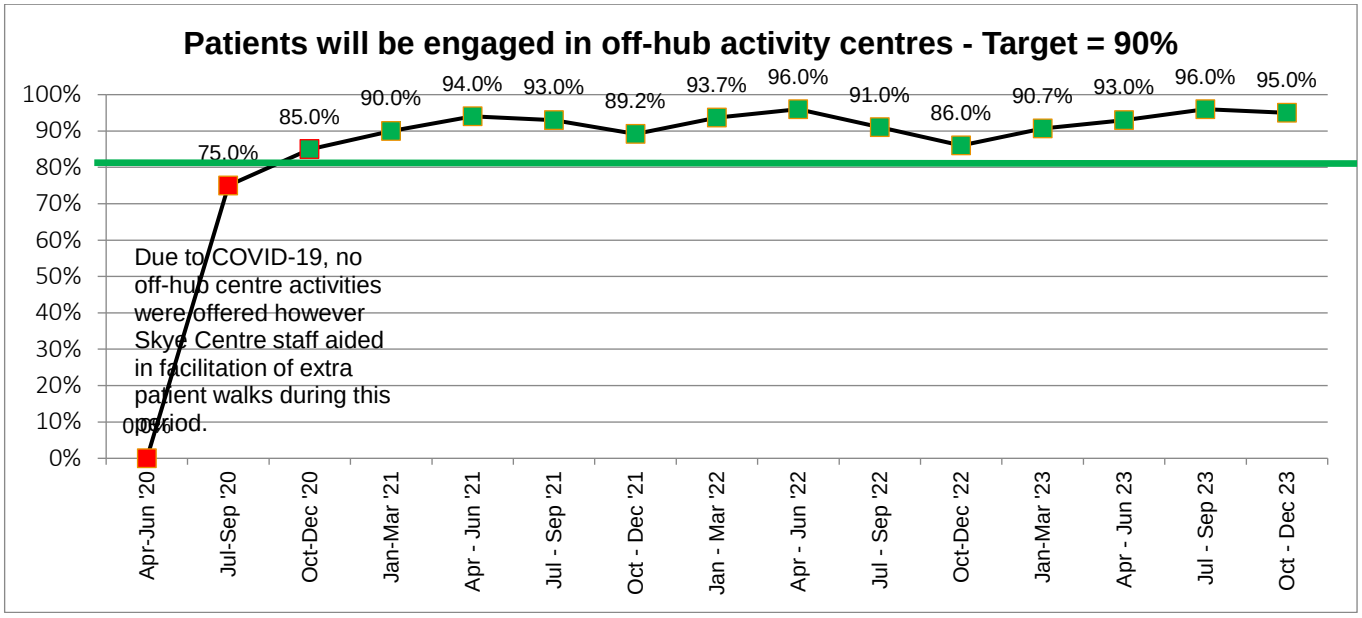
There are a number of factors contributing to this position. Groups that had been being running ended during this time and there were significant deficits in capacity across the Psychology department. Capacity issues were as a result of staff on long term sickness, staff leaving and trainees completing their training. In total this accounted for a deficit of 7 staff. The Psychology Department also had vacancies which also reduced capacity. In addition, there was a high turnover of patients in 1 hub which meant prioritisation of referral assessments and risk assessment work (neither of which are counted in our activity).

Capacity issue recently improved with 2 full time members of staff commenced employment and one long term absence has returned. Interviews are scheduled in early February 2024 for 1 post, which will also increase capacity when new staff member starts. To mitigate future significant staff turnover, traineeship start dates have been staggered so that they finish over the year.

No 3.1: Patients will be Engaged in Off-Hub Activity Centers

Target: 90%
Data for current quarter: 95%
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.

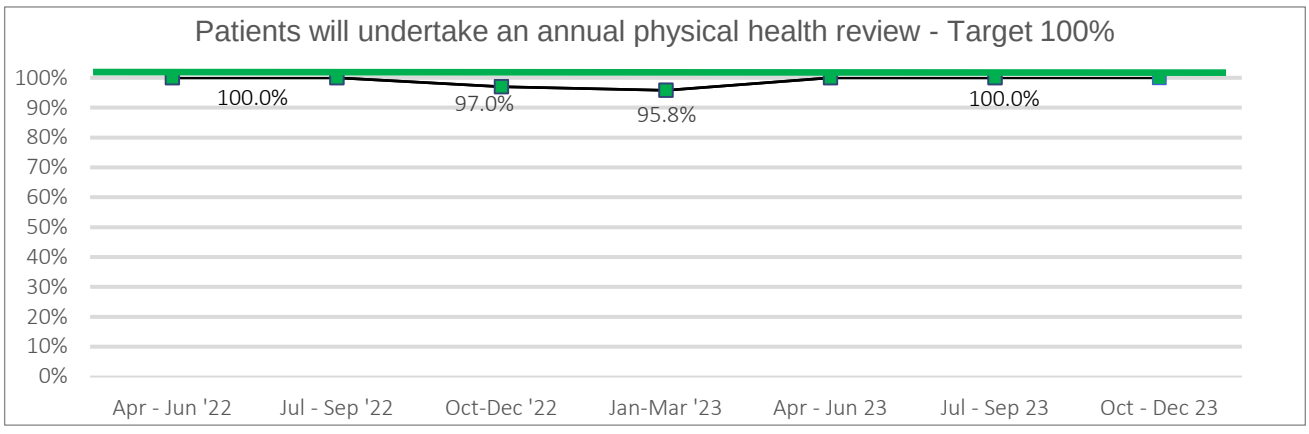
The Activity Oversight Group was established in August 2022 to provide oversight and direction for patient activity. This group have commissioned a revision of the activity target for patients. This will replace this current KPI, it will reflect activity across the different services and be a more accurate indicator related to patient timetabled sessions and activity for every patient.

In October 2023 the compliance was 94%, November was 97% and in December 2023 compliance was 95% giving a quarterly compliance of 95%, which is a slight decrease from last quarter's figure of 96%. This indicator remains in the green zone.

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.



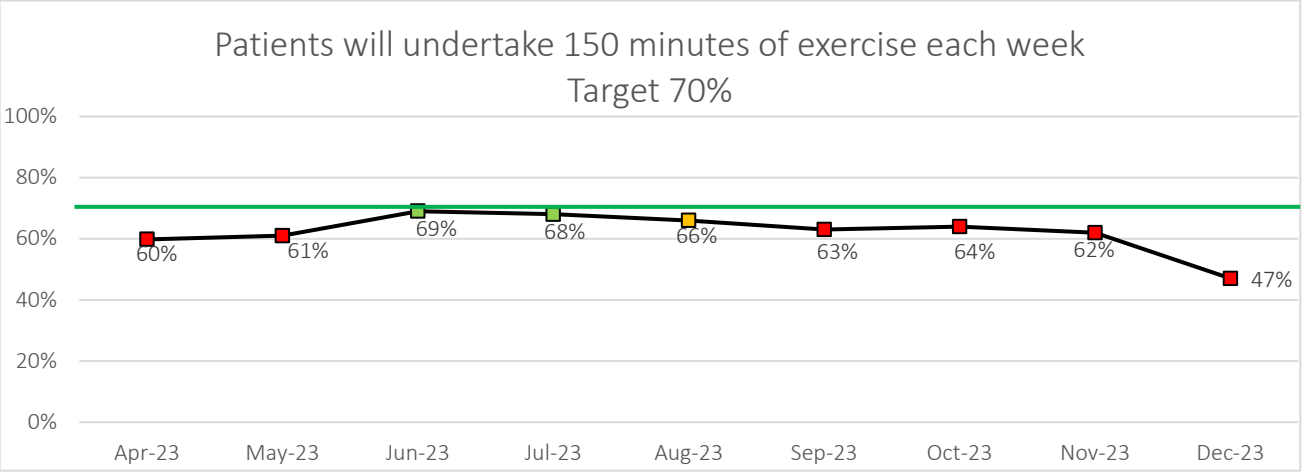
As at 1 April 2022, this KPI was amended to incorporate the uptake of an annual physical health review by all of our patients, rather than the previous data collection of an offering of a review. This KPI now charts the completion of an annual physical health overview by the Practice Nurse. The Practice 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 Q3, 100% of patients who were eligible for an annual physical health review were reviewed by the Practice Nurse. Out of these 25, 22 were reviewed in addition by the GP. Three patients did not attend their face-to-face consultation due to 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: 47%
Performance Zone: Red

This links with national activity standards for Scotland. This measures the percentage 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.

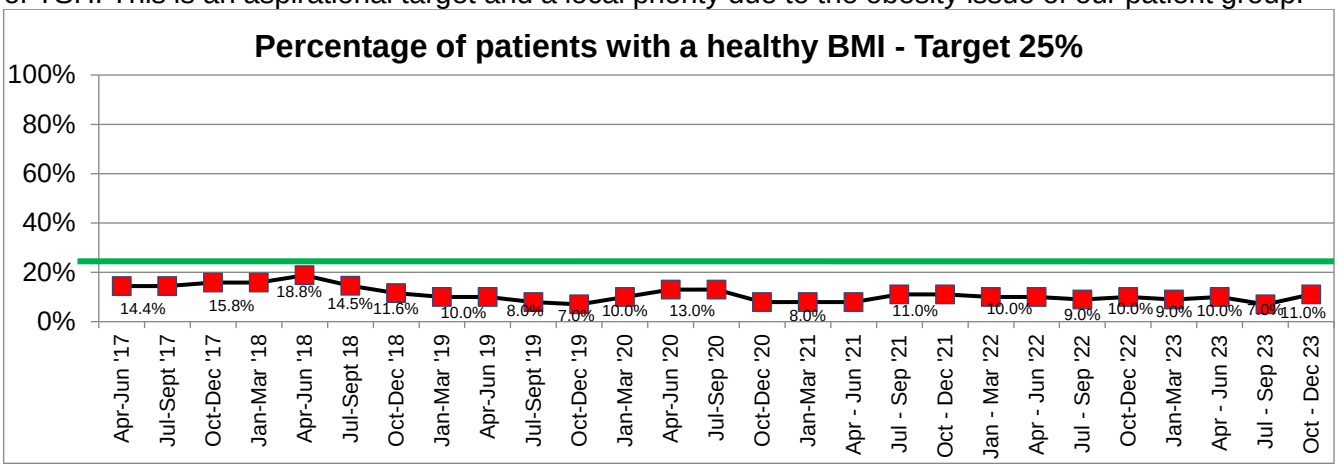
This data is recorded and calculated when patients participate for more than 10 minutes of moderate activity and does not include patients being escorted / or using grounds access to and from the Skye Centre (unless it has been agreed by the patient's keyworker). It does include all other types of physical activity as per the timetable e.g. escorted walks, grounds access, football, hub gym.

During December 2023, levels of patients achieving the physical activity target reduced to similar levels recorded for the same period in 2022. Linked working is being developed across the Activity Oversight Group, the Supporting Healthy Choices group and the PHSG to share awareness of and better support, activity projects and longer term seasonal timetabling.

No 6: Patients will have a Healthy BMI

Target: 25%
Data for current quarter: 11%
Performance Zone: Red

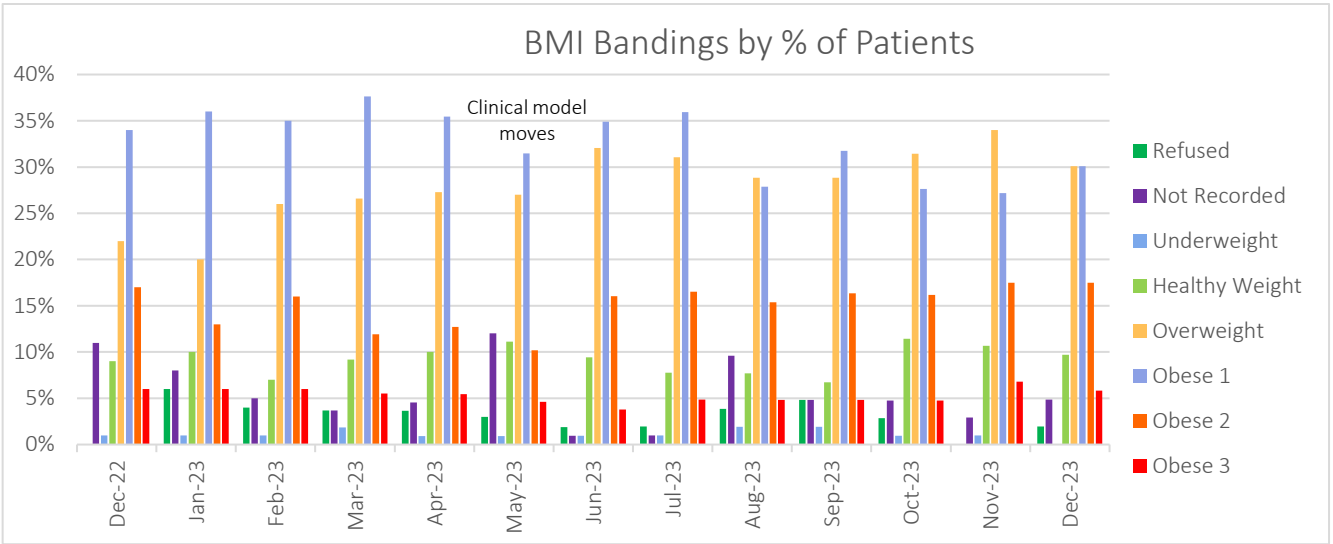
This correlates towards the national target from the care standards as well as a corporate objective of TSH. This is an aspirational target and a local priority due to the obesity issue of our patient group.



During this quarter, 6 patients moved down to a healthier BMI band however 4 did not maintain this weight loss and moved back up to their previous BMI banding by the following month.

Review work ongoing 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 20 patients that have completed the first 12-month cycle, 5 (25%) have met the local KPI by remaining under the 5% weight gain target.

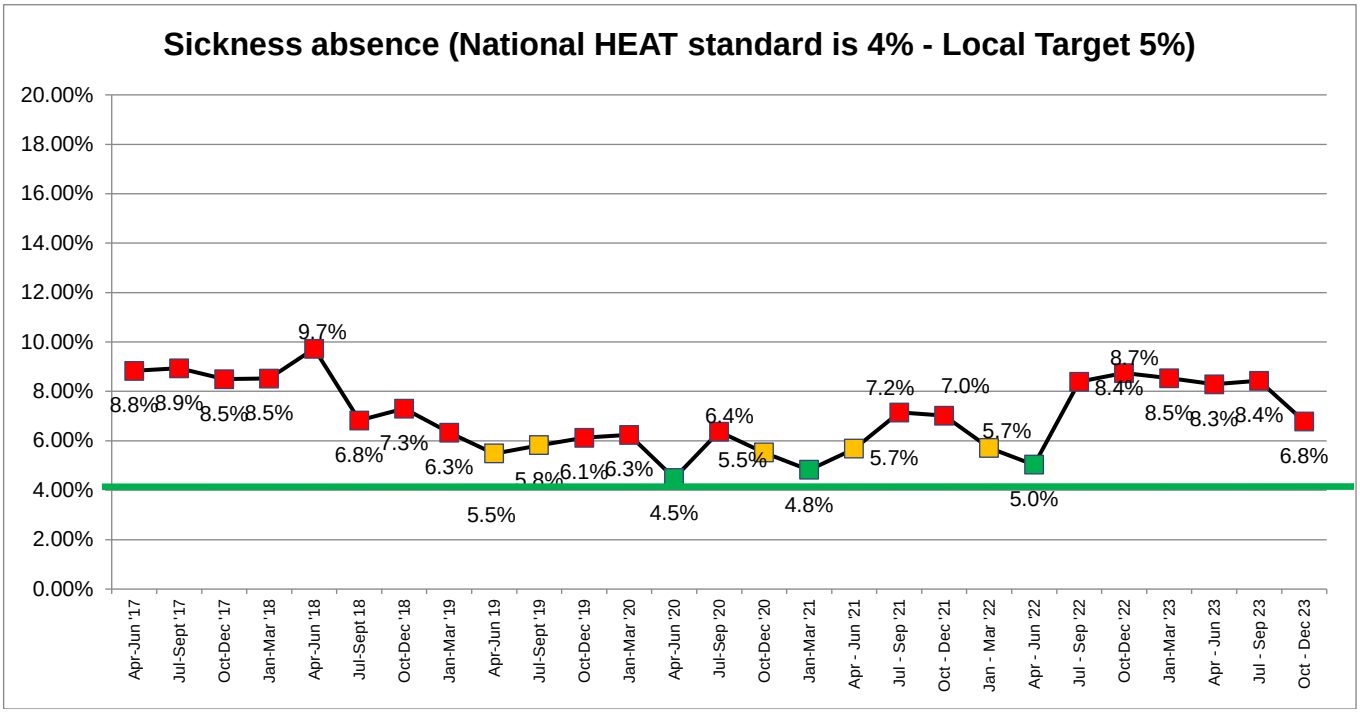
Dietetics, Clinical Quality and SHC are also working to address issues regarding the completion of monthly weight recording by wards in compliance with guidance which has been impacting data collection.



No 7: Sickness Absence (National Heat Standard is 4% - Local Standard Is 5%)

Target: 5%
Data for current quarter: 6.79%
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 including the Corporate Management Team and ultimately Staff Governance Committee. Reasons for short term absence are anxiety / stress / depression, cold / flu, back problems and for long-term absence remains as anxiety / stress / depression and musculoskeletal / injury / fracture and back problems. In addition to 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 and 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 and Q3. This group reports to the Staff Governance Committee and will provide regular updates to the Partnership Forum, Workforce Governance Group and Corporate Management Team. The Task and Finish group review data, by department, in relation to percentages and wte absence trends. There remain four key area of focus at this point which are: Ward Nursing, Skye Centre, Security and Housekeeping. The group consider any changes in data and trends to respond appropriately to any other departments which may need specific focus, however, at present it is believed that the correct departments are represented in the group.

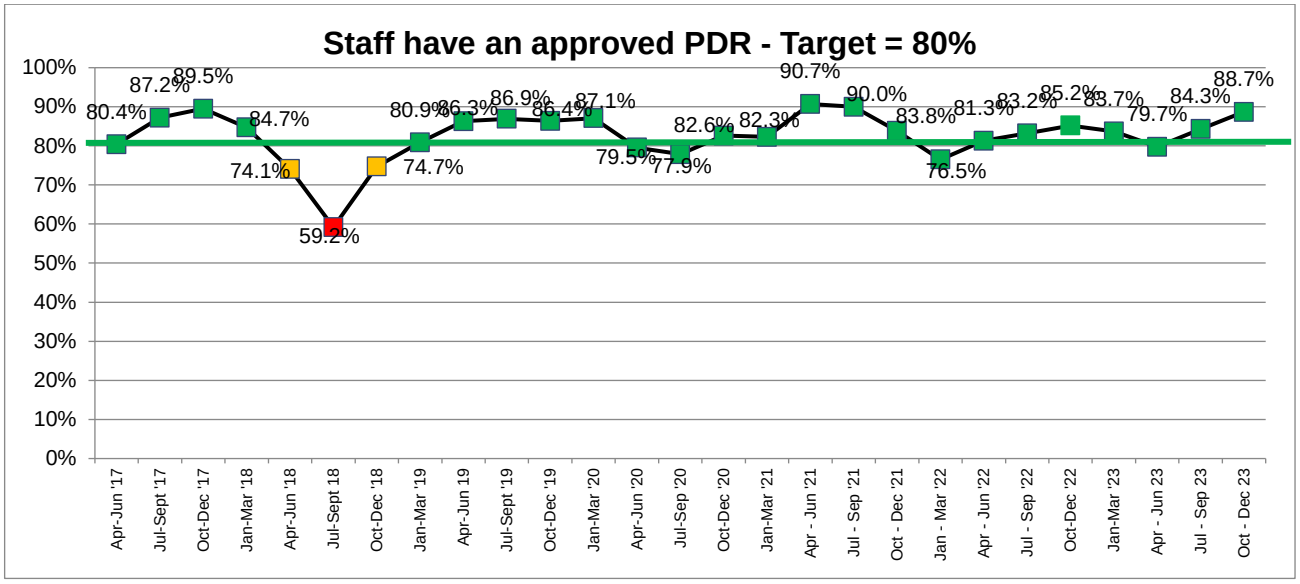
Several actions are underway with oversight from the Task and Finish Group and include:

- Development of a driver diagram to establish key action areas
- Focus on 'return to work' meeting compliance levels
- Review of supportive measures for staff to returning to work, including reasonable adjustments guidance and temporary placement guidance for employees who may require an alternative role, support plans
- Establishment of weekly meetings (in some focus areas) between partnership and managerial teams with support from HR
- Discussion with Occupational Health on targeted support to specific areas and the management referral process for employees.
- Reestablishment of regular review meeting with Occupational Health and Lead Nurses
- Development of 'assistance prompt' questions for first in line managers undertaking absence interviews and receiving calls from people who absent from work
- Monitoring the use and compliance with the absence policy trigger stages, noting that there is an increase in formal stage meetings in 23/24 compared to last year
- Training for frontline managers and enhanced HR support. 30 sessions have taken place to date
- Consideration of the 'wellbeing offer' for staff to ensure organisational support enables employee to optimise their attendance
- Line managers requested to evidence that reflective conversations are taking place with people who absented over the festive period, to identify any trends and agree actions as appropriate in response to this
- Development of further communications across the hospital in relation to the increase in absence over the winter months

No 8: Staff have an Approved PDR

Target: 80%
Data for current quarter: 88.7%
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.

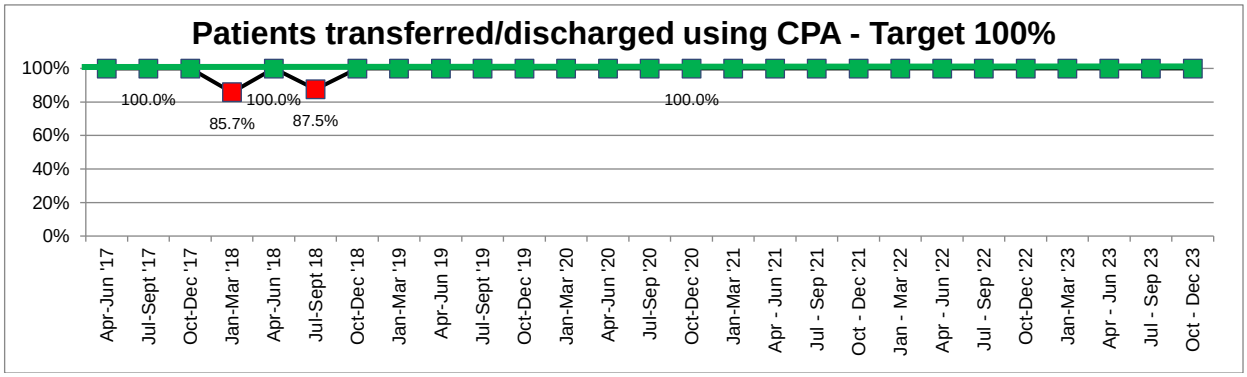


This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In October 2023 the compliance was 86.5%, November 2023 was 88.3% and December 2023 was 91.3% giving a quarterly compliance of 88.7%, which is a continued increase from 79.74% in Q1 and 84.3% in Q2. 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

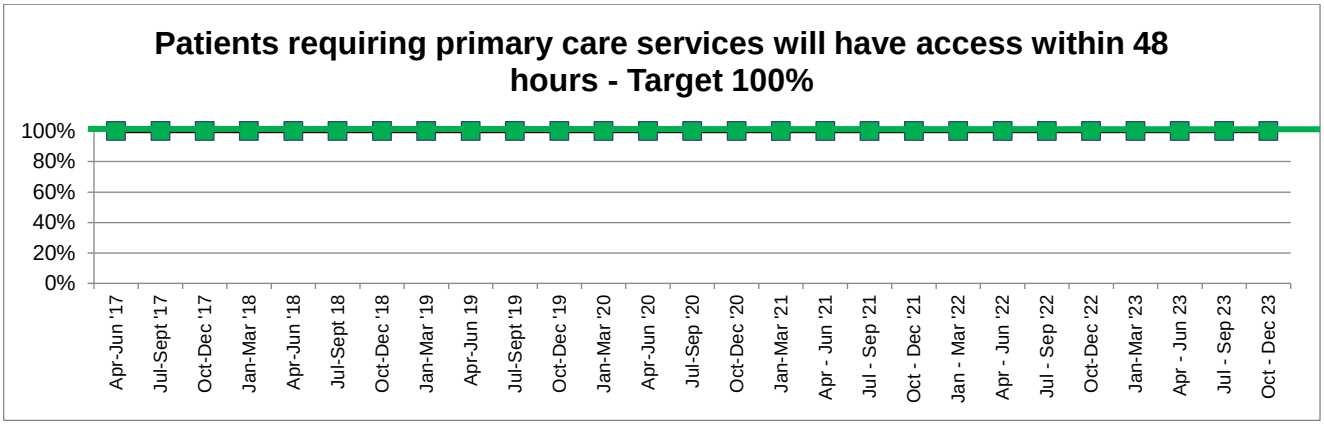
The indicator is linked to the Mental Health Act, 2003 and the streamlining of discharges and transfers. The number of patients transferred out using CPA process are measured through this indicator.



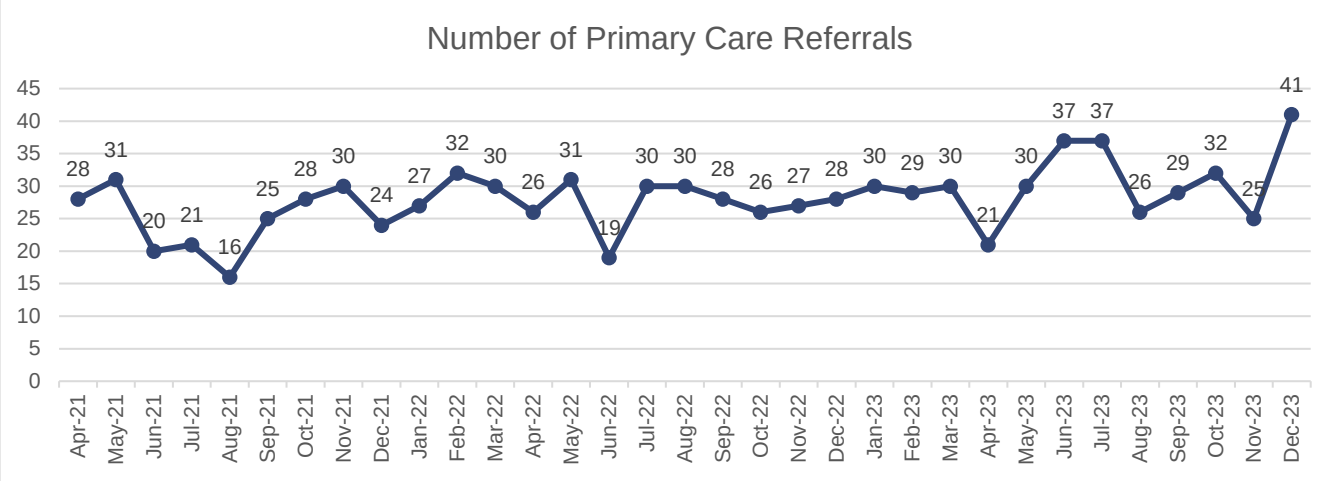
No 10: Patients Requiring Primary Care Services Will Have Access within 48 Hours

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.



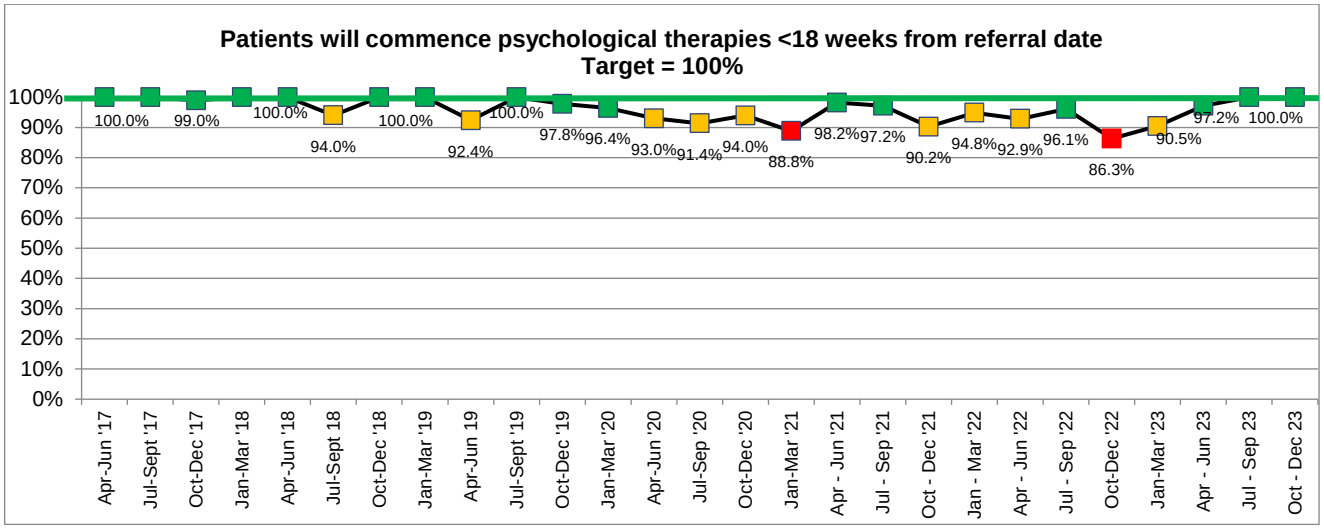
All referrals made to the Health Centre have been actioned within 48 hours. The referrals are triaged when received and onward referral to the most appropriate specialist. These have been actioned by a range of practitioners, including the GP who attends for 2 sessions per week and the Practice Nurse.



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.

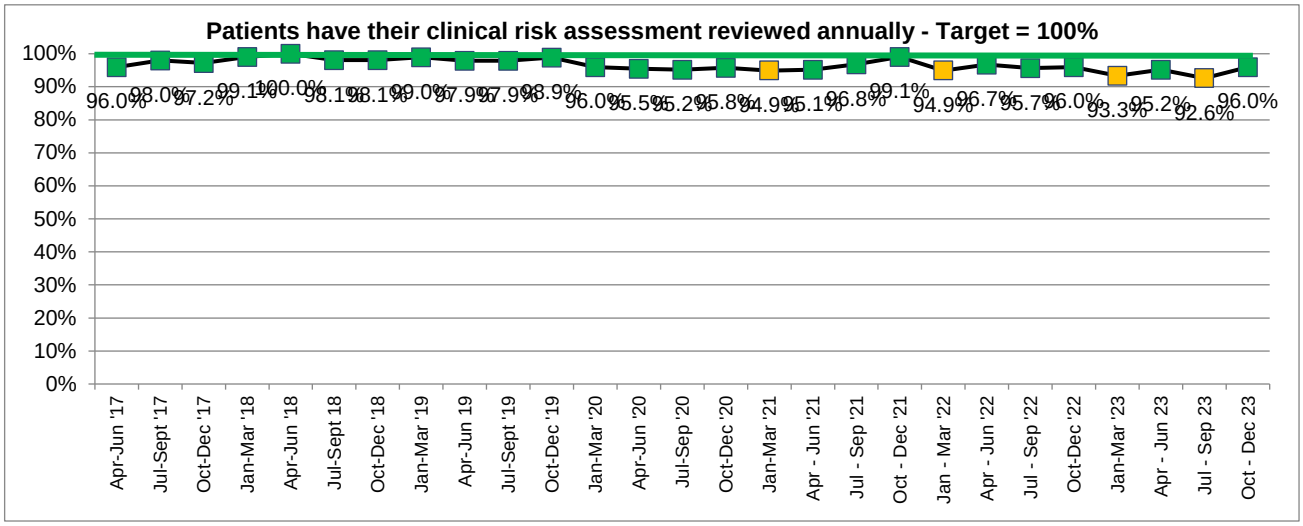


There were no patients waiting beyond the expected referral timeframe to commence psychological therapies during Q3. All patients who are waiting for a therapy should still have regular contact with their psychology team and during their pre-CPA interviews.

No 13: Patients have their Clinical Risk Assessment Reviewed Annually

Target: 100%
Data for current quarter: 96%
Performance Zone: Green

The indicator links with the Mental Health Care and Treatment Act Scotland, 2003. Examples of clinical risk assessments would be a HCR20 / SARA.

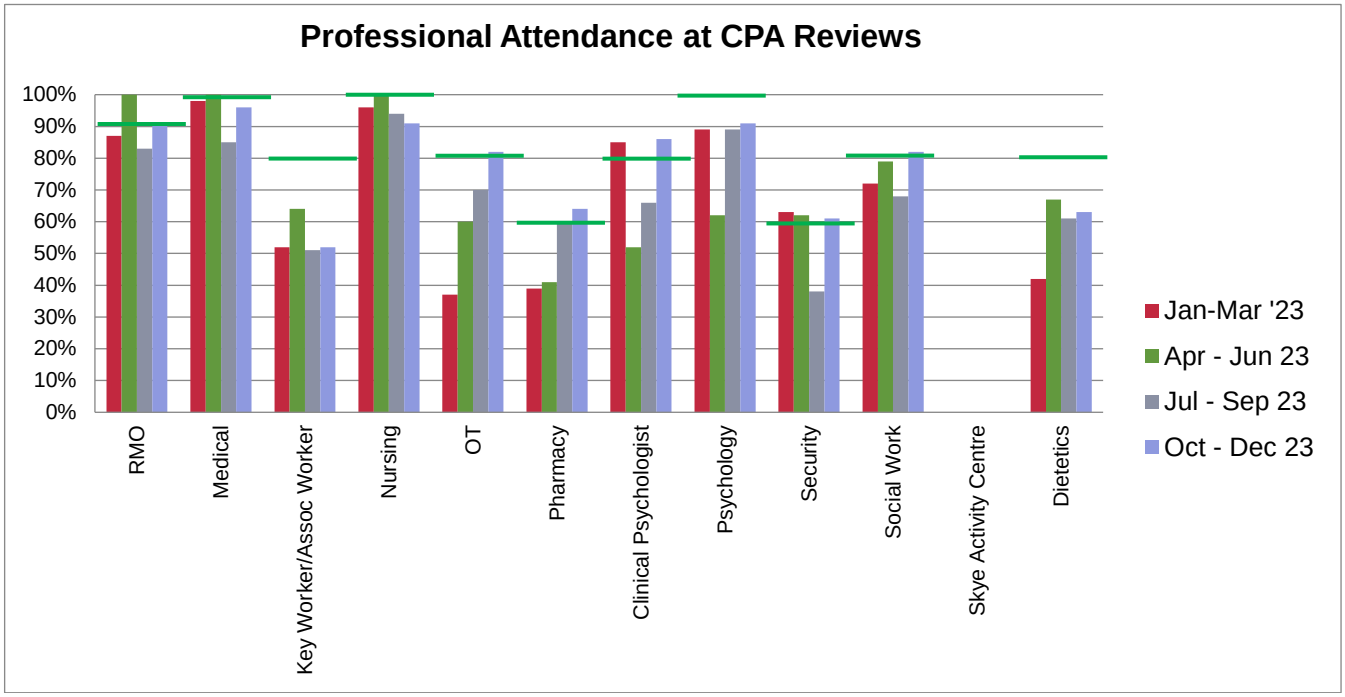


During Q3 there was a reduction in the number of risk assessments which were not closed off within RiO by their expected submission date.

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	Oct 23 n=14	Nov 23 n=21	Dec 23 n=9
RMO	71%	100%	100%
Medical	86%	100%	100%
KW/AW	36%	52%	78%
Nursing	86%	91%	100%
OT	93%	81%	67%
Pharmacy	64%	52%	89%
Psychologist	86%	91%	78%
Psychology	93%	95%	78%
Security	29%	71%	78%
Social Work	71%	91%	78%
Dietetics	71%	75%	20%

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 increased from 83% to 91% in Q3. This indicator moves in to the green zone for this quarter. There were 2 occasions where the VAT was not completed.

Medical – this profession returns to the green zone for this quarter, increasing from 85% in Q2 to 96% in Q3.

Key Worker/Associate Worker – attendance figures increased from 51% to 52% for this quarter. On the 17 occasions where a key worker / associate worker was unable to attend the CPA, a nursing representative attended in their place.

Nursing – during Q3, nursing attendance decreased from 94% to 91%; this profession remains in the amber zone.

OT – attendance has continued to increase during Q3 from 70% to 82% with OT moving into the green zone for this quarter. This can be mainly attributed to staff sickness within the department.

Pharmacy – attendance for this quarter has continued to increase from 60% to 64% meaning this profession remains in the green zone. Lack of attendance can be attributed mainly to staff annual leave and workload.

Clinical Psychologists – this profession's attendance has continued to increase from 66% in Q2 to 86% in Q3. This indicator moves to the green zone. One instance where the VAT form was not completed and a combination of annual leave, sick leave and training made up this percentage.

Psychology – this professions attendance has continued to increase to 91%. This profession therefore moves into the amber zone. On 6 occasions where the Psychologist was unable to attend, a Psychology representative attended in their place for 2 of these.

Security - attendance from security has increased this quarter to 61%. Security moves into the green zone. This can be attributed to staff annual leave and off duty.

Social Work – attendance has increased in Q3 from 68% to 82% therefore this profession moves into the green zone. This can be attributed to staff annual leave and sick leave.

Dietetics – attendance from dietetics has increased from 61% to 63%. This profession remains in the red zone. This can be attributed staff annual and sick leave.

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

Paper No. 24/15

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 February 2024
Agenda Reference:	Item No: 20
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Director of Finance and eHealth
Title of Report:	Network & Information Systems Review
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

3.1 2023 OUTCOME

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.

Our review submission was successful in achieving an extremely positive outcome.

The overall assessment was 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.

3.2 NEXT STAGES

The NIS lead and team are now considering the areas for development, and a plan will be put in place in 2024 to address these in advance of this year's review – the date of which is to be confirmed.

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 is now being reviewed between the NIS and Risk teams for a plan to be put in place to take it forward.

Once again, once our plan is in place, the relevant actions will be tracked by the monitoring group, with full engagement by regular in-person meetings.

4 RECOMMENDATION

The Board is to note the report.

Paper No. 24/15

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:	22 February 2024
Agenda Reference:	Item No: 21
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Programme Director
Title of Report:	Perimeter Security and Enhanced Internal Security Systems Project
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

From a governance and oversight perspective, the following schedule of control and interface points between TSH and Securitas UK are in place:

- Daily *(Mon – Fri)*: Site operational meeting
- Weekly: 'Look ahead' meeting
- Twice monthly: Strategic Oversight Group
- Monthly: Project Oversight Board

The scheduled Project Oversight Board meeting of 18 January 2024 was postponed following an 'in person' exceptional meeting of the Strategic Oversight Group which took place that day. This involved the senior members of the Project Team, the Security Director, the Chief Executive and the UK General Manager of Securitas meeting in person. A further strategic meeting took place on 8th February.

The next Project Oversight Board is scheduled for 21st March.

3. ASSESSMENT

a) General Project Update:

The project is in the final stages. All quality targets are being met; project timescales have moved further (see Project Timescales for a detailed overview of current progress at 3b below) and costs are projected to overspend (See Finance – Project Cost at point 3c below).

b) Project Timescales

Programme revision 55 has been accepted and forecasts completion in July 2024; this includes a two week contingency "float".

As above, an exceptional meeting was held on 18 January 2024. The timescales and resources required for Revision 55 were discussed in detail with the Securitas General Manager UK. This in person meeting was attended by the CEO, Director of Security, Programme Director and Thomson Gray representatives. TSH made clear to Securitas their expectations and the future funding challenges for 2024/5 and sought assurance that Securitas would review the proposed programme and where possible bring elements of delivery forward without detriment to quality. Securitas also highlighted that the TSH Project was an organisational priority for completion and Adam Norris was reporting directly on progress to the European Directorate.

Firm proposals from Securitas for reducing the programme duration are, at time of writing, awaited.

The installation of technology is substantially complete and currently forecast for completion in May. The elements of the project forecast to run over the financial year end are final elements of installation, Site Acceptance Testing of the installation and production of documentation. Some CCTV issues still require resolving, though significant progress has been made; difficulties in addressing these issues have been the primary cause of programme delay.

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 £653k, 6.9% of the projected final cost. This has increased by approximately £20k since the December report to the Board.

The key project outline at the end of January 2024 is:

Project Start Date:	April 2020
Planned Completion Date:	July 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:	£9,444,857
Total costs to date (exc. VAT & retention) at 08/12/23:	£9,191,727
Total costs to end of project (Exc. VAT & retention)	£ 253,130

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 letter to Scottish Government was issued week commencing 29 January 2024 as part of the financial planning for 2024 – 2025 outlining the projected spend from April 2024 to anticipated end date and a response is expected in the coming weeks.

A Rounded breakdown of actual spend to date (Exc. VAT) at the end of January 2024 is:

Securitas	£ 7.269m
Thomson Gray	£ 1.013m
Doig & Smith	£ 0.008m
HVM	£ 0.192m
Staff Costs	£ 0.805m
Income	-£ 0.094m
Total	**£ 9.192m**

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. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND **ARC(M) 23/04**

AUDIT AND RISK COMMITTEE

Approved Minutes of the meeting of the Audit Committee held on Thursday 28 September 2023.

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

Chair:	
Non-Executive Director	David McConnell
Present:	
Non-Executive Director	Stuart Currie
Employee Director	Allan Connor
Non-Executive Director	Pam Radage
In Attendance:	
External Auditor, KPMG	John Blewett
Internal Auditor, RSMUK	Victoria Gould
Head of Risk and Resilience	Allan Hardy
Internal Auditor, RSMUK	Asam Hussain
Director of Finance and eHealth	Robin McNaught
Board Chair	Brian Moore
Personal Assistant	Julie Warren (Minutes)

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting, and apologies were noted from Ms Monica Merson, Head of Planning and Performance, Mr Michael Wilkie, External Audit Director at KPMG, Ms Margaret Smith, Board Secretary and Head of Corporate Governance, Mr Gary Jenkins, Chief Executive Officer, Mr David Walker, Director of Security, Estates and Resilience.

Mr Allan Hardy, Head of Risk and Resilience was noted to be in attendance for the full meeting on behalf of Mr Walker.

2 CONFLICTS OF INTEREST

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

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 22 June 2023 were approved as an accurate record of the meeting.

The Committee:

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

4 MATTERS ARISING – ACTION PLAN UPDATE

There were no additional urgent matters which arose for discussion.

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

Members were content to note all actions as complete and closed.

The Committee:

1. Noted the updated action list.

INTERNAL AUDIT

5 AUDIT FOLLOW-UP PROGRESS REPORT

Members received and noted the Audit Follow-Up Progress Report which Mr Hussain gave an overview of. He advised that the internal audit plan for 2023/24 was approved by the Audit and Risk Committee in June 2023 and that this report provided an update summarising the results of the work to date. Of note, was that the Environmental, Social and Governance Review Report (ESG) had been issued since the last Committee meeting and was on today's agenda for discussion and noting. Secondly, one further audit was underway i.e. new Clinical Model, and would be presented to the next meeting in January 2024.

Mr Hussain advised of a typo on page 4, where it referred to the ESG Review to be presented at the Audit and Risk Committee in November 2023 – this should read September 2023 and would be amended on further iterations of this progress report.

Members noted the timetable for delivery of the 2023/24 Internal Audit Plan as set out in Section 2 of the report, and were content to note the main change with the Security Review being pushed back to Quarter 4, and agreed there were no challenges to this change in timing , as related to the actual timetable of the main project under review.

The Committee:

1. Noted the Audit Follow-Up Progress Report.

6 AUDIT TRACKING REPORT

Members received and noted the Audit Tracking Report which detailed progress made in respect of previous internal audit findings and agreed management actions. Mr Hussain provided a summary of the report and advised that, of the 19 actions live on the tracker, three were not due until 31 December 2023, though were on track. Of the remaining 16 where implementation dates had passed, updates had been provided by management for all actions.

The Committee acknowledged the Actions with new revised target dates for the Incident Management Report ref 3.22/23 and Clinical Observations Report ref 4.19/20 and took assurance from the findings and management action narrative described within the report, given that both actions were in the process of being implemented.

Mr Currie thanked the Internal Auditors for including the progress percentages he had previously requested to be detailed and agreed they now provide a clear snapshot of information and was a good development.

The Chair thanked Mr Hussain and Ms Gould for their report. Members noted the overall positive picture, the progress made to date, and reasons for incomplete and deferred action items.

The Committee:

1. Noted the noted the Audit Tracking Report.

7 ENVIRONMENTAL, SOCIAL AND GOVERNANCE REVIEW REPORT

Members received and noted the Environmental, Social and Governance (ESG) Review Report which Ms Gould provided a summary of. She advised that although this was an advisory review, it provided a positive reported position given the limited resources the State Hospital had, with only

two medium actions raised and no gaps identified. She further advised that actions taken to date were also of a positive nature in terms of required future steps.

Mr Hardy welcomed the helpful report and provided updates on the two medium actions identified. Firstly, he acknowledged there was 13% still to obtain and achieve sustainability and although the State Hospital were in a good place, there were areas of work to progress. Secondly, a proposal for a single person sustainability role was escalated to the Corporate Management Team for consideration and approval.

Mr Currie commented that the actions taken thus far with the move towards sustainability were not to be underestimated, and he was particularly pleased in terms of the reduction of CO2 emissions with the cutback on large numbers of people travelling to onsite meetings as a result of the pandemic, and the more economical option of virtual meetings. He further commented that he felt it to be an important factor in terms of recruitment to take forward sustainability actions. He supported the proposal for the sustainability role as mentioned above, to improve work this area. Mr Currie suggested that 'sustainability resources and overview' could be considered as an item to the Board agenda to continue discussions and oversight in this area.

Ms Radage commented this was an interesting report and acknowledged that The State Hospital were in a more positive position than many other hospitals in Scotland. She questioned if the requirement for the Sustainability Coordinator role was from an external or internal network, and if the timing of the dedicated Officer role i.e. recorded as March 2024, was for decision or actual recruitment to be in place, and if the timing stated was reasonable. Mr Hardy advised that the proposal for this part time post had been requested and would sit under the Director of Security, Estates and Resilience Directorate, though discussions were ongoing at this time. Lastly, Ms Gould advised that the deadline for 31 March 2024 was to include management consideration, decision and actions taken.

Mr Moore reminded members that Ms Cathy Fallon, Non-Executive Director was the Board Non-Executive Climate Change and Sustainability Champion. He suggested that it may be a suitable time to test if any local Champions would be interested in this area and it may be an avenue worth exploring, at both a local in hospital and Board Executive level.

The Chair acknowledged the very interesting and useful report which, although an advisory piece, provided reasonable assurance. He further acknowledged these matters were a "moveable feast" both locally and at a national level, with a key area at national level being the introduction of green vehicles and when to stop utilising non-environmentally friendly vehicles. Positively, The State Hospital was in a good position in this area, as outlined in the report. It was suggested in discussion that an action could be taken forward via the Communications Department to promote how well the organisation were doing and to ask for any volunteers for local champions. Mr Hardy advised this action was already part of the Communications Workplan and was being taken forward. Mr Hardy further advised that the hospital were currently utilising electronic vehicles on site and there was a plan in place on how to take forward the issue of older vehicles, in particular the ambulance which is suited to patient needs. Mr Currie acknowledged the point made around the patient ambulance and the move to net zero and the initial costs inherent in reducing carbon emissions..

The Chair thanked the Committee for the useful discussion in this area and positive progress made. In terms of the later agenda item 'sharing any relevant points with other Board Committees' the Chair suggested that rather than share with full Committees, the report be shared with other Non-Executive Directors who are not members of this Committee. Secretariat agreed to take this forward.

Action: Secretariat

<u>The Committee:</u>

1. Noted the Environmental, Social and Governance Review Report.

2. Agreed to share content of report with Non-Executive Directors who are not members of this Committee.

INTERNAL CONTROL AND CORPORATE GOVERNANCE

8 CORPORATE RISK REGISTER

Members received and noted the Corporate Risk Register (CRR) update which Mr Hardy gave an overview of. He advised that all risks were in date with none due for review. In addition, he provided detailed summaries for all medium risks i.e. HRD111 – Deliberate Leaks of Information, HRD112 – Compliance with Mandatory Level 2 PMVA Training and CE14 – The risk that 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.

Mr McConnell made reference to HRD111 and questioned if these issues were still occurring and Mr Hardy provided assurance around the governance structures in place in this area.

Mr Moore advised that previous reports had made reference to local risk registers (LRR) and queried the status of this. Mr Hardy advised this was the case and an update would be provided to the Board meeting in October 2023.

The Committee:

1. Reviewed the current Corporate Risk Register and accepted this as an accurate statement of risk.

2. Agreed that no additional information was required to be detailed in future reports.

9 FRAUD UPDATE

Members received and noted the Fraud update which provided the Committee with detail of fraud allegations and notifications received from Counter Fraud Services. Mr McNaught advised there had been five alerts received through national notifications this quarter, which were circulated site wide via a Staff Bulletin and uploaded to the Counter Fraud section in the home page of the intranet. He further advised that no issues of concern had been raised in the last quarter.

The Committee:

1. Noted the Fraud Update Report.

10 FRAUD ACTION PLAN

Members received and noted the Fraud Action Plan which demonstrated the proactive approach to tackling financial crime within the organisation. Mr McNaught advised that the two main fraud risks at the State Hospital were in the areas of procurement and sickness absence, both addressed by the introduction of two virtual sessions which will run by Counter Fraud Services. In terms of communication, The State Hospital completed the Board's Fraud Standard Statement for 2022/23 and this had been submitted to Counter Fraud Services as required.

Ms Radage asked if Non-Executive Directors would be involved in the future virtual presentations mentioned in the paper, which were aimed at HR staff and nominated investigation managers involved in internal investigations under the new Once for Scotland Workforce Investigations Policy. She felt it would be beneficial to Non-Executive Directors given the potential of being involved in any future investigations. Mr McNaught agreed to take this forward and confirm the position.

Action: Mr Robin McNaught

The Committee:

1. Noted the Fraud Action Plan.

11 CYBER CRIME REPORT

The Committee received and noted the report on Cyber Crime which was presented by Mr McNaught who advised that the organisation continued to maintain active cyber security monitoring and alerting both locally and nationally. He advised that the hospital was also notified by NHS Scotland National Cyber Security Operations Centre (NHSS NCSOC) and the National Cyber Security Centre (NCSC) of any active alerts or concerns. The alert status for a cyber-attack in the UK continues to be high. Mr McNaught further advised that security systems in place were appropriate and the IT Department were extremely vigilant in this area and quick to notify and update staff. He highlighted areas of unseen work within the eHealth Department relating to updates required in response to potential security issues. These involved strict and challenging time constraints but staff were focused on addressing these together with their normal duties. Members noted the content of the positive report.

The Committee:

1. Noted the Cyber Crime Report.

12 POLICY UPDATE

Members received and noted the Policy Update Report which provided a six monthly overview report from the Policy Approval Group (PAG), which was the final approval group, with overall responsibility for policy implementation sitting with the Audit and Risk Committee.

Mr McNaught advised that as of 19 September 2023 the State Hospital had 116 locally implemented policies. Since the last report, six policies had been archived, either due to conversion to guidance or through being superseded. There were five policies past their review date. Four of these sit within the Security, Estates and Resilience Department. PAG continue to encourage policy owners to progress policy reviews in a timely manner. The paper included a detailed breakdown by the Accountable Executive Director of the current policies past their review dates and those due for review by 31 March 2024.

Ms Radage commented that not much movement had been made with four policies which sat under the Security, Estates and Resilience Department, particularly Estates. She asked after what period of time do these stop being policies and become procedures. Mr McNaught advised that a discussion had been held earlier in the week in relation to policies becoming procedures and that discussions with the Director of Security, Estates and Resilience would continue on his return to ensure progress. Mr Hardy highlighted that attempts had been made to align policies though this can be a complex process. He further advised that the Head of Estates was ensuring that progress was being made.

The Committee:

1. Noted the Policy Update Report.

EXTERNAL AUDIT

13 AUDIT FOLLOW-UP PROGRESS REPORT

Mr Blewett provide a verbal update on External Audit Progress and advised that this was a quieter time of year given that external audit papers were signed off earlier in June 2023. He advised external audit was gearing up for a planning meeting in November to prepare for 2023/24 audit work and that a draft plan would be submitted to the Committee in January 2024.

The Committee:

1. Noted the verbal update from External Audit.

INTERNAL UPDATES FOR INFORMATION

14 SECURITY, RESILIENCE, HEALTH AND SAFETY OVERSIGHT GROUP UPDATE

Members received and noted the report summarising the work of the Security, Resilience, Health and Safety Oversight group and to provide assurance to the Committee that robust arrangements were in place for monitoring and reviewing the effectiveness of management arrangements within the Board.

The Committee:

1. Noted the Security, Resilience, Health and Safety Oversight group update.

15 FINANCE, EHEALTH AND AUDIT GROUP UPDATE

Members noted the update from Finance, eHealth and Audit Group. Mr McNaught confirmed that both groups were addressing business as per their own Terms of Reference and that there were no matters highlighted which were deemed to require escalation to the Committee for consideration.

The Chair acknowledged and appreciated the work of both above groups.

The Committee:

1. Noted the Finance, eHealth and Audit Group update.

16 DRAFT COMMITTEE WORKPLAN 2024

Members received the draft Workplan for 2024, to which the Committee discussed agreed.

The Committee:

1. Agreed the Committee Workplan for 2024.

17 REVIEW OF EFFECTIVENESS OF COMMITTEE

Members received and noted the report on the review of the effectiveness of the Audit and Risk Committee. The Chair thanked members for completing the survey and noted the overall positive and useful report, which covered significant areas of the Terms of Reference. Though it was a positive report in general, Mr McConnell highlighted the issues noted for further discussion.

In relation to fixed terms appointments, Mr Moore advised he recently confirmed with Non-Executive Directors that they were content with such fixed term memberships across all Board Committees. In addition, he confirmed that members were sufficiently independent of other Committees to ensure independence. Lastly, he advised that, looking beyond this Committee, an external evaluation would be undertaken in terms of the Blueprint for Good Governance. Thereafter it would be taken forward for discussion at a Board Development Session. The Committee indicated they were content with this confirmation.

In terms of the survey process itself, Ms Radage queried if the format of the report had been received from the Scottish Government. She felt there was no qualitative data within the report to review its effectiveness and felt it was missing data in order to take action. The Chair echoed this point and highlighted that due to the electronic system, members were unable to comment at each stage rather the end stage, and agreed to feed these points back to the Board Secretary.

Action: Ms Smith

Lastly, Mr McConnell advised this was a useful report which would feed in to next year's Annual Report.

The Committee:

1. Noted the report on Review of Effectiveness of the Committee.

18 ANY RELEVANT ISSUES ARISING TO BE SHARED WITH GOVERNANCE COMMITTIEES

As recorded under item 7 above, for wider sharing, the Environmental, Social and Governance Review Report would be distributed to Non-Executive Directors who are not members of this Committee for their awareness.

Action: Secretariat

19 ANY OTHER BUSINESS

There was no further competent business raised for discussion at this meeting.

20 DATE OF NEXT MEETING

The next meeting will take place on Thursday 25 January 2024 at 9.45am via MS Teams.

End of meeting 1115 hours.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 February 2024
Agenda Reference:	Item No: 22
Title of Report:	Audit and Risk Committee – Highlight Report
Purpose of Report:	For Noting

This report provides the Board with an update on the key points arising from the Audit and Risk Committee meeting that took place on 25 January 2024.

1	Internal Audit	The Committee received progress reporting on audit activity for the current year, which demonstrated that internal audit is on track against this year's plan, with preparatory work underway for 2024/25. Internal auditors presented an updated tracking report, which evidenced good progress on audit actions from management. The Committee received and noted an internal audit report on the management of patient monies that recorded reasonable assurance on the areas examined.
2	External Audit	The External Auditors reported that work was progressing well on the 2023/24 audit work, including an Indicative External Audit Plan.
2	Corporate Risk Register	The Committee received a report on the position on the Corporate Risk Register, highlighting recent updates including the position on risks rated as high and risk distribution. The Committee discussed the way in which the need to reach a breakeven position within a balanced budget should be represented within the Corporate Risk register going forward, including consideration of the financial pressures that may impact the ability to mitigate risks.
3	Climate Emergency and Sustainability	The Committee received and approved the annual report of Climate Emergency and Sustainability for 2023/24, and noted that this would be shared with the whole Board prior to submission to Scottish Government at month end. This presented a positive position on achieving 2030 targets as well as a route map to net zero, subject to available funding for the initiatives required.
4	Finance	The Committee received an update on the financial position noting that the expectation remained for breakeven for 2023/24. The Committee considered the expected pressures for 2024/25 and the need for detailed oversight through the Board and its committees within the context of a pressured financial landscape.

5	Counter Fraud	The Committee noted progress on engagement activities within this workstream; and the Board's approach to countering fraud as part of the updated Fraud Strategy within the Action Plan; and the links made by the Non-Executive Champion in this area to NHSScotland. It was noted that Counter Fraud Services would be scheduled to present to a Board Development Session. There were no amendments made to the action plan, and top 10 risks identified.
6	Cyber Crime Report	The Committee received and noted a report that confirmed that no specific risk had arisen for the organisation, with systems continuing to be successful in identifying and quarantining possible cyber threats.
7	Procurement Annual Report	The Committee received and noted the annual report representing activity throughout 2023/24, and considered the potential for collaborative working with other National Boards in particular. The Committee requested that an overview of existing Service Level Agreements be included in future reporting.
8	Legal Claims Annual Report	The Committee received and noted a high level summary of legal claims activity through CNORIS for the year 2023/24.
9	Reports from Governance Groups	The Committee received and noted update reports on their recent work from the Security, Resilience and Health and Safety Group, and from the Finance, eHealth and Audit Group.

RECOMMENDATION

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

MONITORING FORM

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