THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 23 FEBRUARY 2023
at 9.30 am, held by MS Teams
A G E N D A

9.30am			
1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 22 December 2022	For Approval	TSH(M)22/11
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 23/01
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
10 am	**RISK AND RESILIENCE**		
7.	**Corporate Risk Register** Report by the Director of Security, Resilience and Estates	For Decision	Paper No. 23/02
8.	**Infection Prevention and Control Report** Report by the Director of Nursing and Operations	For Noting	Paper No. 23/03
9.	**Bed Capacity Report:** **The State Hospital and Forensic Network** Report by the Medical Director	For Noting	Paper No. 23/04
10.30am	**** BREAK****		
11.15pm	**CLINICAL GOVERNANCE**		
10.	**Clinical Model Implementation** Report by the Medical Director	For Noting	Paper No. 23/05
11.	**Supporting Healthy Choices** Report by the Medical Director	For Noting	Paper No. 23/06
12.	**Quality Assurance and Quality Improvement** Report by the Head of Planning and Performance	For Noting	Paper No. 23/07

13.	**Clinical Governance Committee:** - Chair's Update – meeting held 9 February 2023 - Approved minutes of meeting held 10 November 2022	For Noting	Verbal CGC(M) 22/04
14.	**Clinical Forum** - Chair's Update – meeting held 17 January 2023 - Approved minutes of meeting held 29 November 2022	For Noting	Verbal CF(M) 22/04
11.50am	**STAFF GOVERNANCE**		
15.	**Workforce Report** Report by the Director of Workforce	For Noting	Paper No. 23/08
16.	**iMatter Report** Report by the Director of Workforce		Paper No. 23/09
17.	**Whistleblowing** **(a) Whistleblowing Champion – Annual Update** **(b) Quarter 3 Report** Report(s) by the Director of Workforce	For Noting	Paper No. 23/10 Paper No. 23/11
18.	**Staff Governance Committee** - Chair's Update – meeting held 16 February 2023 - Approved minutes of meeting held 17 November 2022		Verbal SGC (M) 22/03
12.20pm	**CORPORATE GOVERNANCE**		
19.	**Corporate Objectives 2023/24** Report by the Head of Corporate Governance/ Board Secretary	For Decision	Paper No. 23/12
20.	**Performance Reporting:** **(a) TSH Performance Management Framework** **(b) Performance Report Quarter 3** Report(s) by the Head of Planning and Performance	For Noting	 Paper No. 23/13 Paper No. 23/14
21.	**Finance Report to 31 January 2023** Report by the Director of Finance & eHealth	For Noting	Paper No. 23/15
22.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 23/16
23.	**Board and Committee Membership** Report by the Head of Corporate Governance/ Board Secretary	For Decision	Paper No. 23/17
24.	**Audit Committee:** - Chair's Update – meeting held 26 January 2023 - Approved Minutes of meeting held 27 September 2022	For Noting	 Verbal AC(M) 22/04

25.	**Communications Update** Report by the Head of Communications		Paper No. 23/20
26.	**Any Other Business**		Verbal
27.	**Date of next meeting:** **9.30am on 27 April 2023**		Verbal
28.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
29.	**Close of Session and Reflection on Meeting**		Verbal

Estimated end at 1pm

THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 22/11**

Draft Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 22 December 2022.

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
Medical Director	Lindsay Thomson

In attendance:

Advocacy Manager	Rebecca Carr [Item 12]
Person Centred Improvement Lead	Sandie Dickson [Item 11]
Head of Social Work	David Hamilton
Director of Workforce	Linda McGovern
Head of Planning and Performance	Monica Merson
Head of Communications	Caroline McCarron
Board Secretary	Margaret Smith [Minutes]
Chair of Patients Advocacy Service	Michael Timmons [Item 12]
Director of Security, Resilience and Estates	David Walker

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone to the meeting, and apologies were noted from Dr Sheila Howitt (Chair of the Clinical Forum).

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 27 October 2022 were noted to be an accurate record of the meeting.

The Board:

1. Approved the minute of the meeting held on 27 October 2022, (Paper No. TSH(M) 22/09).

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board received the action list (Paper No. 22/109) outlining progress and confirming that updates would be presented during the course of this meeting. It was also noted as a matter arising that an update on the audit carried out by the Information Commissioners Officer would be discussed as part of the Chief Executive's update. Further, that the formal outcome of the recent visit by the Mental Welfare Commission was awaited. It was noted that a further update would be progressed around carer engagement including an overarching strategy in this respect.

The Board:

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

5 CHAIR'S REPORT

Mr Moore provided an update to the Board in relation to the main areas of focus and sessions attended since the last Board meeting.

He had attended the Patient Advocacy Service (PAS) Annual General Meeting (AGM) on 14 November, and noted that a 12-Month Report from PAS was on today's agenda. There had been two development sessions for the Board since the date of the last Board meeting, including one with internal auditors to enhance the approach to risk management. A second session had taken place for Non-Executive Directors with the Chair of National Education for Scotland (NES) focusing on the governance function of the Remuneration Committee and performance management systems.

Mr Moore expressed thanks to all staff who contributed to the Excellence Awards, which had taken place on 6 December 2022 and for making it so successful. The Chair highlighted how wonderful it was to take the opportunity to celebrate teams and individuals on a face-to-face basis.

He also advised that NHS Board Chairs had continued to meet met with the Cabinet Secretary for Health and Social Care, with key emphasis on the emergency budget and implications for Health Boards, as well as the Agenda for Change pay settlement, and the National Care Service. He noted that the Cabinet Secretary continued to chair monthly meetings with NHS Chairs and Chief Executives focusing on systems pressures, particularly delayed discharge from hospital settings.

The Chair had also attended a meeting of the Patient Partnership Group (PPG) which had been both interesting and informative.

The Vice Chair added that he attended the National Vice Chair Forum Meeting on 6 December 2022, and that discussion had included the role of the Vice Chair, as well as arrangements for Board meetings including use of hybrid technology.

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.

On 31 October, there had been a meeting with the Sharing Intelligence for Health and Care Group, who had produced a multi-sourced annual feedback report. This was led by Healthcare Improvement Scotland (HIS) and had been positive in relation to the findings. Mr Jenkins advised that, following an inspection in November 2022 from the UK Information Commissioner's Office to look at information governance and management processes, the formal report had just been received. This had awarded a

high assurance rating. A small number of minor improvements were identified and would be taken forward, with assurance reporting to the Audit Committee.

The Senior Charge Nurse (SCN) Leadership Development Programme was launched on 8 November 2022 running over six days. The programme was externally facilitated and looked at different opportunities and developments for SCNs

During November, a team from The State Hospital (TSH) had visited Rampton High Secure Hospital, to assess their model of care delivery for female patients. During this month, TSH had received a visit from a team from HMP Glasgow. A visit had also been welcomed from Mr Gavin Gray, Deputy Director for Improving Mental Health Services at the Scottish Government, along with colleagues. They had been impressed by the service model and thanked the TSH team for hosting the visit.

On 28 November 2022, the regular quarterly meeting with the TSH Sponsorship team at Scottish Government took place. Discussions at this meeting covered a number of areas including the Clinical Model, rising cost of energy, security upgrade, and workforce challenges.

Mr Jenkins confirmed that he continued to represent the Board at the regular NHS Chief Executive sessions. There had been focus on the ongoing systems pressures as well as the potential for reform and sustainability initiatives, and the National Care Service. He advised that the Chief Executives Operational Response Group had been stood back up, taking place weekly, to discuss systems pressures and concurrent risks.

In terms of the national picture on industrial action, Mr Jenkins note the position with agreement from Unite and Unison on the Agenda for Change pay offer made, whilst this had been rejected by GMB and RCN have rejected. Within TSH, a framework resilience plan had been developed in the event of potential industrial action, which could be further modified depending on how the situation progressed.

He noted that there had not been any significant development in the national position following the Independent Review into the Delivery of Forensic Mental Health Services.

Within Mr Jenkins noted the considerable work taken forward in relation to the implementation of the clinical model as well as the security upgrade project, and that the Board would receive updates as part of today's agenda.

Locally, he highlighted the opening of the patients 'Nu2U' Charity Shop on 20 December and the patient Christmas Carol event, which had taken place on 15 December 2022, and thanked everyone involved. Additionally, he thanked staff for all of their efforts and for making the Staff Excellence Awards such a successful event. Mr Jenkins had also led Directorate Performance Review Meetings in October and November, and he thanked Directors and their teams for participating.

There was discussion from Board members on systems pressures across the NHS, especially the issue of delayed discharge. It was recognised that there continued to be considerable issues, which would require a whole system approach linking current pressures to resourcing as well as wider preventative initiatives.

<u>The Board:</u>

1. Noted the update from the Chief Executive.

RISK AND RESILIENCE

7 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 22/110) from the Director of Security, Resilience and Estates, which provided an overview of the medium, high and very high risks featuring on the Corporate Risk Register.

Mr Walker presented an overview of the report for the Board. He confirmed that all risks rated as 'High" were reviewed monthly by the risk owners, and brought Risk SD54 to the attention of the Board, as it was out of date. However, review was actively underway and the Climate Change and Sustainability Group would meet in early January 2023. In the meantime the net zero report for the organisation was positive, and had been shared with Ms Fallon as the Board Champion in this area.

Mr Walker highlighted that Risk CE15, Impact of UK and Scottish Covid-19 Inquiries on TSH had been added to the register, as agreed at the last meeting of the Board remained as High, and that work was progressing in this area with a review coming to each meeting of the Corporate Management Team (CMT). Risk HRD111, Deliberate Leaks of Information, had been re-assessed as High, and that the Workforce Directorate were working closely with Risk in this respect. Mr Walker also highlighted Risk HRD112, Compliance with mandatory PMVA Level 2 Training, which had moved from Medium to Low due to the good progress made in this area.

Mr McConnell notes that it was helpful to have Risk CE15 added to the register, noting that TSH were one of a cohort of NHS Boards responding to these inquiries. Ms Fallon asked for clarification around the distinction on Risk ND333 and ND 34, and Mr Walker clarified the difference between out of hours and on call duties. She also asked for some more background on whether there was a discernible pattern in the number of reported staffing resourcing incidents given the flow of information, and Mr Jenkins advised that that this was as aspect that the Task and Finish group were taking forward. He advised that this would include review on reporting accuracy especially around the possibility of duplicate reporting.

Mr Currie commended the clear and helpful layout of the report, and Mr Moore added his agreement that this area was one that continued to demonstrate good progress.

The Board:

1. The Board reviewed the current Corporate Risk Register and approved it as an accurate statement of risk.

8 OPERATIONAL RESPONSE PLAN

The Board received a paper (Paper No. 22/111) from the Director of Nursing and Operations, which provided an update on the progress made to review the loss of staff plan, as well as related work to incident reporting of staffing issues and to monitoring of modified working in the hospital. She advised that once the Task and Finish group had finalised its work, this would be routed back to the Board as an update.

Ms McCaffrey led the Board through the details of the paper and provided feedback from a recent meeting held with the office of the Chief Nursing Officer, in relation to systems pressures. This had produced positive engagement on the initiative to provide staff exiting the organisation with a QR code as a conduit through which to give anonymous feedback on the reasons for leaving.

Mr McConnell asked about how variations in reporting was arising on staffing incidents, and Ms McCaffrey confirmed that this appeared to be a process issue. The intention was to make this more transparent so that there was clarity on trigger points for the loss of staff plan.

The Board were content to note this update.

The Board:

1. Noted the content of the paper.

9 INFECTION PREVENTION AND CONTROL REPORT (INCORPORATING COVID-19 UPDATE)

The Board received a paper (Paper No. 22/112) from the Director of Nursing and Operations, which provided an update in relation to Infection Prevention and Control Activity across TSH. Ms McCaffrey presented this report and provided a summary of the key points.

She highlighted the focus on infection prevention and control activity being considered part of business as usual, rather than being entirely focused on the covid-19 response. In particular, she drew attention to the improvement made in hand hygiene compliance and the need to sustain this over time. Further, clinical audits showed overall improvement but there were some areas below standard and these areas had action plans in place, supported at Senior Charge Nurse level.

Ms McCaffrey also asked the Board the assurance provided in relation to levels of compliance for face-fit testing for clinical staff; and the work in place through self-assessment to prepare for inspection visits by Healthcare Improvement Scotland.

Ms Fallon asked about what action it was possible to take to improve non-compliance by staff, and Ms McCaffrey outlined the way in which the Infection Prevention and Control Group encouraged local ownership and responsibility for compliance. This was a shift within the hospital, as prior to Covid-19 there had been more of a focus on responsibility perceived to lie more with the Infection Control Lead.

Mr McConnell asked whether there were any indications that there may be a change in covid measures (e.g. use of facemasks) in the near future. Ms McCaffrey noted that TSH would continue to review all national guidance in terms of how it should be implemented at a local level. She noted the need to lead in such a way to give patients, carers and staff confidence that the lifting of any existing measures was being taken forward at the right time.

Mr Moore summed up for the Board, noting that improvements had been made and this was evidenced in reporting, but there was still scope for further improvements.

<u>The Board:</u>

1. Noted the content of report.

10 BED CAPACITY IN THE STATE HOSPITAL AND FORENSIC NETWORK

The Board received a paper (Paper No. 22/113) from the Medical Director, which detailed the actions taken to monitor the bed capacity within TSH within the context of the wider Forensic Network.

Professor Thomson summarised the report, and noted that TSH remained closed to patient admitted under exceptional circumstances, given current staffing pressures. She also advised that some additional pressure be in the system due to a rolling programme of essential repairs that required to be carried out in medium secure care within NHS Lothian. In response to a question on pressures throughout the forensic estate, Professor Thomson advised that this remained a key area of focus. There was continued engagement with Scottish Government, following the Independent Review into the Delivery of Forensic Mental Health Services.

Mr Jenkins added that it would be important for progress in this regard at a national level. In the meantime TSH was not able to provide surplus capacity to meet the demand in the system; especially given the wider context of the need for patients to be cared for at the right level of security. Mr Moore asked about the time line for legal challenges in this regard; and Mr Jenkins confirmed that this was through excessive security appeals with the receiving Health Board retaining responsibility for provision of an appropriate bed. Professor Thomson outlined the context around an appeal for excessive security and added that patients admitted into TSH could not appeal for the first six-month period. .This was an area of careful clinical consideration and decision-making based on the individual patient's circumstances.

The Board noted the system pressures, and details contained within the report.

The Board:

1. Noted the content of report.

CLINICAL GOVERNANCE

11 MY VOLUNTEER JOURNEY ACROSS THE FORENSIC NETWORK

A presentation was delivered by Ms Sandie Dickson titled 'My Volunteer Journey across the Forensic Estate', which was about a volunteer visitor and their experience in this regard.

Ms Dickson outlined this journey, which had begun with monthly visits to a TSH patient. The volunteer had felt that these visits were greatly appreciated by the patient, and that she had been able to contribute to the patient's care journey. When it had been time for the patient to move to a medium secure setting, he had asked if she could continue to visit him there. Ms Dickson explained that although there had been some challenges in setting this up at first, it had been made possible. These visits then continued up until the Covid-19 pandemic, which meant a shift to virtual visiting. They had learned together as to how to make this work, and were now able to alternate virtual visits with in person visits. From the volunteer's point of view, she has continued to feel appreciated and that she is making a valued contribution to this patient's progress.

Ms Dickson also provided some feedback from the patient, who was enthusiastic about what this experience had meant for him – he had enjoyed getting ready for a visit in the hospital alongside the patients. When the time had come to move to a medium secure setting, he had been nervous. However, knowing that his volunteer visitor would move with him had been instrumental in helping him to do so. He had emphasised that she had been the only person who moved with him. Ms Dickson also advised that the medium secure setting had taken learning from this, and had also set up a volunteer visiting scheme.

Ms Fallon spoke about how touching this story was to hear, and that it showed the need for a system of additional support for patients as they move within the forensic system. Professor Thomson agreed that this service was important for patients and could make an enormous difference. Professor Thomson noted that not all volunteers would be able to make this move due to logistical considerations e.g. geographical location and asked about the existing capacity of volunteer visitors available. She also advised that she would also link this to the Forensic Network through its Inter- Regional Group to ensure awareness to help support volunteers moving with patients. Ms Dickson offered the view that there were a sufficient number of volunteers at TSH to support patients' needs, but this was something kept under review. The new clinical model would provide an opportune time to do so. There were presently around 20, and this meant that the service could be provided in a mutually beneficial way. Mr Currie noted that it was important to make sure the cohort of volunteers could be well supported. He also noted that it would be interesting to consider further how the benefit of this service was measured i.e. how could the positive impact on patients' lives be demonstrated.

Ms Radage asked if there could be a further opportunity to promote the volunteer role through social media, and it was agreed that this would be taken forward to explore this possibility.

Action – Ms McCaffrey

The Board noted the positive feedback from this story and the learning take from it.

The Board:

1. Noted the content of the presentation.

12 PATIENT ADVOCACY SERVICE; 12 MONTH REPORT

Ms Rebecca Carr and Mr Michael Timmons joined the meeting to present a detailed account of the Patients Advocacy Service Annual Report.

Ms Carr described the key achievements made by the service, highlighting success made both in meeting prescribed targets as well as areas of good practice and development within the service. She wished to highlight the wealth of experience within the team and the strong links to stakeholders across TSH. The team were able to take a flexible approach to meeting patient needs, and this had been reflected in the feedback received from patients themselves. Mr Timmons provide an overview of the organisational and service developments made to date as well as areas for future development, such as use of social media and recruiting volunteers. He underlined the importance of internal relationships with TSH staff groups so that PAS could provide the right service for patients.

Ms McCaffrey advised that she and Mr Jenkins routinely met with Ms Carr and Mr Timmons to support these relationships. Mr McConnell commented on the usefulness of the report, and asked a question about attendances by advocates at CPA and tribunal meetings as to whether there was any challenge in providing that service. Ms Carr clarified that all patients were able to access the advocacy service to support them, and that this was based on patient choice at the time.

Mr Currie offered the view that the independent nature of the service was crucial to build confidence, and that it was good to see patients engaging with PAS as a clear sign of that confidence being in place. This was also reflected in the complaints process where the number of complaints which evidenced listening and learning from patient concerns showed that the system was working. Ms Carr noted the excellent relationship with the complaint service, especially supporting patients to take forward their concerns in the way that they wished to do so. The focus on early resolution was also positive for patients.

Ms Fallon asked about whether PAS would also engage with carers, and Ms Carr confirmed that the focus was on supporting patients but that it may be useful to reflect on how contact with carers was reported in the future. She added that it was also important to remember that at times the views of patient and carers could differ and be in conflict.

Professor Thomson underlined the value that PAS added to TSH services, and asked for any reflections that PAS may have on being an independent body working within a restricted environment. She used the example of mental health tribunals as an area in which PAS were involved noting that these were currently continuing virtually using telephone lines. Ms Carr advised that in providing advocacy support to patients, it was felt within PAS that TSH provided constructive channels through which any aspect of concern from patients about their care could be raised. In relation to tribunals, she advised that PAS would concur that technical difficulties had been experienced meaning telephone lines were being used, and that a return to in person arrangements would be beneficial.

Mr Moore summed up for the Board on the positive nature of reporting, and the detailed breakdown of issues. In future reporting it would be helpful to receive more detail about patient drop-in sessions. He also commented on the patient feedback received at the Patient Partnership Groups, which demonstrated confidence on the part of patients in using PAS. He thanked Ms Carr and Mr Timmons for their helpful presentation, and for the work of the PAS team throughout the year.

<u>The Board:</u>

1. Noted the content of the report.

13 CLINICAL MODEL IMPLEMENTATION UPDATE

The Board received a paper (Paper No. 22/115) from the Medical Director, to provide an overview of the progress made on the implementation of the new clinical model.

Professor Thomson provided an overview, emphasising the way in which this was driving forward. She noted that the Clinical Guidance Groups had now provided a second draft of the guidance documents which were now going to be consistency checked, with the aim of being finalised for 31 January 2023. The contingency planning group were meeting to address the issue of excess Major Mental Illness (MMI) patients should a plan for this contingency be required following implementation.

Planning on the implementation for patient moves was underway, as was planning for initial staff moves required, as well as on longer term planning around the allocation of staff across the sub specialties. Discussions were being taken forward on the future leadership model. The PPG were actively contributing to ensure that patients' views were being listened to.

Ms Merson added that a key plank at this stage of implementation was continued engagement with both patients and staff. In addition to the above, there had been a seminar series presentation, as well as updates through staff bulletins. There would be critical activity during January and February and it was essential that all staff had awareness of the implementation programme.

Mr Currie commented on the positive nature of progress, and asked that the Board be kept advised of progress, especially any unexpected events that may impact on delivery. He also asked whether the Equality Impact Assessment required to be reviewed in terms of overall implementation. Ms Merson advised that each clinical guidance document does have an individual assessment attached to it, and these would be reviewed as part of the process before the end stage of implementation.

Mr Moore asked about the contingency planning for the event of excess MMI patients, and whether this could be the case across sub specialties e.g. in transitions. Professor Thomson advised that the CMT had endorsed the preferred option of patients being placed within the ward most suited to their needs during each day (and then boarded if necessary overnight in another ward). This would be as a contingency, and the model may not always work across sub-specialties perfectly.

The Board were content with the progress made to date on implementation of the new clinical model, as evidenced by reporting.

<u>The Board:</u>

1. Noted the content of this update.
2. Agreed that the Clinical Governance Committee and the Board would each receive detailed updates at their meetings in February 2023.

14 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

The Board received a paper from the Head of Planning and Performance (Paper No. 22/116) which provided update reporting on progress made towards quality assurance and improvement activities since the date of the last Board meeting. Ms Merson presented the report, summarising the key workstreams reported including clinical audit and the development of the Activity Oversight Group through an evidence based approach. She asked the Board to note the continued development of quality improvement initiatives including training, as well as on evidence for quality through continued assessment shown through the evaluation matrix.

Ms Fallon noted the comprehensiveness of the report which gave confidence overall. She asked about whether there were issues with the use of RiO dashboards on the part of staff, and suggested that a column should be added to the evaluation matrix to show the expected completion date.

Action – Ms Merson

Ms Fallon also commented that it was helpful to see the focus of the Activity Oversight Group on the impact of staffing levels on patient outings.

Professor Thomson advised that there had been a technical issue experienced with use of RiO dashboards, with the system itself and that eHealth were aware of the need to resolve this. The dashboards would prove helpful in accessing patient data.

Mr Currie noted that it was positive to see additional places for training in QI, as these approaches should be hard wired into the system, and would contribute to staff development.

Mr Moore noted the data in respect of reporting of discussions with patients in the Variance Analysis Tool, which had been an issue in reporting previously and hadn't shown improvement.

Action – Ms McCaffrey / Ms Merson

The Board noted the content of the report, which continued to provide useful data and information.

The Board:

1. Noted the content the report and updates contained therein.

15 CLINICAL GOVERNANCE COMMITTEE

The Board received a copy of the approved minutes of the meeting, which took place on 11 August 2022, as well as a verbal update from Ms Cathy Fallon, as the Chair on the latest meeting, which took place on 10 November 2022. In particular, this meeting had considered the delivery of primary care provision within TSH including the GP service, as well as a focus on patients' physical health. Further, the meeting had received overviews on feedback and incident reporting. There had also been a dedicated report on the impacts of Covid-19 and the committee would consider at its next meeting in February 2023, whether this reporting was still required.

The Board:

1. Noted the approved minutes of the Clinical Governance Committee, paper no. CGC(M) 22/03 held on 11 August 2022.
2. Noted the verbal update from the Chair of the Clinical Governance Committee from the meeting held on 10 November 2022.

16 CLINICAL FORUM

The Board received a copy of the approved minutes of the meeting, which took place on 20 September 2022, and noted that there had been a further meeting on 29 November 2022.

The Board:

1. Noted the approved minutes of the Clinical Forum meeting held on 20 September 2022. CF(M) 22/03

STAFF GOVERNANCE

17 WORKFORCE REPORT

The Board received a report from the Director of Workforce (Paper No. 22/117) to provide an update on overall workforce performance to 30 November 2022, and Ms McGovern summarised the metrics contained within the report for the Board.

Ms Fallon asked about the possibility of comparing the staff turnover rate to previous years to identify any patterns or trends over time. Ms McGovern explained that changes in the process meant that this

would be available back to 2019/20 and that she would add this detail to reporting. The process for streamlining exit interviews had been reviewed and it was hoped to get more valuable data going forward to enable evaluation work to be carried out.

Mr McConnell asked about development work on policy training, particularly on the benefits accrued from that. Ms McGovern advised that policy training was work that was underway and that the wider development work was related to national policy work being progressed through 2023, and that TSH would be involved alongside the other national boards.

Mr Currie asked whether it would be possible to further evaluate the data in terms of the impacts that absence due to Covid-19 had made over time. It would be helpful to be able to identify these impacts. He added that it would be helpful to cross refer absences through the next six months and take a comparison to the wellbeing workstream to see if this would be a helpful addition in decision-making in directing resources towards the areas that made the most difference for staff.

Action(s) – Ms McGovern

The Board noted the content of the report, and the suggested actions for the way forward as well as the more detailed work undertaken by the Staff Governance Committee.

The Board:

1. Noted the content of the report

18 WHISTLEBLOWING QUARTER TWO REPORT

The Board received a report from the Director of Workforce (Paper No. 22/118) which outlined the progress made in the last six months on implementing the strategy, and monitoring of the key performance indicators (KPIs). Ms McGovern outlined the key points for the Board, highlighting the way in which the strategy was supported through an action plan, and related key performance indicators. She emphasised the work undertaken in relation to “Speak Up Week” and the initiatives taken to make sure that all staff were aware of the whistleblowing policy, and relevant contacts to support it.

Mr Moore advised that it was expected that an appointment would be made to the role of Non-Executive Whistleblowing Champion by the Cabinet Secretary for Health and Social Care, following a recruitment process. He also noted that annual reporting was due to be submitted to government by 28 February, and therefore a report would be brought to the next Board meeting. He also highlighted the Independent National Whistleblowing Officer website, which had published two reports so far, with recommendations outlined therein.

The Board:

1. Noted the content of the report and the updates contained therein.

19 STAFF GOVERNANCE COMMITTEE

The Board received a copy of the approved minutes of the meeting, which took place on 18 August 2022, as well as a verbal update from Ms Pam Radage, as the Chair, on the latest meeting, which took place on 17 November 2022. Ms Radage noted that this meeting had received reporting on both wellbeing as well as whistleblowing, and that it was helpful that the Lead Professional Nurse Advisor was now routinely attending the meetings. The meeting had also discussed recruitment strategy and how to encourage more interest in working at TSH through social media channels.

The Board:

1. Noted the approved minutes of the Staff Governance Committee, paper no. SGC(M) 22/03 held on 18 August 2022.
2. Noted the verbal update from the Chair of the Staff Governance Committee from the meeting held on 17 November 2022.

CORPORATE GOVERNANCE

20 CORPORATE GOVERNANCE IMPROVEMENT ACTION PLAN

The Board received a report (Paper No. 22/119) from the Head of Corporate Governance/Board Secretary updating the TSH Corporate Governance Improvement Action Plan to support the key corporate governance priorities as part of the NHS Scotland Blueprint for Good Governance.

Ms Smith advised that there was expectation that version-2 of the blueprint was expected to be published through Scottish Government very shortly, and this would help to inform the way forward. In terms of the existing plan, she highlighted Item 4 relating to the performance framework, as well as Items 6 and 7 relating to the arrangement for Board/Committee meetings. The move to hybrid meetings had been highlighted earlier in the meeting by way of the update from the NHS Vice-Chairs, and this would be trialled within TSH using the existing equipment within the Boardroom.

Mr Currie offered the view that virtual meetings had proven to be very effective to date, and that any change should be considered carefully and certainty offered for the arrangements made. Ms Fallon agreed with this point. There was agreement around the table that it would be appropriate to close Item 4 in relation to the performance framework on this plan, given the structure now in place.

Mr Moore added that it would be useful to revisit the section focused on the influencing the culture of the organisation and make a link to the whistleblowing agenda especially as to how the Board could evidence the effect made. This could be part of the refreshed discussion once the new blueprint had been published.

The Board:

1. Noted the content of the report and agreed to close performance reporting as detailed therein.

21 BOARD WORKPLAN 2023

Members received the Board Workplan (Paper No. 22/120) for review and agreed that this set out a clear plan for the organisation of business for the coming year.

The Board:

1. Reviewed and approved the revised workplan.

22 FINANCE REPORT TO 30 NOVEMBER 2022

A paper was submitted to the Board (Paper No. 22/121) by the Finance and eHealth Director, which presented the financial position to 30 November 2022, reporting on revenue and capital resource spending plans as well as the projected yearend financial outturn.

Mr McNaught summarised the detail of the report, noting that this was set on achieving a yearend breakeven position, with £0.811m efficiency savings. He advised the Board that this was subject to confirmation of the Agenda for Change Pay Circular for 2022/23 which was still awaited. Therefore, this was subject to change but a course of prudent management was being followed with maintenance of a

contingency reserve. He also confirmed that it was expected that the capital allocation would be utilised in-year. He also noted that external auditor costs were subject to increase and that this had been raised with Audit Scotland at a national level.

Mr McNaught also outlined the work underway on draft base budgets for the coming year, and highlighted the need to carefully monitor energy costs over the coming two-year period with early indication that there could be additional pressures particularly in 2023/24. It was indicated that capital budgets would be held at current levels.

Mr Currie asked whether there would be any opportunity through capital funding to invest further in mitigation of expected increases in energy costs e.g. solar panels or other green initiatives. He also asked about efficiency measures within revenue budgets and how this would affect not only the current year but also future years; and if decision-making may have to include pausing or changing activity as a result. Mr McNaught referenced the three-year template for financial forecasting which included the increased savings pressures throughout this period. The focus was on recurring savings, and this was under close monitoring but not indicative to date of bringing a pause to activity at this stage. He added that with respect to energy costs, the national Directors of Finance group was keeping this under careful review. It may require escalation to NHS Board Chairs and NHS Board Chief Executives groups as a national pressure. He noted that in respect of the capital budget, this may bring some future flexibility and that there was alertness to any opportunity that may arise for further investment. Mr Walker also referenced the recently received net zero report, and that the path to reaching targets as set out was very much in focus in terms of the possibility of new initiatives.

In response to a query from Mr McConnell, it was confirmed that NHS Boards had raised a collective concern in respect of external audit costs – routed through Scottish Government to Audit Scotland. Mr McConnell also asked about the net financial impact of the new clinical model, and this was confirmed as cost neutral.

Mr Moore asked about the position on substantiating roles that had been created temporarily through additional funding for Covid-19, as well as the overall value and sustainability framework including projected savings of 3% in the coming year. Mr Jenkins noted that TSH had taken early consideration of the workstreams being led under this framework; and Mr McNaught agreed adding that this would be kept under close monitoring especially around the potential for yielding savings. He added that TSH continued to work collaboratively with the other national boards. With respect to posts created in response to Covid-19, theses were being considered for continuation if possible.

The Board:

1. Noted the content of the report.

23 PERFORMANCE REPORT – QUARTER 2

The Board received a report from Head of Planning and Performance (Paper No. 22/122) which presented a high-level summary of organisational performance through the reporting of Key Performance Indicators (KPI's) for Quarter 2: July - September 2022.

Ms Merson noted that there were three KPI's off target for this quarter and led the Board through the detail in respect of each. This referred to six monthly review of care and treatment plans which had only just missed the target and work was being focused on improvement in this area, including the recording of documentation to ensure that performance was recorded accurately. The KPI for patient BMI remained off target and the Board would receive an update form the Supporting Healthy Choices workstream at its next meeting. The target for sickness absence was also off target, and the Staff Governance Committee would receive detailed reporting and analysis in this respect to take appropriate detailed oversight.

Ms Merson also asked the Board to note the performance around attendance at CPA reviews, which had deteriorated in this quarter. Ms Fallon asked what the consequences of this could be for specified

groups, and Professor Thomson advised that it was optimal to have each discipline there as each had a valuable contribution to make. However, if this was not possible logistically then there were other routes through which their advice would be sought be fed into the process.

Mr Moore summarised for the Board, noting that the structure of this report was both clear and helpful in indicating performance across targets.

The Board:

1. Noted the content of the report.

24 SUSTAINABLE CENTRALISED VISITING – UPDATE

The Board received a report from Director of Security, Resilience and Estates (Paper No. 22/123) which outlined the progress made with sustainable centralised visiting.

Mr Walker advised that excellent progress was being made in this respect, with funding secured and the programme of works underway. The expectation was that this would be finalised on target for the end of the financial year, though indications were that this could potentially be completed at an earlier date.

The Board:

1. Noted the update report.

25 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report from the Director of Security, Resilience and Estates (Paper No. 22/124) detailing the update of the Perimeter Security and Enhanced Internal Security Systems re-fresh project and planning for the remainder of this year.

The Board noted this paper, and that the project was nearing conclusion. A further report would be presented in a private session of the Board, given the security and commercial sensitivities.

The Board:

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

26 AUDIT COMMITTEE

The Board received a verbal update from the Chair of the Audit Committee, Mr McConnell, from the meeting held on 29 September 2022. He advised that the committee had received an update form internal auditors on the tracking of actions from completed audits, and this was demonstrating good progress. The committee had also had updates on the Corporate Risk Register, cyber security and counter fraud as well as the arrangements for external audit for this year, and the handover process for this. The committee had also undertaken a self-effectiveness s audit of its own performance.

The Board:

1. Noted the content of the verbal update provided.

27 ANY OTHER BUSINESS

The Board discussed the flow of business during the meeting and this would be something to keep under continual review to ensure that all matters could be given appropriate consideration. The Chair recorded his thanks to both the Non-Executive Directors as well as the Chief Executive and the leadership team for all of their work and contributions throughout the year. He extended this to patients as well for their feedback and contributions throughout what had been a difficult and challenging time, as these had been of great value.

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

28 DATE AND TIME OF NEXT MEETING

The next public meeting would take place on 23 February 2023, by way of MS Teams.

29 PROPOSAL TO MOVE TO PRIVATE SESSION

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

The meeting ended at 1.20pm.

ADOPTED BY THE BOARD _____

CHAIR _____

DATE _____

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	April 2022	QA and QI	Update on Carer's clinic workstream	K McCaffrey/ Monica Merson	Updated: April 23	Update June 2022: Progress with clinic in 2 Hubs during Feb – May 2022. Given positive feedback, further clinics will be held on 3-monthly basis. Feedback Reporting to be prepared end of November, and then update back to the Board planned for December meeting. **Update December:** This is part of Realistic Medicine Update – Completion of four clinics at a minimum required before detailed assessment could be undertaken, timing of final clinical was at end of November and work is underway and not yet complete. This should return to the Board as part of QA/QI report. **Update: February 2023:** Delayed update due to vacancy arising in project manager role, this is being reviewed by Head of Planning & Performance.
2	October 2022	Operational Response Plan	Update on trigger points of escalation and link to the Board resilience of loss of staff plan,	K McCaffrey	Updated: June 23	**Update December 22:** Paper presented to Board advising of Task and Finish Group being set up to complete this work. **Update February 23:** Group is underway, and continuing to meet – agreement that full revision of

						papers to be progressed in short time scale – update to Board in June 23
3	October 2022	Comms Report	Update on carer social events in current year / overall carer strategy for TSH	K McCaffrey	Updated: February 23	**Update December:** This is under active review, with consideration of a different approach post Covid and implementation of new clinical model, with the change to the Family Centre as central visiting space, as well as feedback from carers that they would like smaller more tailored events. Therefore, review will take place in spring 2023 on refreshed way forward. At December Meeting Board asked about carer strategy overall – is this in place as anchor document, and this should come back to Board as an update. **Update February 2023:** This is a policy gap that has been identified and has been included in PCIT service objectives for this year – engagement work is progressing with stakeholders and report to come to CGC in November. Two Carer events panned for 2023 – June and December. **CLOSE**
4	October 2022	Ehealth Annual Report	Feedback to Board after NIS Audit	R McNaught	December 22	**Update December:** NIS audit report expected to be available for February 2023 meeting Remitted to Audit Committee – update provided as part of Jan 23 meeting.

						CLOSE
5	December 2022	Volunteer Story	Flagged that social media could be used to promote role of volunteering	K McCaffrey	February 23	**Update February 23:** Reviewed potential for social media use as part of overall strategy – balanced against need to target for specific skills in forensic mental health setting. **CLOSE**
6	December 2022	QA and QI Report	Add target column to evaluation matrix VATs – update re patient reports to show improvement	M Merson M Merson/ K McCaffrey	February 23	**Update February 2023:** Report updated In each aspect **CLOSE**
7	December 2022	Workforce Report	Further analysis of staff turnover; as well as of impact of c-19 absences as comparator – to be routed to Staff Governance Committee	L McGovern	February 23	**Update February 2023:** Reporting remitted to SGC **CLOSE**

Last updated – 14.2.23 – M Smith

Author:
Margaret Smith
Board Secretary 01555 842012

Paper No. 23/02

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 February 2023
Agenda Reference:	Item No: 7
Sponsoring Director:	Director of Security, Estates and Resilience
Author(s):	Risk Management Facilitator
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

3.3 Update on Proposed Risks for inclusion on Corporate Risk Register

N/A

3.4 Corporate Risk Register Updates

No changes to any CRR gradings since December 2022 update

3.5 High and Very High Risk – Monthly Update

The State Hospital currently has **Six** 'High' graded risks. Latest updates are below:

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

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

Monthly Update: Level 3 PPE training and Bronze Commander Training completed. Paper went to CMT in January 23, implementation plan detailed and accepted. Mock exercise due onsite in February 2023 with sign off due after completion. Once live, incidents will continue to be monitored and analysed by the Risk and Resilience Team with the risk assessment updated as required. Meeting scheduled with Risk Management and PMVA Team to update Datix Recording requirements.

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

Monthly Update: Latest Obesity figures reduced slightly to 79.7% from 82.7% in January 23 although it was noted that 9.3% of patients had missing data, this is an increase of 5.5% in November 22. Reasons for missing data include refusal, mental wellbeing at the time of weigh in and unable to weigh patient (for example, physically unable). Dietetics team advised that January can be higher as patients do not wish to be weighed directly after the festive period.

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

Monthly Update: Staffing issues continue to affect TSH. Daily meeting takes place to monitor staff resources in real time managed through the 'Safe to Start' Process.

Staffing Resource incident numbers continue to remain high. Through Datix, we are now able to identify which wards have been closed, partially closed and modified working. Closures are also being checked with the weekly indicator report to ensure accuracy. Additional fields have been added to the Datix form and are now monitored through Tableau, dashboard is undergoing some testing before being rolled out to the wider hospital.

Staffing is being monitored daily and continues to be a priority for the Hospital, recruitment is ongoing and modified working/closures being utilised where required. On-Call being utilised on the weekends and during difficult periods to provide support to nursing staff if escorts are required. Workforce Governance Group and Activity Oversight Group are monitoring and taking action to improve current process.

- **SD54 Implementing Sustainable Development in Response to the Global Climate Emergency**

Monthly Update: Risk is currently at High. Carbon Report is now available, action plan to be completed based on results and risk will be reviewed at the next Climate Change and Sustainability. Risk Assessment will be updated once position at TSH is clear. Meeting Scheduled for 21st February to update Risk assessment.

- **HRD111 – Deliberation Leaks of Information**

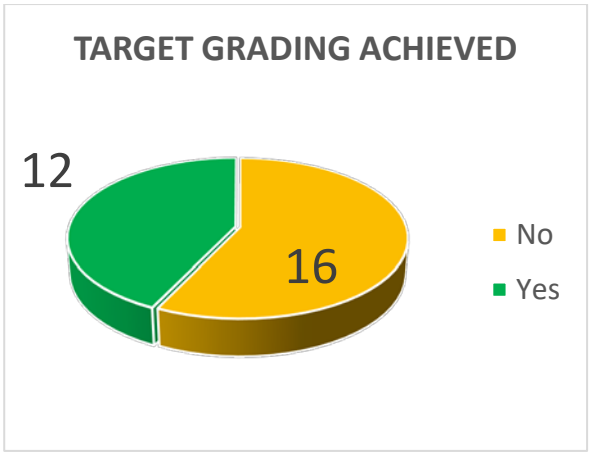
Monthly Update: Risk continues to remain at High after 4 potential leaks were reported in Q3. Rated under grading Major x Possible. Media Leaks continue to be monitored through Datix and Information Governance Group. 1 Incident reported in Q4 which involved information shared by patient via lawyer. Staff training figures are above target for Confidentiality, Records Management and Data Protection however Information Governance Essentials is at 71%, this was reported to Information Governance Group for action to be taken.

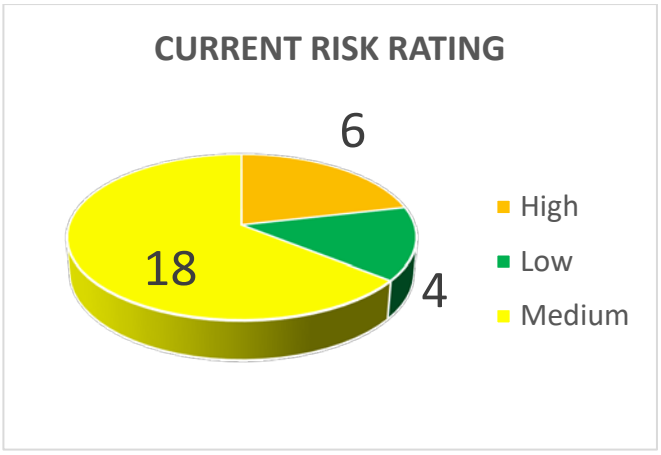
Director of Workforce is taking forward action, a Short Life Working Group will be appointed to complete this task and feedback progress to the Board and Audit Committee.

- **CE15 - Impact of UK and TSH Covid-19 Inquiries on TSH**

Monthly Update: To date, informal requests for information made by both Scottish and UK Inquiries have been submitted through Central Legal Office. Business Manager role currently out for recruitment for 12 month internal secondment. CMT reviewed risk on 1 February and agreed it should remain at High until recruitment successfully completed. To be reviewed again on 1 March.

3.6 Risk Distribution





Currently 12 Corporate Risks have achieved their target grading, with 16 currently not at target level.

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 and is being further monitored through the work plan detailed below.

A work plan is underway to focus on risks not at target level in 2022/23, this will be taken forward by the Risk Management Facilitator and Head of Risk and Resilience who will liaise with risk owners. The work plan will involve working with risk owners and action officers to ensure risks are up to date and relevant, review ongoing work to reduce risk to target level and ensure appropriate grading.

The Board is undertaking self-assessment of its risk appetite, and how this impacts management of risk. Further work is progressing to enhance oversight of Corporate Risks by each of the Board's governance committees.

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

Review Periods:

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

4 RECOMMENDATION

The Board are asked to review the current Corporate Risk Register, as an accurate statement of risk; and to feedback any comments and/or additional information members would like to see in future reports.

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	Board Workplan / CMT
Risk Assessment (Outline any significant risks and associated mitigation)	There are no significant risks related to the publication of the report.
Assessment of Impact on Stakeholder Experience	There is no impact on stakeholder experience with the publication of this report.
Equality Impact Assessment	The EQIA is not applicable to the publication of this report.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	The Fair Scotland Duty is not applicable to the publication of this report.
Data Protection Impact Assessment (DPIA) See IG 16	Tick One ✓ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

Paper No. 23/02

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	01/03/23	Clinical Governance Committee	Monthly	-
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Moderate x Possible	Moderate x Likely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	18/02/23	Clinical Governance Committee	Monthly	-
Corporate ND 71	Health & Safety	Failure to assess and manage the risk of aggression and violence effectively	Major x Possible	Major x Possible	Major x Possible	Director of Nursing & AHP	Director of Nursing & AHP	18/02/23	Clinical Governance Committee	Monthly	-
Corporate SD 54	Service/Business Disruption	Implementing Sustainable Development in Response to the Global Climate Emergency	Major x Likely	Major x Likely	Moderate x Rare	Security Director	Head of Estates and Facilities	18/02/23	Security, Risk and Resilience Oversight Group	Monthly	-
Corporate CE15	Reputation	Impact of Covid-19 Inquiry	Extreme x Likely	Extreme x Possible	Extreme x Rare	Chief Executive	Board Secretary	18/02/23	CMT	Monthly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Possible	Moderate x Unlikely	HR Director	HR Director	17/02/23	HR and Wellbeing Group	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	18/04/23	Corporate Governance Group	Quarterly	-
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Chief Executive	18/04/23	Clinical Governance Committee	Quarterly	-

Corporate CE 12	Strategic	Failure to utilise appropriate systems to learn from prior events internally and externally	Major x Possible	Moderate x Possible	Moderate x Unlikely	Chief Executive	Risk Management Team Leader	18/04/23	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate CE 14	ALL	The risk that Coronavirus (Covid-19) could affect The State Hospitals primary aim to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff.	Major x Almost Certain	Moderate x Possible	Minor x Possible	Chief Executive	Chief Executive	18/04/23	Corporate Governance Group	Quarterly	-
Corporate MD 32	Medical	Absconsion of Patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Associate Medical Director	18/04/23	Clinical Governance Committee	Quarterly	-
Corporate MD 33	Medical	Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Medical Director	Associate Medical Director	18/04/23	Clinical Governance Committee	Quarterly	-
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Unlikely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	18/04/23	Clinical Governance Committee	Quarterly	-
Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Major x Rare	Major x Rare	Security Director	Security Director	10/04/23	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	10/04/23	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Unlikely	Moderate x Rare	Security Director	Security Director	10/04/23	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 53	Service/Business Disruption	Serious security breaches (eg escape, intruder, serious contraband)	Extreme x Unlikely	Extreme x Rare	Extreme x Rare	Security Director	Security Director	10/04/23	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	10/04/23	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	18/03/23	Clinical Governance Committee	Quarterly	-

Corporate FD 90	Financial	Failure to implement a sustainable long term model	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance & Performance Director	Finance & Performance Director	01/03/23	Finance, eHealth and Performance Group	Quarterly	-
Corporate FD 91	Service/Business Disruption	IT system failure	Moderate x Possible	Moderate x Possible	Moderate x Possible	Finance & Performance Director	Head of eHealth	01/03/23	Finance, eHealth and Performance Group	Quarterly	-
Corporate FD 96	Service/Business Disruption	Cyber Security/Data Protection Breach due to computer infection	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth	01/03/23	Finance, eHealth and Performance Group	Quarterly	-
Corporate FD 98	Reputation	Failure to comply with Data Protection Arrangements	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth/ Info Gov Officer	01/03/23	Finance, eHealth and Performance Group	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	01/03/23	HR and Wellbeing Group	Quarterly	-

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	01/04/23	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	01/05/23	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	01/04/23	Finance, eHealth and Performance Group	6 Monthly	-
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Moderate x Rare	Moderate x Rare	HR Director	Training & Professional Development Manager	01/05/23	Clinical Governance Group	6 Monthly	-

Paper No. 23/03

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 February 2023
Agenda Reference:	Item: 8
Sponsoring Director:	Director of Nursing and Operations
Author(s):	Senior Nurse for Infection Control
Title of Report:	Infection Prevention & Control Report (Including Covid19 activity)
Purpose of Report:	For Noting

1. BACKGROUND

This report is presented to the Board to provide an update in relation to Infection Prevention and Control (IPC) activity.

2. INFECTION PREVENTION & CONTROL ACTIVITY

The Infection Control reporting structure is under review. The Infection Prevention and Control Group (IPCG) will be the operational group 'the doing' group and the Infection Control Committee will be the governance group, reporting through to the Clinical Governance Group. This group provides assurance reporting to the Clinical Governance Committee.

The first meeting of the IPCG was held on 07th February which set the scene and expectations for the group. This group will meet monthly thereafter.

The Infection Control Committee will have their first meeting 09th March.

All Infection and Prevention work continues however no data has been gathered during this review period to allow for re-structuring of reports.

Infection Control Spot Checks / Audits

The Infection Control Team along with the Lead Nurses/Skye Centre Manager are undertaking spot checks on a fortnightly basis i.e. the entire site including the Skye Centre will be checked monthly. This process began in January 2023; reports will be collated after the last area has been checked.

Face Fit Testing

Following data presented at the July 2022 Infection Control Committee an agreed compliance target of 85% was set, to ensure that there was adequate clinical staff available to provide Duty Resuscitation Nurse (DRN) cover on each shift.

At the time of writing this report 89% of clinical trained ward base staff are face fit tested, therefore meeting the local target of 85% and the RAG rate is green. This is a 1% decrease from last report; however this is reflective of staff leaving the organisation)

Information on the number of staff from each ward who are tested is presented in the monthly report. An up to date list of face fit testers is circulated to the Senior Charge Nurses and Lead Nurses on a monthly basis to provide information on staff that have been tested and can provide the necessary cover.

Infection Control Environmental Audit Tool

A scoping exercised was undertaken regarding the merging of the new Infection Control Environmental (ICE) audit and current e-control book Workplace Inspection. However, it was viewed by the Health and Safety Advisor that it was not possible, as the Work Place Inspections were specifically for Health & Safety control books albeit there are duplications within both documents. This will be re-visited later in the year.

The Infection Control Team circulated the ICE audit to the Senior Charge Nurses for completion and feedback with a return date of the 14th November 2022. A follow up audit has been scheduled for March 2023. All 10 wards returned their audits tools for auditing within the agreed timescales.

A database has been developed to monitor audit compliance and this is being populated with data and analysed. Results will be submitted to the Infection Control Group in April 2023.

Product Request Checklist

As part of the HAI Standard 9 the Senior Nurse for Infection Control requested a review of the New Product/Commodity Form, which has been used since 2013. A meeting was organised with Infection Control, Risk Management, Estates, Housekeeping to review what is required, and it was agreed for a checklist to be developed to replace the existing form. The original form was viewed as outdated following COVID 19 and moving forward this will ensure that all relevant individuals are included and advice is sought when purchasing new equipment. This work is being trialled by the Senior Charge Nurses and is expected to go live April 2023.

3. COVID19 Activity

The number of patients that have tested positive for Covid19 since March 2020 is 120, in addition there have been 9 patients that have tested positive for Influenza A.

There has been an influx of respiratory illness over the Autumn/Winter months, demonstrated in the chart below

Table 1: Tests, Location and Confirmed Covid19 and Flu A cases

Month	Number of tests undertaken	Confirmed patient cases	Ward affected
November	3 (plus 1 refusal)	0	
December	15 (plus 1 refusal)	3 (Covid 19) 7 (Flu A)	Mull 1 (x3) Arran 1 (x1) Arran 2 (x1) Iona 1 (x1) Iona 2 (3) Lewis 2 (1)
January (25.01.2023)	4	2 (Flu A)	Lewis 1 (x1) Iona 1 (x1)

Vaccinations (up to 25.01.2023)
The uptake rate is shown below:

- 67% received booster (vaccine depending on availability)
- 60% received the seasonal flu vaccination

In Scotland, boosters for healthy 16-49 year olds and the Autumn 2022 vaccination programme will end on 31 March 2023.

HIS Infection Prevention and Control Standards

The Senior Nurse for Infection Control continues to work alongside HIS to ensure that forensic settings are assessed proportionately against the Standards. The Infection Control Team have undertaken a 'self-assessment' against the standards and are currently working through area were compliance can be increased.

Future plans

Discussion will take place in March 2023 regarding the wider use of facemasks within the State Hospital. This discussion will follow local surveillance on respiratory illness.

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	
Financial Implications	No financial implications identified.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Nursing and AHP Directorate Board requested information.
Risk Assessment (Outline any significant risks and associated mitigation)	Not identified for this report.
Assessment of Impact on Stakeholder Experience	Not identified.
Equality Impact Assessment	Not formally assessed.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not identified as relevant.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ✓ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 February 2023
Agenda Reference:	Item No: 9
Sponsoring Director:	Medical Director
Author(s):	PA to Medical Director
Title of Report:	Bed Capacity within The State Hospital and Forensic Network
Purpose of Report	For Noting

1 SITUATION

Capacity within the State Hospital 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 2022 until 31 January 2023.

	MMI	LD	Total
Bed Complement	128	12	140
Staffed Beds	108	12	120
Admissions	3	0	3
Discharges / Transfers	7	0	7
Average Bed Occupancy: Available beds/All beds			88.3% 75.7%

Please note that there were 106 patients as of 31 January 2023 and 15 patients with a primary diagnosis of Learning Disability.

14 patients have been identified for transfer from TSH and 9 have been fully accepted for transfer. We have one MMI patient at TSH under the Exceptional Circumstances clause.

Please note that we have had 1 patient death within this time frame, and I have not included this in the Discharge/Transfer figures in the table. He was an MMI patient.

b) TSH Contingency Plan

A contingency plan has been finalised through CMT. This remains as follows:

I Ongoing Actions

a) Formal transfer review meeting established on a monthly basis (AMD)
b) Monitoring of imminent transfers (next 2-3 weeks) at weekly Patient Pathway Meeting and likely bed state reported to directors weekly (AMD)
c) Regular meeting in place to discuss with NHS Greater Glasgow and Clyde fully accepted patients for transfer to Rowanbank Clinic (CEO).

II Additional Actions agreed by CMT in the event of further bed pressure:

a) Use Mull 3 for patients to sleep in but to be located in another ward during day. 2 staff required to open ward at night. Facility time would not be possible. Establish operational group to plan this (ND).
b) Any agreement to use last bed must be with AMD / MD consent or out of hours with duty director consent. Communicated to RMOs (MD).

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. A copy of the weekly bed report across the Forensic Network is attached dated 30/01/23 – see Appendix 1. The Orchard Clinic has temporarily reduced its capacity by 7 beds for urgent repairs.

30.01.23.xlsx

The Scottish Government has asked the Network to convene a meeting to discuss prison transfers in view of cases raised with the Minister of Mental Health by HMP Edinburgh. This will be discussed initially at the Network's Inter-regional group meeting on 10/2/23.

3 ASSESSMENT

The current bed situation within TSH remains eased but it is recognised that there is a natural variation in the number of referrals and admissions and further pressure is likely in the future unless the medium and long term plans outlined by the Network are progressed. TSH remains closed to exceptional circumstance patients due to workforce issues. The Orchard Clinic's temporary closure of 7 beds for urgent work will cause further pressure across the forensic estate.

4 RECOMMENDATION

The Board is asked to note the report.

MONITORING FORM

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

Paper No. 23/05

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 February 2023
Agenda Reference:	Item No: 10
Sponsoring Director:	Medical Director
Author(s):	Head of Planning and Performance Consultant Psychiatrist
Title of Report:	Clinical Model Implementation – Update
Purpose of Report:	For Noting

1 SITUATION

Planning for Implementation of the Clinical Model was in an advanced stage prior to the Coronavirus pandemic. Work was paused in March 2020 and restarted in June 2021 to consider the current context, previous work carried out and what the future conditions would require prior to any restart. Planning and engagement has progressed. This paper updates the Board on progress towards implementation following the last update in December 2022.

2 BACKGROUND

The clinical care model describes the way The State Hospital provides high secure services to patients with a mental disorder many of whom have offended. The need to review the Clinical Care Model arose from issues raised through a staff engagement exercise which focused on readiness to change. At the Board meeting in June 2022, the Board approved Project Initiation Document which provided detailed plans for the implementation of the model. A project group has formed to take forward planning for the implementation of the new Clinical Model. The Board have received regular updates since implementation commenced.

3 ASSESSMENT

As the implementation phase of the project continues, project implementation activities and processes have included

- The Clinical Model Implementation Short Life Working Group continue to meet monthly
- The Project Plan is updated regularly and attached for information (Appendix 1).
- The Project Oversight Group have met monthly.
- Updating issues log and escalation of issues to the Project Oversight Board to support project management and effective decision-making.
- The Project Group meet weekly to progress project planning and management

Below is an update from progress achieved since the last report to the Board in December

Clinical Guidance

- Clinical Guidance Groups have formed and have provided a third draft of the clinical guidance for each of the clinical sub specialities.
- These clinical guidance documents have been reviewed by the Project Oversight Board at their February meeting. Sign off of the content is expected within the next few weeks.
- Final editing will take place over March to ensure there is consistency
- An overarching guidance document has been drafted to provide coherence across the pathway and ensure that there is consistency of approach in key processes.

Patient Mapping and allocation to sub specialities

- Patient mapping exercise was carried out in January.
- Where possible patients who were identified as requiring to move ward to be within the service that best suited their needs, would be moved with their peers.
- Where room adaptations have been made for specific patients, the patient would stay in these.
- Patients in correct service should remain in their existing rooms.
- 1 bed should be kept in Admissions Service to be available for emergency admissions.
- MMI patients would be allocated a bed in the MMI ward, even if this was not their nominated service, rather than utilise contingency arrangements.
- If any patients require to move more than once, then this is kept to a minimum.

Contingency Planning

- A contingency planning group have met to develop plans for addressing an excess of Major Mental Illness (MMI) patients should that position be realised following implementation of the model.
- Each department across TSH have developed plans for how they will operate within the new Clinical Model

Movement of Patients

- An implementation group have met to develop plans for the physical movement of patients. These have been presented to the POB and agreement reached on the most effective option
- RMOs have been advised to inform the project team of any patient who will required additional support for the move so that their needs can be considered and a tailored approach developed.

Communications - Patients

- All patients have had a 1:1 discussion with their RMO, or deputy, regarding whether they are moving or not. This has been followed up with a letter detailing the service, hub and ward they are moving to. Patients have been informed the moves will take place in March.
- All patient carers have also been sent a letter providing them with the same details.
- Engagement with Advocacy and PCIT have taken place to support patientsat this time.

Communications - Staff

- To support staff communications, monthly update reports in the form of flash reports, summarising the month's activities and detailing the next steps, were issued in December and January (Appendix 2 and 3). These flash reports have been extensively shared and paper copies have been in place within hospital reception to ensure whole workforce remains informed regarding progress of the Clinical Model.
- In addition, there is a specific intranet page which holds all Clinical Model information.
- A project team e-mail is available for staff to engage with the project.
- The TSH weekly staff bulletin has carried updates for staff and all user e-mails have been distributed to inform staff of progress.
- Communications and Engagement Plan has been reviewed and updated.

- A Clinical Model session was held as part of the ‘Seminar Series’ to raise awareness and update staff
- A further Seminar Series in planned for the end of February 2023.

Workforce

- The Workforce Group have met and developed plans for some minimal initial staff movement required prior to patient moves. The group has also supported professional groups to consider how they allocate staff across the sub specialties.

Service Leadership

- Discussions have taken place to describe and scope and responsibilities of the Hub and sub speciality leadership across the Hubs.
- Proposed approach to service leadership is in development and an interim approach to support service leadership to be in place to support the initial stand up of the services is also in development.
- The PPG have remained active in planning for the Clinical Model and have had discussions with key staff members to ensure patients perspectives and integral to plans.

EQIA/DPIA

- EQIA has been drafted and escalated to the POB for sign off
- DPIA has been drafted and reviewed by the Data Controller. Review by POB in progress.

4 RECOMMENDATION

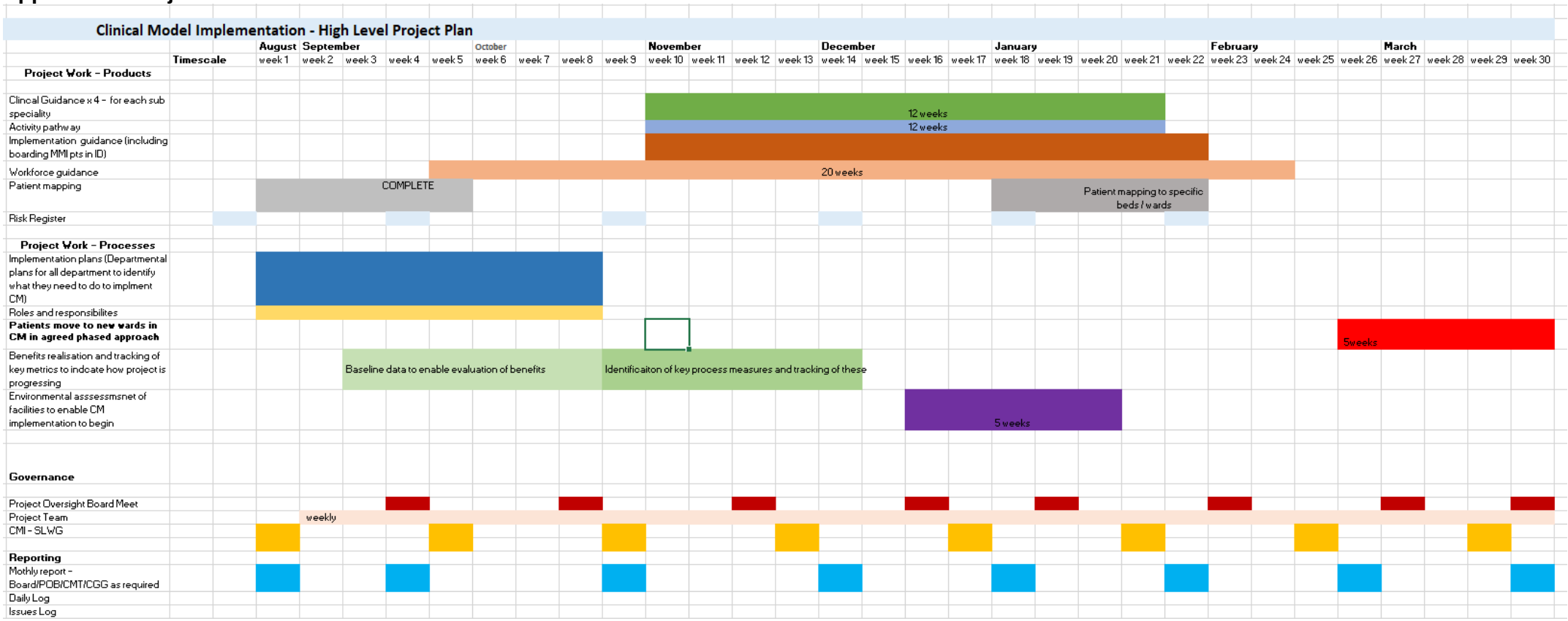
Board members are asked to:

- Note the contents of the attached documents.
- Discuss the implication of these for TSH.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supports the implementation of the Clinical Model
Workforce Implications	Some of the actions may result in additional workforce resources being required
Financial Implications	As above
Route To The Board Which groups were involved in contributing to the paper and recommendations	Corporate Management Team and Clinical Governance Committee
Risk Assessment (Outline any significant risks and associated mitigation)	Risk that the current patient population will not fit into the clinical model
Assessment of Impact on Stakeholder Experience	Stakeholder experience may by impacted due to the new model being unable to be implemented at this time
Equality Impact Assessment	An EQIA has been completed for this project in 2020
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	n/a
Data Protection Impact Assessment (DPIA) See IG 16	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included

Appendix 1: Project Plan



Appendix 2: December Flash Report

Clinical Model Flash Report – December 2022

Successful implementation is a shared responsibility.

Aim of Report:

The Clinical Model describes how clinical care is structured and delivered. As we move into the implementation stage for the new Clinical Model, we will provide a monthly report on work that has been delivered recently and describe the plan for the coming months. The aim is to have patient moves completed by the end of March 2023.

Clinical Model Activity in December 2022:

- Seminar Series was delivered on the Clinical Model. Presentation is available on intranet.
- Second drafts of the Clinical Guidance shared with the SLWG and Project Oversight Board. Drafts can be located on the intranet.
- Bed contingency paper developed and presented at CMT; discussions ongoing re options.
- PPG developed proposal for consideration as part of the Clinical Guidance.
- Update paper presented at TSH Board meeting.

Overview of the New Clinical Model:

The Clinical Model had been developed to provide an enhanced treatment environment with a focus on recovery. There are four sub-specialties within the model – Admission and Assessment, Treatment and Recovery, Transition and Intellectual Disability.

Planned Work in January 2023:

- Final Patient Mapping to be completed.
- Final drafts of Clinical Guidance documents to be completed.
- Bed contingency planning discussions to continue.
- Final draft of Implementation Guidance to be shared.
- Review of the Workforce Guidance.

Planned Meetings – January 2023

Clinical Model Implementation SLWG:
24 January 2023
Clinical Model Project Oversight Board:
25 January 2023

Key Project Milestones:

To deliver the Clinical Model, the following Key Planning Elements will be developed:

- Clinical Guidance.
- Workforce Guidance.
- Guidance for the physical movement of patients.
- Patient Mapping.
- Activity Pathway.

Communication and Engagement:

PPG have Clinical Model as a standing item and have started to consider what they need in preparation for the model.
Clinical Model Project Team will attend Partnership Forum monthly.
All Heads of Service are encouraged to include the new model as a standing agenda item in their team meetings.
TSH Clinical Model intranet page can be accessed here.

Next Steps:

- All Heads of Service to share the Clinical Guidance second drafts with their teams and feedback is requested back to the Leads of the groups.

Contact Details:

- If you have any queries or concerns, please contact the Clinical Model Project Team on: TSH.ClinicalModelProjectTeam@nhs.scot

Appendix 3: January 2023 Flash Report

Clinical Model Flash Report – January 2023

Successful implementation is a shared responsibility.

Aim of Report:

The Clinical Model describes how clinical care is structured and delivered. As we move into the implementation stage for the new Clinical Model, we will provide a monthly report on work that has been delivered recently and describe the plan for the coming months. The aim is to have patient moves completed by the end of March 2023.

Clinical Model Activity in January 2023:

- Patient Mapping completed
- Third drafts of Clinical Guidance shared with SLWG and Project Oversight Board
- Bed contingency continues with SOP in development
- Communication plan in development for patients, carers and staff to inform of moves
- Planning commenced for the movement of patients
- First phase staff moves carried out, second phase planned in February

Overview of the New Clinical Model:

The Clinical Model had been developed to provide an enhanced treatment environment with a focus on recovery. There are four sub specialties within the model – Admission and Assessment, Treatment and Recovery, Transition and Intellectual Disability.

Planned Work in February 2023:

- Communication with patients and carers
- Planning for guidance for movement of patients
- Clinical Guidance to be completed
- POB to sign off plans for movement and final drafts of clinical guidance documents
- Heads of Service to share how staff will operate across hubs and services.

Planned Meetings – February 2023

Clinical Model Implementation SLWG:
28 February 2023
Clinical Model Project Oversight Board:
24 February 2023

Key Project Milestones:

To deliver the Clinical Model, the following Key Planning Elements require to be developed:

- Clinical Guidance.
- Workforce Guidance.
- Guidance for the physical movement of patients.
- Patient Mapping.
- Activity Pathway.

Communication and Engagement:

PPG have Clinical Model as a standing item and have started to consider what they need in preparation for the model.
Clinical Model Project Team will attend Partnership Forum monthly.
All Heads of Service are encouraged to include the new model as a standing agenda item in their team meetings.
TSH Clinical Model intranet page can be accessed here.

Next Steps:

- All Heads of Service to share guidance with teams and feedback how they will work across the sub specialties. Patient communication re moves.

Contact Details:

- If you have any queries or concerns, please contact the Clinical Model Project Team on: TSH.ClinicalModelProjectTeam@nhs.scot

Paper No. 23/06

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 February 2023
Agenda Reference:	Item No: 11
Sponsoring Director:	Medical Director
Author(s):	Chair of the PHSG/SHC Group and Lead Dietitian
Title of Report:	Supporting Healthy Choices Progress
Purpose of Report:	For Noting

1 SITUATION

The Supporting Healthy Choices Group is focused to support TSH in managing obesity as rates continue to prevail at between 83 to 93% of patients being overweight or obese with the risk of associated comorbidities and known increased risk of morbidity and mortality from the current COVID -19 pandemic.

2 BACKGROUND

The second SHC action plan was agreed by the board in the August 2021 and a subsequent plan of progress commenced with this and to be undertaken by the project lead.

3 ASSESSMENT

Following agreement of the actions interim measures were agreed to support some of the ongoing pieces of work with others agreed to be actioned once the SHC project manager in post.

Of the actions agreed to maintain/commence;

Action	Progress	February 2023
Monthly weight/BMI monitoring of patients continues	Ongoing, reported into Rio and reports from such and used for Tableau data	Ongoing, supported by CQ team. Review of KPI for obesity with local KPI agreed to monitor this
Review provision of hospital shop bags	Skye centre action (JG)	Awaited feedback from Skye centre
Patient related information on aspects related to health via use of physical health education boards on all wards.	Actioned currently monthly by dietetics team	B5 post no longer in place. Some partial work supported by Dietetic assistant as resource allows.

Review of weight management pathway to include information on national weight management tiers and dissemination to wards and health centre for staff education,	Actioned Oct ’21.	Version 9 updated and circulated Sept ’22. Reflective to support national weight management tiers.
Audit of patient menu choices to identify if colour coding in line with FSA national coded increases uptake of healthier/healthy choices,		Completed – not sufficient evidence to support ward ordering copies being in colour, colour copies on display in the wards continue.
Funding for health psychologist post (versus trainee post),	Post recruited to	Substantive post holder in place since Oct ’22.
Scoping of weight history screening tools to assess all patients within 6 months’ admission,	Currently ongoing by dietetic team	Tool agreed by PHSG, going to clinical forum in March and for implementation alongside new clinical model
Annual takeaway audit (last completed 2020)	Annual audit ceased when practice improved and guidelines for patients orders in place	Guidelines and practice reviewed Jan ’23. Annual audit to resume again to check compliance
Full length mirrors have been agreed for communal areas and spend agreed to purchase.	Now in place	Done
Counterweight plus (meal replacement plan) has been maintained in practice for designated patients	Ongoing. Bid for 2022/3 funding and end of year report completed April/May ’22.	Ongoing. 4 patients currently Jan ’23. Further funding agreed for 2022/3. Implementation plan update due March ’23. New Weight Management tool database (WMT) on TURAS due imminently.
Work to progress the move from Health and Wellbeing plans (HWP) to Nutrition and Physical Health Care plans (NHCP) is ongoing.	Currently ongoing with Nursing practice development and prof Nursing Officer. NPCP will combine NST and Physical Health checklist with separate (nutritional) care plan using current nursing plans. Pilot on Lewis due August.	NST will remain, Checklist being audited on Iona Feb ’23. Training re care plans to follow. Overall role out anticipated April onwards.

The project manager was appointed and commenced work with SHC in November 2022 but will return to her substantive post on 1/3/23. The post is going out to advert.

Additional areas or work: outcome measure and data management; mealtimes – standard operating procedures, review of Food Fluid Nutritional Care (FFNC) standards needs to fit with new clinical model; .

Day time confinement secondary to staffing issues is likely to have an adverse effect on the SHC initiatives.

4 RECOMMENDATION

The Board is asked to note the current progress and situation.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 February 2023
Agenda Reference:	Item No: 12
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Performance Head of Clinical Quality
Title of Report:	Quality Assurance and Quality Improvement
Purpose of Report:	For Noting

1. SITUATION

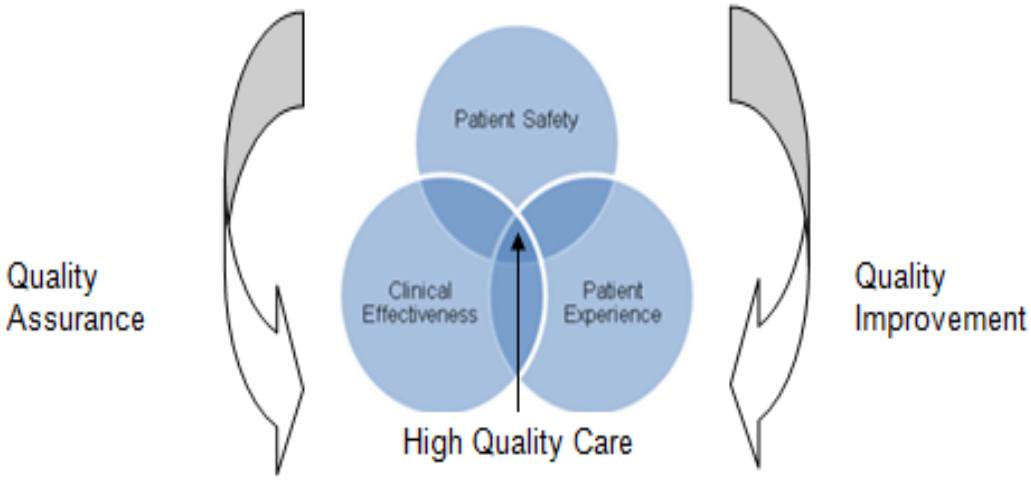
This report provides an update to The State Hospital Board on the progress made towards quality assurance and improvement activities since the last Board meeting in December 2022. The report highlights activities in relation to QA and QI and outlines how these relate to strategic planning and organisational learning and development. It contributes to the strategic intention of The State Hospital (TSH) to embed quality assurance and improvement as part of how care and services are planned and delivered.

2. BACKGROUND

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

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

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



3. ASSESSMENT

The paper outlines key areas of activity in relation to:

- Quality assurance through:
  - Clinical audits and variance analysis tools
  - Clinical and Support Services Operating Procedure Indicators Report
- 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	Covid monies have been approved to continue with the Daily Indicator Report due to Clinical Quality Dept staff workload/weekend working.
Route to Board (Which groups were involved in contributing to the paper and recommendations)	Route to the Board is via the CMT.
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 weekly indicator report will have a positive impact on stakeholder experience as they will be getting more fresh air, physical activity and 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 2022

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 audit reports that have been approved since the last Board Meeting in December 2022 are:

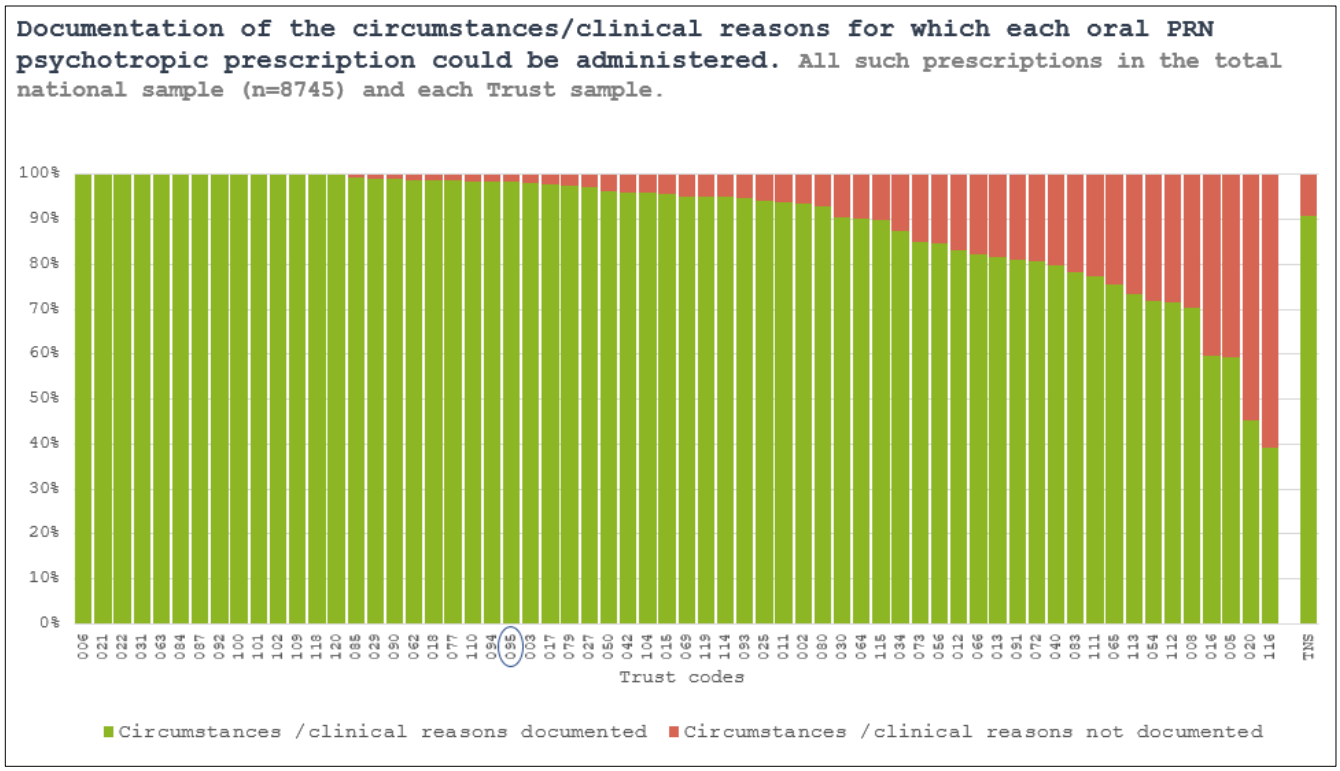
- Prescribing of antipsychotic medication in adult mental health services (national benchmarking project)
- Local KPI - Limit weight gain of patients from admission to equal to, or less than 5% of admission weight over first 12 months following admission

Prescribing of antipsychotic medication in adult mental health services (national benchmarking project)

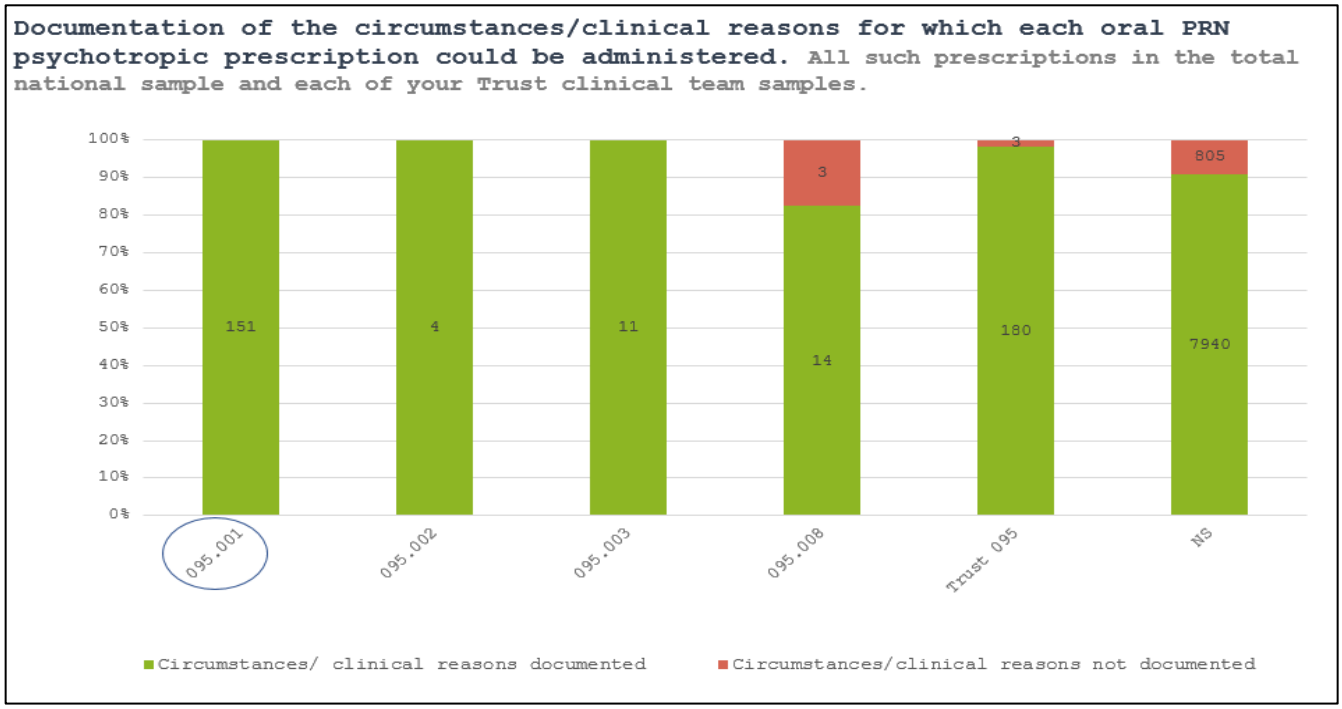
The audit included 683 clinical teams in the UK, and 62 NHS organisations (including other high secure hospitals).

The Scottish Forensic Network code within the report is 095 and TSH code is 95.001

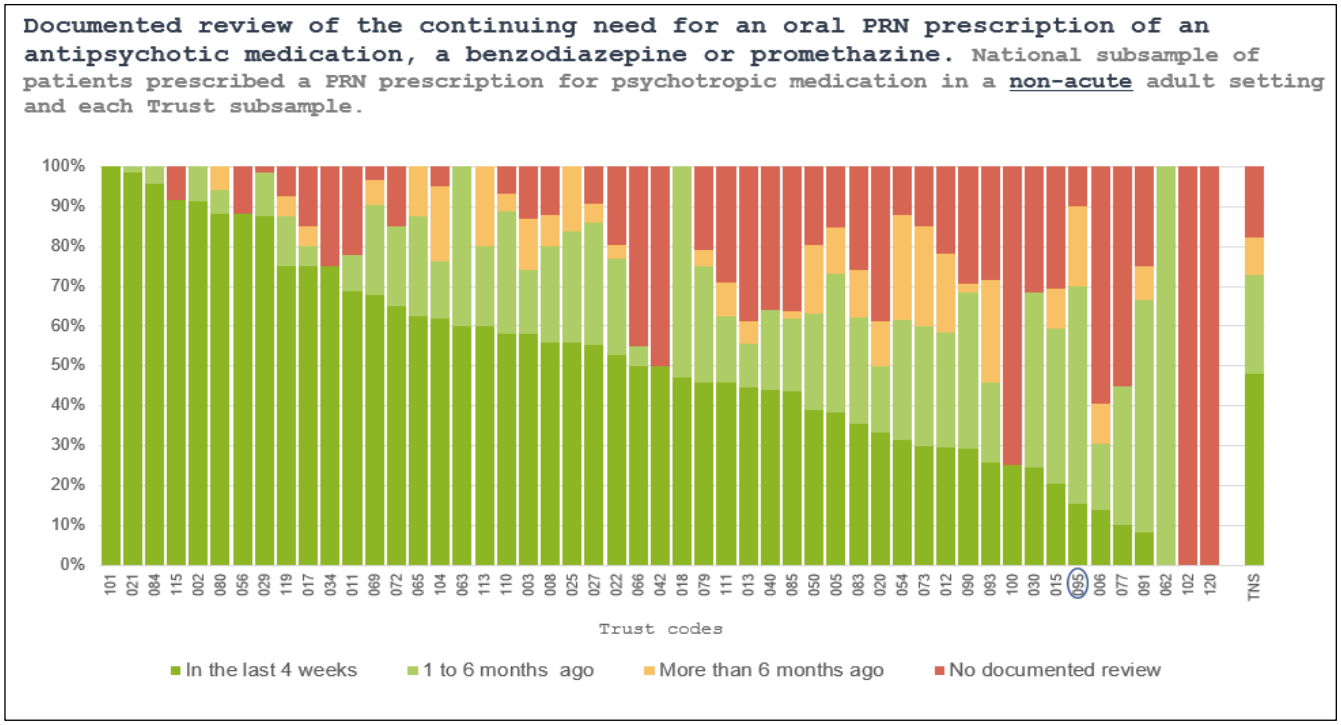
Areas of good practice included:
Across all organisations, the Forensic Network provided evidence that the vast majority of patients had the clinical reasons for each oral PRN prescription documented.



TSH provided evidence that all psychotropic PRN prescriptions had a clinical reason documented where they could be administered.

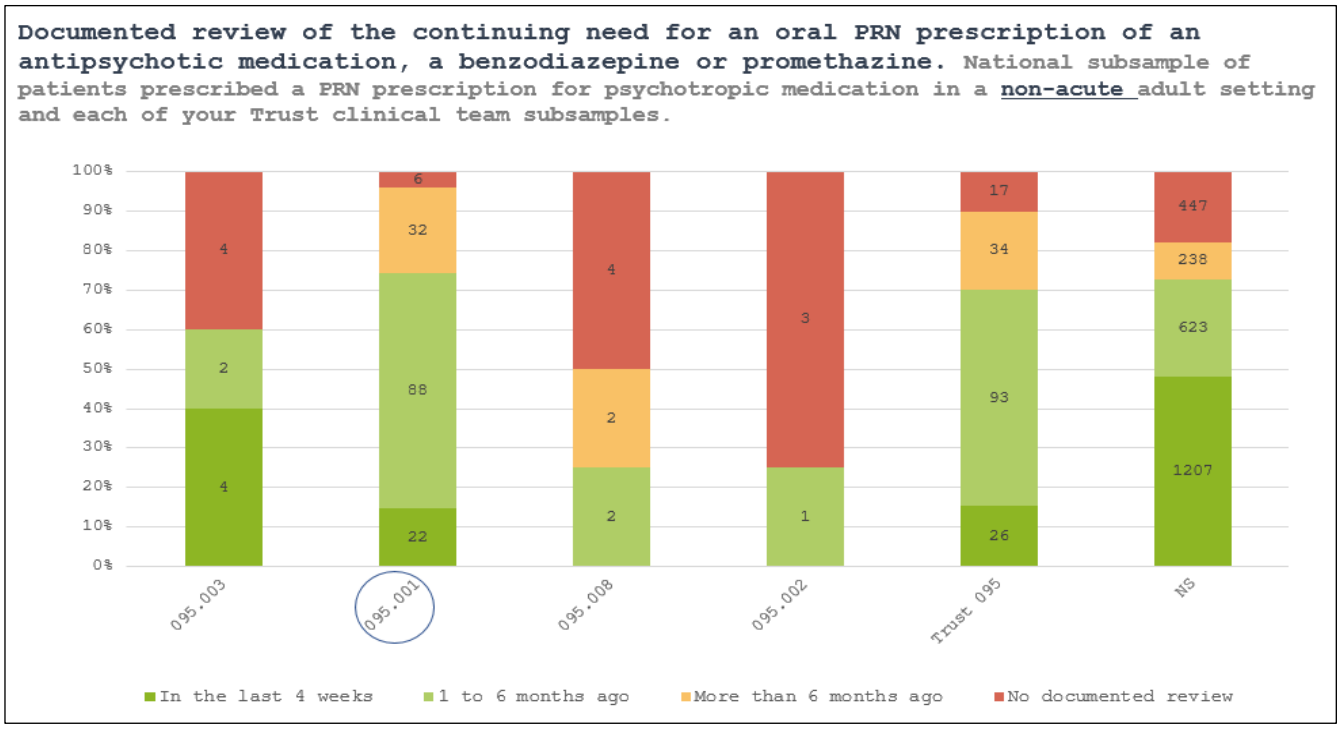


Areas for Improvement included:
As can be seen below, an area for improvement across the Forensic Network will be documented when a review of the PRN prescription has taken place.



This is also an area for improvement for TSH. As can be seen below, there were 38 PRN prescriptions that either had no evidence or had not been reviewed within 6 months. This has been added to the Medicine Committees improvement plan. Initial discussions are around clinical teams

using the RiO dashboard more routinely as this clearly shows how often the patient has required PRN in the previous 12 months.



Local KPI - Limit weight gain of patients from admission to equal to or less than 5% of admission weight over first 12 months following admission

Data collection has commenced to look at weights on admission and over the patient's first year with us. As can be seen for the 10 patients below, six of them had increased their weight by more than 5% by month 2. It has been noted that Iona 1 is more successful than other wards at keeping their patient's weight below 5% gain in the first few months. This will be explored further through the Physical Health Steering Group with a view to understanding their good practice.

Table 1: % weight change from admission

% weight change from admission + or -									
	Ward	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8
Patient 1	Lewis 1	0.0%	13.5%	15.5%	19.7%	19.0%	22.0%	25.8%	25.8%
Patient 2	Iona 1	-0.5%	-0.7%	-2.1%	-2.0%	-2.3%			
Patient 3	Arran 1	0.0%	8.4%	11.2%	17.7%	24.0%	27.1%	29.9%	29.9%
Patient 4	Iona 1	-0.6%	-0.6%	1.1%	1.2%	-2.4%	-1.2%	-1.2%	-1.2%
Patient 5	Lewis 1	0.0%	9.8%						
Patient 6	Iona 1	-4.9%	-4.1%	-4.1%	-4.7%	-4.2%	-1.8%	-0.5%	0.8%
Patient 7	Lewis 1	5.8%	8.2%	11.1%	10.9%	10.5%	11.8%	13.1%	
Patient 8	Iona 1	4.1%	6.0%	10.4%	12.8%	10.8%	14.4%		
Patient 9	Lewis 1	7.4%	11.6%	10.4%	14.3%				
Patient 10	Iona 1	-0.5%	-7.8%	-4.7%	-1.7%	0.1%			

Clinical Governance Committee

At the meeting in February 2023, the following papers were presented with a number of quality assurance and improvement activities contained within them:

- Psychological Services 12 monthly report
- Clinical Governance Group 12 monthly report
- Workforce Governance report
- Learning from Feedback report
- Learning from Complaints report
- Incident Reporting and Patient Restrictions report
- Self-effectiveness report
- Corporate Risk Register - clinical
- COVID-19 Update
- Areas of Good Practice/Areas of Concern
- Discussion Item - Clinical Model

Variance Analysis Tool (VAT) – Flash Reports

Flash reports were introduced in October 2022 to provide a very quick overview of the areas within the VATs that are either improving, or require some attention. The December 2022 report is below for information.

Data showing improvement from last report
Overall VAT Completion increased from 96% to 97%. **Medical** – Improvement in the provision of both the Mental State and Physical Health Report from 82% to 94%. All reviews were attended by the patient's consultant. **Nursing** – Completion of Nursing interventions was 97%. All BEST, PECC and Nursing reports were provided. KW/AW attendance increased from 48% to 77%. **Social Work** – Completion of Social Work VAT interventions was 100% with no areas on concern. **Psychology** - completion increased from 87% to 91%. Provision of reports remained consistent at 80%. **Security** – All Security reports provided. **Advocacy** again attended all Patient Case Reviews. **Dietetics** – Provision of the report increased from 94% to 100%.
Data showing concern from last report
Nursing – Discussion of the nursing report with the patient prior to the case review decreased from 88% to 60% - with the VAT not being completed on 4 occasions – Arran (1), Lewis (1) and Mull (2). **Occupational Therapy** – Although completion of the OT VAT interventions was excellent at 100% results continued to be affected by staff vacancies.

Pharmacy – have been affected in November by staff vacancies. No interventions were carried out on Lewis where there is no longer a Pharmacist in post.

Security – Security attendance data was not supplied by Arran.

Skye Activity Centre – completion was 100% but results for provision of reports and SAC representative discussing the report with the patient prior to the review were affected by department closures and staffing issues.

Any challenges with the systems that are being addressed

Nursing - Suggest the introduction of a new sub-head on nursing RiO progress notes - Nursing CPA Report discussion. This is the nursing intervention that is most often not completed. Work ongoing.

Please highlight any support required

Security - Support from Clinical Security Liaison Manager on Arran to complete their VAT data

Clinical Quality Flash Reports to Activity Oversight Group

The Activity Oversight Group took over the role of monitoring the activity data earlier this year. Clinical Quality now produce a flash report for each meeting that highlights areas of improvement, concern and any system issues. The most recent report is below and will be discussed in full at the Activity Oversight group.

Data showing improvement from this time last year

In the last week, all activity indicators have seen improvements. The average daily number of timetable activities provided to our patients was 273 with a total weekly number of 1913.

We have seen the highest number of patients accessing fresh at some point in the week since the end of September 2022.

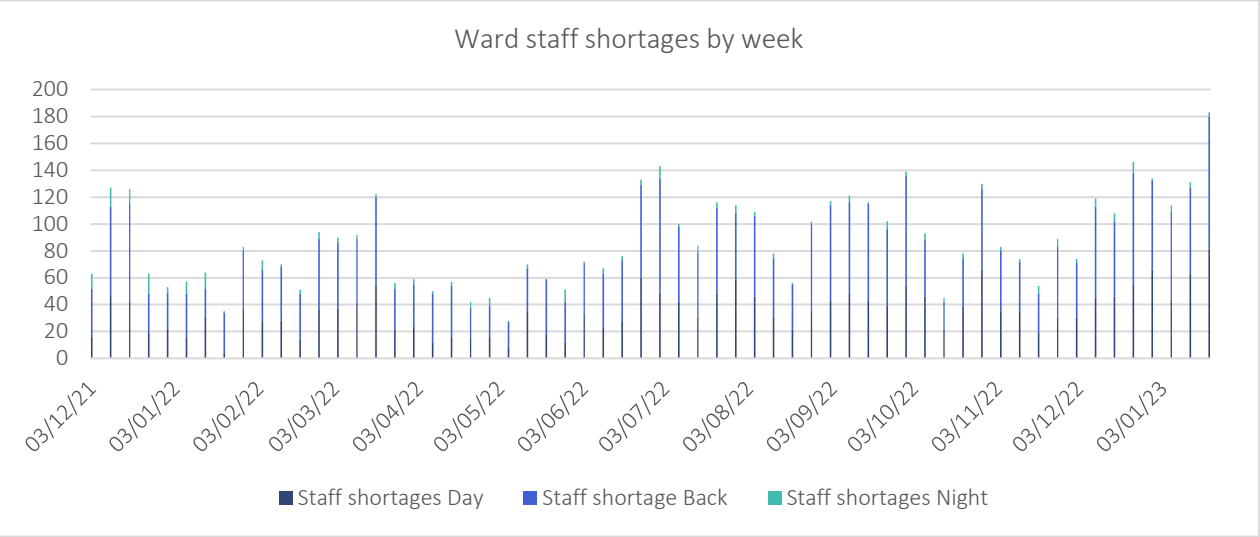
All patients within the hospital last week accessed physical activity or a timetable activity at some point in the week.

Last week (week beginning 20 January) saw the highest percentage of timetable activities going ahead since we started reporting this data in 2020 (77.8%). This coincides with the changes to the timetable that the Skye Centre has implemented.

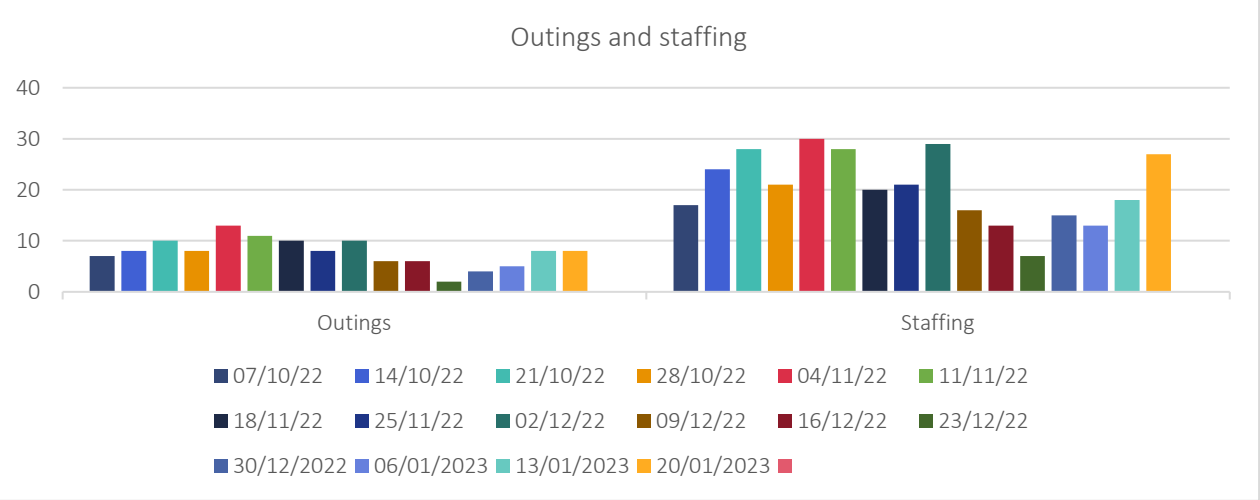
Data showing concern from last report

The total number of patients requiring PRN and the number of PRNs being administered increased significantly from 9 patients at the end of November to 21 patient's week beginning 6th January.

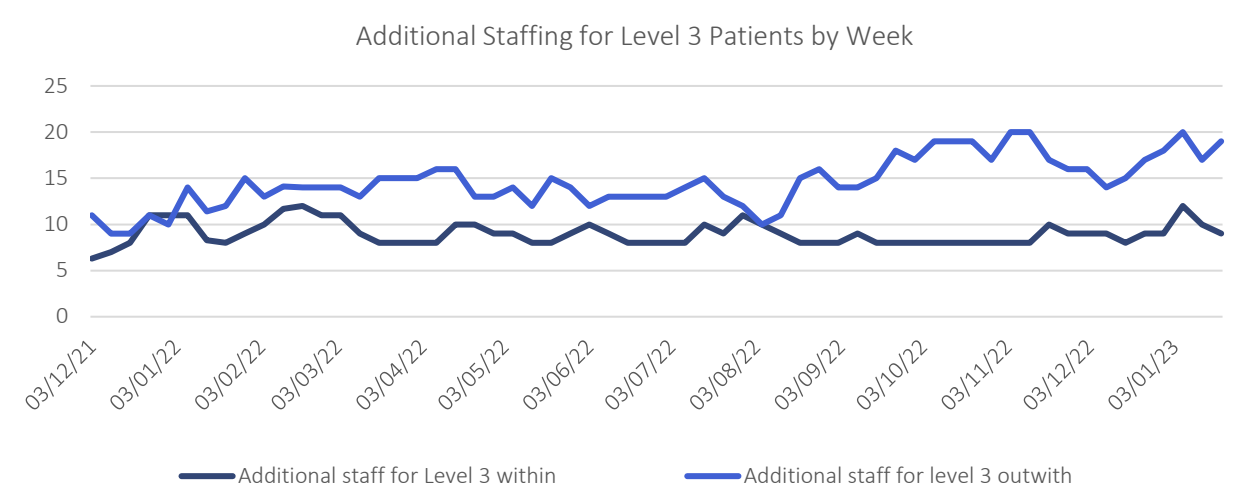
We saw the highest number of ward staff shortages since we started reporting this data in 2020. These shortages resulted in 71 episodes of modified working, 16 episodes where wards had to close for part of the shift and 17 episodes there they closed for the full shift.



Staff required for outings also increased last week which would have increased the number of ward staff shortages on the wards:



Additional staff required for patients on level 3 observations reduced very slightly, but is still very high compared to this period last year:



Areas with sustained levels
n/a
What areas have been worked on in relation to systems in the last month
The Hospital Leadership Team dashboards are now live on tableau. On 31 January, a training event was held over Teams to demonstrate how to use the dashboards, along with the reasons for the dashboard. The session was recorded and placed on the tableau channel to allow staff to view at a time that suits them. Work has started on the additions required to the RiO timetable to allow us to move away from staff having to complete the timetable and a physical activity form with the same data. It is scheduled to have this live in February.
Any challenges with the systems that are being addressed
n/a
Please highlight any support required
n/a

QUALITY IMPROVEMENT

QI Forum

The QI Forum's purpose is to champion, support and lead quality improvement initiatives across the hospital and raise awareness and understanding of QI approaches. The QI Forum met recently and has a focus to raise awareness of outcomes for mental health and build capacity to support and embed QI.

QI Capacity Building

Planning is underway locally for QI essential training; however, this has been impacted by staffing challenges across TSH. Three colleagues have commenced the ScIL training in January 2023 on cohort 43. This course will continue throughout 2023. Preparation underway for planning projects for each participant. Applications are currently open for the Scottish Coaching and Leading for Improvement Programme (SCLIP), TSH have been allocated one place on this training course, applicant shortlisting has been completed. Early planning is underway to offer another round of TSH3030. The aim of this would be to support new teams in QI activity following the implementation of the Clinical Model.

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.

The six key themes of RM are:

1) Building a personalised approach to care
2) Changing our style to shared decision making
3) Reducing harm and waste
4) Becoming improvers and innovators
5) Reducing unwarranted variation in practice and outcomes
6) Managing risk better

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 2022 to 31 January 2023, 31 guidance documents have been reviewed. There were 25 documents which were considered to be either not relevant to TSH or were overridden by Scottish guidance and 7 documents which were recorded for information and awareness purposes.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
Mental Welfare Commission (MWC)	4	4	0
SPSO	1	1	0
Royal College of Psychiatrists	1	1	0
National Institute for Health & Care Excellence (NICE)	25	1	0

As at the date of this report, there are currently an additional four evaluation matrices nearing the end of the review process.

Table 3: Evaluation Matrix Current Situation

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
MWC	Social Circumstances Reports (SCR) – Good practice guidance on the preparation of SCRs for MHOs & managers	CGG	Following discussion at CGG in Nov 2022, a question was raised regarding the decision made on 1 recommendation. A response was made to Jan's CGG however further action is required and is currently ongoing.	Apr 2022	Feb 2023
NICE	Self Harm: Assessment, management & preventing recurrence	MHPSG	Evaluation matrix required. Lack of co-operation regarding availability requested from sub-group was addressed by MHPSG Chair in January 2023 Review	Sept 2022	Mar 2023

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
			arranged for 9 Feb 2023.		
Royal College of Psychiatry	Supporting mental health staff following the death of a patient by suicide: A prevention & postvention framework	MHPSG	Forwarded to Clinical Quality by a medic to consider for review. MHPSG to review. Responses requested from sub group by 15 Feb 2023.	Dec 2022	Mar 2023
SIGN	Pharmacological management of migraine	Medicines Committee	Review meeting arranged for 3 Feb 2023.	Sept 2022	Apr 2023

There are currently five additional evaluation matrices, which have been outstanding for a prolonged period and await review by their allocated Steering Group. The progress of the first two evaluations from HIS and the MWC was temporarily paused due to TSH adapting to the COVID-19 pandemic however as per Gold Command, action on matrix completion began again at the start of July 2020. The responsibility to review these matrices changed ownership from the PMVA Review Group to the Patient Safety Group, which recommenced meetings in September 2020. Work is progressing with both, with an anticipated completion date of summer 2023.

The review of the Public Health England guideline was unable to be completed within the tight deadline set by the Supporting Healthy Choices group due to poor attendance at the review meeting and delay in members submitting feedback responses. Given the appointment of the Supporting Healthy Choices Project Officer, this has been flagged up for review as a matter of urgency.

The Rehabilitation after Traumatic Injury guidance from NICE is currently approaching the end of the review process – it should be noted that this is a fairly comprehensive document and as such, an amended review process is being followed in order to reduce the time required by all MDT members involved.

The final guidance regarding MS has completed the review process and will be tabled at the next Physical Health Steering Group for a final decision to be agreed and will thereafter be removed from this table.

Table 4: Evaluation Matrix Summary

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
HIS	From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell	Patient Safety	Evaluation matrix completed with 28 outstanding recommendations Patient Safety meeting took place mid-September. Evaluation matrix being updated as draft Clinical Care Policy is now currently under consultation.	Jan 2019	Summer 2023

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
	people in mental health care				
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 currently under consultation with seclusion tier 1 and 2 being incorporated. Both to be launched together.	Oct 2019	Summer 2023
PH England	Managing a healthy weight in adult secure services - Practice guidance	SHC	Unable to be completed within the tight deadline set by the Supporting Healthy Choices group due to poor attendance at review meeting & delay in members submitting feedback (May 2021) prior to group being paused. Documents provided to newly appointed SHC Project Officer in order to progress this and obtain an outcome (Jan 2023)	Feb 2021	Apr 2023
NICE	Rehabilitation from Traumatic Injury	PHSG	After initially being considered not relevant to TSH setting, decision was changed & evaluation matrix was required (Apr 2022). Due to large number of recommendations, review process was split into 2 parts: Part 1 - reviewed by AHP/Manual Handling Advisor (commenced June 2022 & completed Dec 2022) & Part 2 - wider multi-disciplinary review. Part 2 review commenced Jan 2023 with deadline of 3rd Feb 2023.	Jan 2022	Mar 2023
NICE	Multiple sclerosis in adults: Management UPDATED	PHSG	Previously reviewed in Oct 2014 when recorded for information purposes only. At that point, TSH had no patients with an MS diagnosis & PHSG agreed that should this change, the guideline would be used. Current 2022 situation is same however;	June 2022	Feb 2023

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
			investigations regarding 1 patients' possible diagnosis took place with a return of no diagnosis. Review now completed by Practice Nurse & GP. Both agree that no evaluation matrix required as current situation remains unchanged. To be tabled at the next scheduled PHSG for agreement.		

THE STATE HOSPITALS BOARD FOR SCOTLAND

Clinical Governance Committee CGC(M)22/04

Minutes of the meeting of the Clinical Governance Committee held on Thursday 10 November 2022.

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:

Person Centred Improvement Lead	Sandie Dickson [Items 11 & 12]
Social Work Mental Health Manager	David Hamilton [Items 7 & 8]
Consultant Forensic Psychiatrist	Dr Sheila Howitt [Item 6]
Chief Executive	Gary Jenkins
Consultant Forensic Psychiatrist & Chair of PHSG	Dr Khuram Khan
Lead Allied Health Professional	Lindsay MacGregor [Item 9]
Director of Nursing and Operations	Karen McCaffrey
Director of eHealth and Finance	Robin McNaught
Board Chair	Brian Moore
Head of Corporate Governance & Board Secretary	Margaret Smith
Head of Clinical Quality	Sheila Smith
Medical Director	Professor Lindsay Thomson
Personal Assistant to Corporate Services	Julie Warren [Minutes]

1 APOLOGIES AND INTRODUCTORY REMARKS

Ms Fallon welcomed everyone to the meeting, and apologies were noted from Monica Merson, Head of Planning and Performance who was unable to attend the meeting. However, Dr Howitt advised she would lead on discussion item number 6 in the absence of Ms Merson.

2 CONFLICTS OF INTEREST

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

3 TO APPROVE THE MINUTES / ACTON NOTE OF PREVIOUS MEETING HELD ON 11 AUGUST 2022

The Minutes of the previous meeting held on 11 August 2022 were noted to be an accurate record of the meeting.

The Committee:

1. Approved the minute of the meeting held on 11 August 2022.

4 PROGRESS ON ACTION NOTES

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

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

The Committee:

1. Noted the updated action list.

5 MATTERS ARISING

There were no additional urgent matters which arose for discussion.

6 DISCUSSION ITEM – CLINICAL MODEL

A presentation which provided an overview of the implementation works taken to date was delivered by Dr Howitt. Dr Howitt advised that the presentation was prepared in conjunction with Ms Merson, Head of Planning and Performance.

Dr Howitt provided thorough updates on key areas such as:

- The current context and considerations i.e. impact of coronavirus, patient population numbers, and female pathway and workforce challenges, including contingency plans.
- The benefits and intentions aimed to be achieved through the new model, such as increased patient physical activity, feeling of progression for patients, effective use and deployment of available resources, enhanced treatment environment with a more tailored approach.
- Clinical guidance updates which included key treatment and recovery objectives, definition and purpose, structure, admission and transfer criteria, staffing, procedural and security guidance, activity aims, care planning and risk assessment and outcome measures / KPI's. Work was being progressed by each of the four groups established and it was hoped the final draft would be available at the end of January 2023.
- Staff engagement to ensure patients and staff were as well advised as possible, and included a newly created recorded presentation outlining the model journey and works to date which was available on the intranet.
- Patient engagement was a regular topic of discussion featured at the Patient Partnership Groups.
- Other key current work strands involved were the bed contingency discussions and options appraisal, hub versus service leadership discussions, collaborative work with the Activity Oversight Group and workforce guidance in development.
- Lastly, intended timescales on products, processes and governance were noted.

The Committee received this detailed presentation very warmly and found it helpful in supporting understanding the extensive work carried out which provided assurance.

The Chair took the opportunity to advise at the move to the new model.

Mr Currie raised awareness of expectation management and the potential risks around this, in-particular possible slippage in meeting deadlines and timescales, with staff appreciating that pieces of work may not be achieved within the timescales set, which may be out with the hospital's control. Mr McConnell followed this by asking about system pressures that may affect model implementation and the options available in terms of the starting position, solutions for this and resolving temporary measures.
Dr Howitt explained that sufficient beds were available for the male mental illness population suited to high secure care, however the issue remained that patients continued to be on the waiting list for transfer to medium and low secure care.
Professor Thomson echoed this point and advised that The State Hospital's Board were recently sighted on capacity where approximately 16 patients were at the stage of transfer however, the congestion in the system was a network wide issue.

Professor Thomson also noted that these risks named were implementation risks, with the main risk

being a model drift, for example, the security issue around patient disassociations and impacts of these, given the need to place patients within the most suitable ward, so that the model could work to its full potential. She further advised that in the following years, this would be monitored closely. Lastly, in terms of expectation management, Mr Jenkins highlighted that external and unknown risks were additional challenging factors, for example funding for patients, digital infrastructure risks and the ability of patients to move through the system.

Mr Moore noted the potential of up to 70 patients where moves within the hospital could be expected and queried the number of related staff moves and potential timescale in this regard. Mrs McCaffrey advised of the intention to minimise staff moves and that patients would be moved to familiar multidisciplinary teams where possible, thereafter an incremental plan to move staff would be reviewed.

In relation to patient outcomes, Mr Jenkins acknowledged that national work to move to three year planning cycles would support the review of patient outcomes in the longer term and development of long term strategy.

The Committee recognised the importance to remain sighted on Clinical Model works and agreed it would be beneficial for this item to be included in future agendas. The Committee also recommended that an update report be brought to the next meeting of the Board in December, and that monthly Flash Reports would be circulated to Non-Executive Board Members in the meantime.

Action: Monica Merson

Members thanked those involved in this area of extensive work and for the very interesting and reassuring presentation.

The Committee:

1. Noted the presentation on Clinical Model as was delivered.

2. Agreed that the Clinical Model would remain a standing item going forward.

7 CPA/MAPPA 12 MONTHLY REPORT

Members received and noted the Transfer / Discharge Care Programme Approach (CPA) and Multi Agency Public Protection Arrangements (MAPPA) Annual Report, covering activity from the period 1 October 2021 to 30 September 2022.

The report evidenced the successful implementation of the clinical model principles and highlighted a number of key areas of work, such as governance arrangements, CPA performance, MAPPA interventions, patient and carer involvement, stakeholder feedback, as well as a progress update.

Of particular note, Mr Hamilton, helpfully advised that the carer attendance figure was low due to the lack of carers patient had, rather than a non-attendance issue.

Mr Hamilton made reference to the very positive 100% target and achievement rate with regards to CPA's which took place for all patients transferred or discharged from the organisation throughout the last year. The Committee agreed this was an area of good practice and would be added to the respective list.

Action: Ms Julie Warren

Mr Currie advised he was reassured with Mr Hamilton's update and explanation of the low carer attendance rate and wished to reiterate the impressive figures adhered to during challenging times throughout the year where coronavirus affected staffing resources.

Mr McConnell queried further detail around the current issues pertaining to MAPPA information

sharing at a national level due to concerns raised by Police Scotland and what the impact of this was for The State Hospital. Mr Hamilton advised that Police Scotland sought to limit disclosure of information solely to MAPPA meetings. This raised a degree of concern given that the CPA processes allowed for effective communication with partnership agencies and was a change in practice following a review of policies by Police Scotland. With regards to State Hospital patients, a route was available to address this issue. Mr Jenkins further noted that, in terms of background, ownership transferred to Police Scotland from the Home Office and was a national issue.

Lastly, the Committee noted that in June 2022, the CPA Administrator retired after 40 years of service within the hospital, which has had an impact on service delivery. The Social Work service and clinical secretaries have absorbed this work, although recruitment was underway in relation to this post, which was recognised to be crucial to the Transfer / Discharge CPA process. On behalf of the Committee, Mr Jenkins advised he met with the individual in person prior to her retirement to express thanks for her contribution to the service.

The Committee:

1. Noted the Transfer / Discharge Care Programme Approach and Multi Agency Public Protection Arrangements Annual Report.

8 CHILD AND ADULT PROTECTION 12 MONTHLY REPORT

Members received and noted the Child and Adult Protection Annual Report, covering activity from the period 1 October 2021 to 30 September 2022.

The report evidenced the continued implementation and responsibilities of the Social Work Service and highlighted a number of key areas of work in Keeping Children Safe, Adult Support and Protection, Corporate Parenting, Training, Stakeholder Involvement, Quality Assurance and Improvement, as well as planned work.

Mr Hamilton, provided an overview of the key performance headlines and achievements over the past twelve months.

Mr Moore queried whether there were any helpful learning points from the unusual external source referral with regards to financial harm. Mr Hamilton provided a summary of the context of this referral and highlighted the good partnership working as a positive outcome.

The Committee:

1. Noted the Child and Adult Protection Annual Report.

9 REHABILITATION THERAPIES 12 MONTHLY REPORT

Members received and noted the Rehabilitation Therapies Annual Report, covering activity from the period 1 October 2021 to 30 September 2022.

Ms MacGregor, provided a detailed overview of the report which covered key areas such as the current resource commitment, summary of core activity over the previous 12 month period, the comparison with the previous years planned recommendations and activity, key performance indicators, quality assurance and improvement activity, and the planned quality assurance and quality improvement work for 2023.

Mr McConnell queried what the impact on the AHP service was due to vacancies within the service as well as the work undertaken to support ward areas at times of staff shortages. Ms MacGregor advised that the recruitment process was underway to fulfil these posts however, availability of AHP's was recognised as a national issue. She further advised that work would be taken forward to better profile and promote working within the Allied Health Professional service at The State Hospital to attract individuals.

In terms of impact on service during times when the AHP team provided support to ward areas following periods of staffing shortages, she advised that KPI's had been impacted with the number of completed assessments decreased. However, she also offered the view that there had been some positive impacts, with AHPs working with nursing colleagues more closely during difficult times, and this brought the potential of future benefits for the multi-disciplinary team working relationships. Mr Moore asked for further detail on this positive step. Ms MacGregor further advised that with the redeployment of staff, a detailed and more in depth understanding of working practices was achieved and slicker ways of working identified. Also of note was the positive team relationships created during this time, which was thought particularly relevant given the move to the future clinical model.

Mr Currie suggested that updates on progress of key milestone pieces of work be regularly provided to the Committee throughout the year prior to the Annual Report being presented. Professor Thomson highlighted that as rehabilitation was a responsibility wider than the AHP Service, the Clinical Governance Group would continue to discuss key pieces of work and would sight the Committee on any issues which may arise.

The Committee:

1. Noted the Rehabilitation Therapies Annual Report.

10 PHYSICAL HEALTH STEERING GROUP 12 MONTHLY REPORT

Members received and noted the Physical Health Steering Group Annual Report covering the period 1 October 2021 to 30 September 2022. Dr Khuram Khan, provided a detailed summary of the report.

Dr Khan advised that there was a percentage increase in patients accepting flu vaccination from 66.6% to 74.4%, and that there were 34 patients who fell into the additional "at risk" group, of this, 27 (79.5%) patients consented to flu vaccination, which was an increase from last year.

Mr Currie raised his concern around the number of patients within the "at risk" category who have not received the Covid-19 and flu vaccinations. Professor Thomson advised that in terms of Covid-19 vaccinations for this round of boosters, 46 patients declined (including 12 patients who have consistently refused vaccination). However, following 1:1 input with patients from Responsible Medical Officer's and Specialty Doctors, this increased the uptake by eight. Of the 26 who declined boosters, Professor Thomson advised that she wrote to these patients to express general concerns around this and potential effects on the care model. Dr Khan also advised that he would be seeking the support of the onsite General Practitioner in an attempt to encourage patients to accept the booster vaccinations.

Members recognised the positive impact made on the array of areas by the newly appointed General Practitioner to the hospital, in terms of improvement and progress, particularly in terms of the improvement in completion of physical health review.

Members also recognised the positive figure around completion of Key Performance Indicators, having recovered following the coronavirus period.

Lastly, following the Chair's recent attendance at a Patient Partnership Group, she informed the Committee of the positive patient feedback received in relation to the meal options available.

The Committee:

1. Approved and noted the Physical Health Steering Group Annual report.

11 PERSON CENTRED IMPROVEMENT SERVICE 12 MONTHLY REPORT

Members received and noted the Person Centred Improvement Service Annual Report which covered the period November 2021 to October 2022. Mrs Dickson, highlighted key areas of note

from the report. The various attendees at Patient Partnership Groups including Non-Executive Directors and multidisciplinary staff was noted to be encouraging.

Mr McConnell expressed his support to the Person Centred Improvement Team of the work completed over the last 12 months and his view on the worthwhile Non Executive invitation and attendance, which was an appreciated involvement experiencd by stakeholders.

The Committee:

1. Approved the planned achievements and key actions recorded to be taken forward over the next 12 months and noted the content of the Person Centred Improvement Service annual Report.

12 LEARNING FROM FEEDBACK

Members received and noted the Learning from Feedback Quarterly Report (Q2 of 2022/2023) which provided the Committee with an overview of activity related to feedback for the second quarter of the financial year 2022/23 (1 July to 30 September 2022). Mrs Dickson, provided members with a brief summary of the report and highlighted the following areas in terms of feedback shared relating to concerns and a number of themes identified;

- Value placed on activity and patient frustrations relating to limited access as a result of staffing resourcing challenges.
- Inconsistencies relating to the visiting process.
- Value of social relationships with peers and family/friends.
- Lack of access to technology.
- Importance of consistency of input from a core group of staff.
- Aspirations for patients to be more meaningfully involved in care and treatment planning.
- Impact of increased fuel costs for visitors and volunteers.
- Need for agreed process to support reasonable access to patients' bedrooms during the day.
- Prioritisation of visits in the Family Centre.

Compliments were shared around access to digital devices for carers, patient care and a rapid response to feedback relating to Covid-19 restrictions, which impacted on patient movement.

Feedback response times was measured for the first time this quarter, with 72% of those asked to respond doing so within 7 days.

Mrs Dickson further advised that patients were in discussion around opportunities to offer peer support in terms of instructors, whereby guidance and advice could be provided from patients at the rehabilitation and recovery stage to those patients newly admitted to the hospital. The Committee Chair welcomed this useful initiative.

Non-Executive Directors expressed their views around the commendable event held and achieved in light of the memorial service held for a patient's family member, whereby the patient was unable to attend the funeral service outwith the hospital. The event was noted as commendable to all staff who achieved this event given the emotional and sensitive feelings involved, and the human based approach taken.

The Chair welcomed the overall update on effective feedback in terms of ensuring that patient and or carer experience informed service delivery and took assurance in this regard.

The Committee:

1. Noted the Learning from Feedback Report, pertained to Quarter 2, and its relevance, in terms of ensuring that patient and or carer experience informed service delivery.

13 LEARNING FROM COMPLAINTS

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

The report provided an overview of activity of complaints, concerns and enquiries for the second quarter of the financial year 2022/23. The report also detailed the complaints received, the stages at which they were handled, as well as complaints closed within this period.

Ms Smith provided a high level account of the content of the report and provided assurance on two key areas;

1. the hospital's positive performance in supporting resolution of complaints in a timely manner, and

2. the work ongoing with the Patients Advocacy Service and Complaints and Legal Claims Officer to reassure patients to come forward and raise complaints without fear of impacting on relationships with staff.

Mr Currie welcomed the report and commended staff for their efforts in resolving 34 complaints in a timeous manner. He noted the openness of the learning taken forward by the organisation, which would ultimately build confidence and strength in the system from a staff and patient perspective.

Mr McConnell queried whether the recent spike in communication issues related to the same previous issue in quarter one. Ms Smith advised these were different specific issues although had a similar theme around communication between internal teams and a breakdown in flow of information and understanding of practice.

Ms Fallon requested further detail around the issue with a patient not obtaining solicitor information after a 20 day period of being admitted to the hospital. Professor Thomson took the opportunity to explain that patients were advised on admission to seek and make contact with a solicitor with the help of the Patients Advocacy Service. With regards to this particular complaint, the exact detail was unknown at the time of the meeting, however assurance was sought from Professor Thomson on explanation of the process for patients to which the Committee were content to accept.

The Chair commended Ms Smith and Complaints and Legal Claims Officer on their very comprehensive report and thanked them for the extensive work by the department.

<u>The Committee:</u>

1. Noted the Learning from Complaints Report, pertaining to Quarter 2 and its relevance, in terms of ensuring areas of improvement and learning taken.

14 INCIDENT REPORTING AND PATIENT RESTRICTIONS

Members received and noted the report on Incidents and Patient Restrictions which provided the Committee with an overview of activity of Incidents and Patient Restrictions within the second quarter 2022/23. The report showed the type and the amount of incidents received through the incident reporting system (Datix). Further, it updated all the restrictions applied to patients during the period 1 July to 30 September 2022.

Professor Thomson provided an overview of the content and advised that during this quarter, one patients tested positive for illegal substances. Contact was made with the laboratory to recheck the sample, given potential impacting factors and queries. The reason for the positive result was still inconclusive. Ms Fallon had previously queried with Professor Thomson whether the hospital experienced this issue in the past. Professor Thomson advised similar issues of false positives were raised on one occasion in 2020 and two in 2021.She further advised that the issue would be explored again with the laboratory in respect of testing accuracy. Further assurance was provided to the

Committee on the restrictions and monitoring in place including the use of drug detection dogs.

Following room searches, there was five finds of medications over two hubs. On two occasions, Housekeepers found secreted tablets within a patient's bedroom i.e. when a patient had secreted their own medication Members of the Committee agreed this was an area of good practice on the part of Housekeeping Staff and would be added to the list of good practice.

The Chair advised she would take this opportunity to formally write to the Head of Estates and Facilities to emphasise this area of good practice to express thanks to these individuals on behalf of the Committee.

Action: Mrs Cathy Fallon / Ms Julie Warren

Members acknowledged the extensive in-depth narrative contained within the report and took assurance from the tracker.

The Committee:

1. Noted and approved the content of the Incidents and Patient Restrictions Report, pertained to Quarter 2 2022/23.

15 WORKFORCE GOVERNANCE REPORT

The Committee received and noted the Workforce Governance Report for Quarter 2, which was presented by Mrs McCaffrey.

Mrs McCaffrey advised that the organisation was required to monitor and report on nursing staffing levels in the hospital to ensure these are adequate to deliver safe and effective patient care, which was rated as high on the Corporate Risk Register. Achieving safe staffing was an essential element of care quality, and monitoring and reporting on this demonstrated the hospital's preparedness for the implementation of Safe Staffing legislation. The Committee recognised that although work regarding preparation for the local implementation of safe staffing legislation was ongoing, there was no proposed date for enactment at this time.

In relation to previous agreement, the topic of safe staffing legislation would be an item on the Staff Governance Committee agenda and taken forward there, however the Clinical Governance Committee would continue to take detailed oversight of any impacts that this could have on the safe and effective delivery of clinical care.

The Committee:

1. Noted the update from the Workforce Governance Group in respect of Quarter 2

16 PATIENT MOVEMENT REPORT

Members received and noted the Patient Movement Report providing statistical information and an overview of the activity across admissions, discharges and transfers at 30 September 2022, which was presented by Professor Thomson.

Mr Moore queried the nature of the patient referral from NHS Ayrshire and Arran, which was refused after assessment as incomplete. Professor Thomson advised this was part of normal functioning and entirely normal within the Forensic Network conflict resolution system.

Mr Moore also questioned the nature of the patient who remained waiting on the transfer list from The State Hospital post the 12-month mark. Professor Thomson explained that contact with external agencies remained ongoing to progress this matter.

The Committee:

1. Noted the update on figures of patient movement as reported at 30 September 2022.

17 COVID-19 REPORT

Members received and noted The State Hospital Clinical Response to Covid-19 Global Pandemic update report, prepared and presented by Professor Thomson.

Professor Thomson advised that since the last report in August 2022 there had been no wards closed due to outbreaks during the reporting period, although there had been positive Covid-19 patient cases as detailed in the report. Of note, she advised of the decision taken by the Corporate Management Team to return oxygen cylinders and the stand down of the medical ward established in Mull Hub in April 2020 which was equipped and ready to accept any patient who required enhanced care for symptoms of Covid -19.

The Committee were reassured with the two options available for patients in the State Hospital who were Covid-19 positive and noted that should the medical ward be required in future, oxygen cylinders would be required to be sourced and delivered.

Professor Thomson further advised that Dr Tom Gillespie, Infection Control Doctor, would retire on 11 November 2022. It was thought appreciative to formally write to express our thanks to him for his extensive support and expert advice to the State Hospital throughout the pandemic as a whole.

Action: Professor Lindsay Thomson

Lastly, the Committee agreed to take a decision in February 2023 as to whether the Covid-19 report would stand down its reporting in to the committee. It was felt potentially relevant at that time to continue, given the expected peak in staff illness during the winter period and for the Committee to be sighted in February 2023.

Action: Committee Members

Mr Currie acknowledged the improvement in infection prevention and control practices and the learning achievement in line with enhanced working practices. Mrs McCaffrey as Chair of the Infection Control Committee (ICC) advised this would remain a focus on the ICC work plan, and practices would continue to be monitored.

<u>The Committee:</u>

1. Reviewed and discussed the update position as was outlined in the report in respect to the clinical management and governance of the organisation in response to the global Covid-19 pandemic and the current State Hospital outbreak.

2. Agreed that a Covid-19 Report be prepared and presented to the next Clinical Governance Committee in February 2023 then review decision on continued purpose at that time.

18 CORPORATE RISK REGISTER – CLINICAL UPDATE

Members received and noted the Corporate Risk Register clinical update which was presented by Professor Thomson. She provided specific updates on the main points from the report which included updates on CE15 – Impact of Covid-19 Inquiry, ND17 – Failure to assess and manage the risk of aggression and violence effectively and ND70 - Failure to utilise our resources to optimise excellent patient care and experience.

The Committee voiced their assurance from the clinical risk register as was detailed in the report, and the benefit of the workshop with Non-Executive Directors, which took place in October 2022 which accurately reflected the appetite for risk within the organisation.

The Committee:

1. Noted the reviewed current clinical Corporate Risk Register.

2. Accepted it as an accurate record following amendment as agreed above.

3. Agreed that no additional information was required for future reporting.

19 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

The Committee received and noted the template document on Areas of Good Practice and Matters of Concern for 2022/23.

There was discussion around the table and members agreed that a number of areas discussed throughout today's meeting were proven as areas of good practice. Members agreed to add the following areas to the list of good practice;

1. Secretion of medication found by housekeeping staff as detailed in the Incidents and Patient Restrictions Report

2. The Transfer / Discharge Care Programme Approach 100% compliance target achieved as detailed in the Annual Report.

3. The significant work undertaken by the relatively new General Practitioner, Dr Ross Stewart, and his positive impact and systematic approach in improving patient general medical care services.

4. The successful memorial service held for a patient from a person centred approach as was referred to in the Learning from Feedback Annual Report.

Action: Mrs Sheila Smith / Ms Julie Warren

No areas of concern were raised although Ms Fallon as Chair, queried the status of contact made with Head of Communications in terms of feedback from the Committee regards areas of good practice identified during meetings, and dissemination of this information via a Staff Bulletin as the most effective manner.

Action: Head of Communications / Mrs Sheila Smith

The Committee:

1. Agreed on areas of good practice which would be documented going forward.

2. Acknowledged there were no matters of concern raised to note.

20 CLINICAL GOVERNANCE COMMITTEE WORKPLAN 2022/23

Members received and noted the Committee Work plan for 2022/23. No updates of changes were offered therefore was accepted.

The Committee:

1. Noted and approved the Clinical Governance Committee workplan.

21 ANY OTHER BUSINESS

Members raised no other items of other business.

22 DAY, DATE, TIME AND VENUE FOR NEXT MEETING

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

The meeting concluded at 1255 hours

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL FORUM

Minutes of the Clinical Forum held at 10.00am on Tuesday 29 November 2022 via Microsoft Teams CF(M) 22/04

Chair:

Dr Sheila Howitt	Consultant Forensic Psychiatrist

Present:

Josie Clark	Lead Professional Nurse Advisor
Lindsey MacGregor	Lead Allied Health Professional

Apologies:

Alan Blackwood	Senior Charge Nurse
Dr Aileen Burnett	Consultant Clinical Psychologist
Dr Jana de Villiers	Consultant Psychiatrist
Sandie Dickson	Person Centred Improvement Lead
Margaret Smith	Head of Corporate Governance & Board Secretary
Marcus Topping	Practice Nurse

In Attendance:

Natalie Bordon	Clinical Psychologist (Item 12)
Ben Green	Clinical Liaison Security Manager
David Hamilton	Social Work Team Leader
Sheila Smith	Head of Clinical Quality
Julie Warren	Personal Assistant (Minutes)

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

The Clinical Forum Chair, Dr Sheila Howitt, welcomed everyone to the meeting. Apologies were noted as detailed above.

NOTED.

2 CONFLICT(S) OF INTEREST

The Chair highlighted a potential conflict of interest regards agenda item 10 and her role as Clinical Lead within the Clinical Model and Chair of the Clinical Forum. She advised that the update provided would be from her role as Clinical Lead for the Clinical Model. Members advised they were content with this position.

AGREED.

3 APPROVAL OF PREVIOUS MINUTES

The minutes of the previous meeting held on 20 September 2022 were approved as an accurate record.

APPROVED.

4 URGENT MATTERS ARISING

There were no urgent matters which had arisen over the preceding seven days.

NOTED.

5 REVIEW OF ROLLING ACTIONS LIST

The Forum received the action list and noted progress on the action points from the last meeting. The remainder of actions were completed or on today's agenda for discussion.

NOTED.

6 GROUNDS ACCESS POLICY UPDATE

Mr Ben Green, Clinical Liaison Security Manager advised that the Grounds Access Policy was halted in October due to the poor attendance response rate to meetings arranged to discuss the policy. He further advised that it was hoped the policy would go live following a fuller discussion around the table with sufficient relevant members of staff on the policy content. Lastly, Mr Green noted that the EQIA and DPIA would be completed thereafter, shortly after the festive period.

NOTED

7 UPDATE FROM AREA CLINICAL FORUM CHAIR'S GROUP FOR SCOTLAND

The Clinical Forum Chair advised members that key items of discussion at the last meeting of the Area Clinical Forum Chair's Group in September included;

- Election of a new Chair.
- Discussion on winter pressures.
- Recruitment issues.
- The financial picture for 2023.

Dr Howitt agreed to circulate minutes from this meeting once available.

NOTED.

8 UPDATES FROM EACH ADVISORY COMMITTEE ON SALIENT BUSINESS POINTS / APPROVED MINUTES TO NOTE

(a) Nursing and Allied Health Professions Advisory Committee

Members received and noted the minutes of the Nursing and Allied Health Professions Committee dated 11 October 2022. Nil of significance was raised.

NOTED.

(b) Medical Advisory Committee

Members received and noted the minute of the Medical Advisory Committee which took place on 12 September 2022. Nil of significance was raised.

NOTED.

(c) Psychology Professional Practice Meeting

Members received and noted the minutes of the Psychology Professional Practice meeting which took place on 7 November 2022. Nil of significance was raised.

NOTED.

(d) Update Report from Dentist, GP and Optometric

Members received and noted the September to November 2022 update in relation to the Dentist, GP and Optometric Services. Of note, was the significant improvement made by the newly appointed General Practitioner and the positive steps he made across the service. It was highlighted this was identified as an area of good practice at the Clinical Governance Committee in November 2022.

NOTED.

9 BOARD CHAIR / CHIEF EXECUTIVE OFFICER UPDATE

Due to the Clinical Forum having been rescheduled at late notice, the Board Chair or Chief Executive were not available to attend today's meeting.

NOTED.

10 UPDATE ON CLINICAL MODEL

Members were provided with a verbal update on progression of the Clinical Model by Dr Sheila Howitt, as Clinical Lead. Dr Howitt advised that flash reports on clinical model updates continue to be produced and issued site wide on a monthly basis. The implementation group were next due to meet in December 2022 where the second draft of the clinical care documentation would be discussed in advance of the final draft being produced in January 2023.

NOTED.

11 REVIEW OF FORUM DURING 2022

Members discussed and reviewed the Forum's overall performance throughout 2022 and agreed that, positively, members met regularly and momentum continued after the impact on the coronavirus pandemic and staffing resources. Cohesion was maintained with regular updates received on specific areas, and additionally, having linkage with the Board Chair and Chief Executive. The Forum acknowledged the challenging factor was member's attendance throughout the year due to turnover of staff.

NOTED.

12 AOCB

a) Ms Clark advised that the Clinical Care Policy would be issued in due course and members were asked to provide feedback.

NOTED.

b) Dr Natalie Bordon, Consultant Psychologist, joined the meeting at this time to present the following policies;

Patient Access to Sexually Explicit Materials and Patient Access to Violent Materials Policy

Dr Bordon delivered an update on the above policies by way of a presentation in order to seek the Forum's views prior to these being issued for full consultation and submission to the Policy Approval Group.

The presentation contained a detailed account around a number of key areas such as the full definition of sexually explicit material, the practice in place across other high secure forensic services in NHS England, literature definition and outcomes, security and monitoring of permitted material, the current hospital's policy content, and lastly, final recommendations to the Forum following the current review.

Detailed discussion took place focused on clinical advice on each policy in the context of what is permitted within The State Hospital. Suggestion and agreement was made around the benefit of bringing both policies together. Dr Bordon advised that she would note the Forum's views and include these prior to the merged policies being issued for full consultation and submission to the Policy Approval Group.

NOTED.

13 DATE AND TIME OF NEXT MEETING

The next meeting of the Clinical Forum would take place at 10am on Tuesday 17 January 2023 via Microsoft Teams.

Meeting concluded at 1130 hours

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 February 2023
Agenda Reference:	Item No: 15
Sponsoring Director:	Director of Workforce
Author(s):	HR Advisor / Training & Professional Development Manager
Title of Report:	Workforce Report
Purpose of Report:	For Noting

1 SITUATION

This report provides an update on overall workforce performance to 31st January 2023.

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

2 BACKGROUND

The State Hospital use a dashboard system called Tableau. The system has the ability for managers to set up subscriptions to reports on particular days so that they receive an auto-notification.

The Tableau dashboards are updated on a daily basis with attendance information using information from the SSTS system, meaning that the information available is live and as accurate and up to date as the information input by managers. A monthly upload from EESS enables turnover information to be available, and there is also a monthly upload from JobTrain with recruitment information. The final development at this stage will be to provide centrally available establishment and vacancy level figures and this work is still ongoing.

The information is provided to the end of January 2023, with the exception of the national figures which are up to 31 December 2022.

3 ASSESSMENT

- **Absence and Attendance Management**

    - The information available shows that the absence rate for January 2023 is 10.36%. The rolling year average is 6.79%.
    - Within Nursing, the absence rate for January 2023 is 12.87%. The rolling year average is 8.18%
    - 59 staff were being managed through the formal stages of the Attendance Policy and 27 staff were off on long term absence.
    - Key reasons for short-term absence were anxiety/stress/depression, cold/cough/flu and gastrointestinal. For long-term absence, the main reasons were anxiety/stress/depression, injury/fracture and other known causes (not specified).
    - Covid related absence accounted for 0.52% of all absence.
    - Daily updates on all staff absence are now generated via Tableau and sent to all managers who have requested this report.
    - Detailed work continues to be undertaken in targeted departments looking at trends in absence reasons and patterns of absence, using this information to identify what supports can be put in place to support individuals in remaining at work as well as supported back to work from absence.
    - Details of Salus compliance against KPIs are now available for Q1-Q3. This shows that all management referrals are seen and responses provided within the 15-day KPI.

- **Recruitment**

    - Seven separate posts were advertised in January, totalling 8 vacancies. There are 19 individuals with confirmed start dates and a further 8 with conditional offers pending checks and clearances.
    - Work is ongoing to consider the KPI for recruitment to ascertain how the timelines can be reduced. There are four areas of note where the TSH figure is significantly above the KPI
        - Advert Live to Closing Date KPI is 10 days. TSH timescale was 16 days. This was due to a number of hard to fill posts having extended closing dates.
        - Closing date to Shortlist complete KPI is 5 days. TSH timescale was 9 days. This is due to the timescales taken by hiring managers to process this. All hiring managers are reminded via email to complete within 5 days of advert closing.
        - Invite to Interview to Interview date KPI is 7 days. TSH timescale is 15 days. This is due to the timescales taken by hiring managers to provide a date for interview. Best practice would be for hiring managers to have an interview date stated within candidate advert.
        - Conditional Offer to Pre-checks KPI is 20 days. TSH timescale was 30 days. This can partly be attributed to PVG checks and Disclosure Scotland checks taking longer than usual.

- TSH participated at the recruitment fayre at Queen Margaret University, Edinburgh on 1 February and will also participate in the RCN Recruitment Fayre on 21 February in Glasgow. Advertisement for a virtual recruitment event is underway with 7 potential applicants joining this event so far and we predict this will rise in coming days.
- A pilot is being trialled via MS Forms with new starts from December 2022 to date requesting feedback on their on-boarding experience: responses were received from 10 out of 15 individuals. This pilot will be expanded to request additional feedback forms for staff at 6 months and 12 months post employment on their initial experiences within TSH. Findings from the initial report have been interesting, including 4 out of 10 new starts not being contacted by their Manager prior to their start date. Further analysis will be undertaken and work will be undertaken to action key areas and improvements in communication with the candidate prior to start date.

- **Supplementary Staffing**

  - 48.69 WTE supplementary staffing were required through overtime or excess hours for the whole organisation. 33.76 WTE supplementary staffing was required for Nursing.
  - Work will be overseen by the Workforce Governance Group on analysing the use of overtime / excess hours and supplementary staff.

- **Employee Relations**

  - One new informal and two formal employee relations cases were identified. There were six ongoing cases.

- **Turnover**

  - Six staff ended their employment at The State Hospital in January 2023. This brings the total number of staff who have left within financial year 2022/23 to 76 to date.
  - Exit interviews are offered to all staff on leaving the organisation. A trial is underway with MS Forms enabling staff to complete the exit interview through this function. Staff are given both the link and a QR code to access this. Eight individuals have completed the exit form in this way to date, providing useful information. Further analysis and work continues on the data to consider retention issues.

- **PDPR Compliance**

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

The National Turas Appraisal online system is used for recording details of PDPR meetings and completed annual reviews.

As at 31 January 2023:

- The total number of current (i.e. live) reviews was 525 (85.1%) – an increase of 0.2% from December 2022.

- A total of 62 staff (10.1%) had an out-of-date PDPR (i.e. the annual review meeting is overdue) – a decrease of 0.9% from December 2022.

- A further 30 staff (4.8%) had not had a PDPR meeting – an increase of 0.7% from December 2022. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.

There are currently nine departments below the State Hospital's 80% minimum compliance threshold (a decrease of two departments from last month). This includes:

- eHealth – compliance level 69.2% (increased 4.9%). Non-compliant for 16 months. This equates to 1 overdue update and 1 with no PDPR in place
- Executive Director Reports – compliance level 64% (decreased 6.8%). Non-compliant for 16 months. This equates to 4 overdue updates and 5 with no PDPR in place.
- Forensic Network – compliance level 60% (no change). Non-compliant for 1 month. This equates to 1 overdue update and 1 with no PDPR in place.
- Health Records – compliance level (66.7% (decreased 8.3%). Non-compliant from 1 month. This equates to 1 overdue update.
- Hub Admin & PAs – compliance level 45.8% (no change). Non-compliant for 4 months. This equates to 11 overdue updates and 2 with no PDPR in place.
- Iona 3 – compliance level 74.1% (increased 4.9%). Non-compliant from 1 month. This equates to 6 overdue updates and 1 with no PDPR in place.
- Lewis 2 – compliance level 76.7%. Non-compliant from 31 January 2023. This equates to 4 overdue and 3 with no PDPR in place.
- Procurement – compliance level 66.7% (no change). Non-compliant for 1 month. This equates to 2 overdue updates.
- Psychology – compliance level 66.7% (decreased 8.3%). Non-compliant for 1 month. This equates to 5 overdue updates and 1 with no PDPR in place.

Progress reports continue to be provided to all departmental managers on a monthly basis, and compliance levels are monitored and reviewed quarterly by the Organisational Management Team.

4 RECOMMENDATION

Board members are invited to note this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Links to the Attendance Management Policy and aids monitoring of 5% attendance target locally. The national target is currently 4%.
Workforce Implications	Failure to achieve 5% target will impact ability to efficiently resource organisation.
Financial Implications	Failure to achieve 5% target results in additional spend to ensure continued safe staffing levels
Route to Board Which groups were involved in contributing to the paper and recommendations.	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 5% target will impact on stakeholder experience
Equality Impact Assessment	Not required for this report as monitoring summary report.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	There are no identified impacts.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 February 2023
Agenda Reference:	Item No: 16
Sponsoring Director:	Director of Workforce
Author(s):	Training & Professional Development Manager Organisational Development & Learning Advisor
Title of Report:	iMatter Update
Purpose of Report:	For Noting

1 SITUATION

This report summarises the key themes of the 2022 iMatter cycle and provides a short analysis of the findings as they relate to the State Hospital. It is important to note that the survey gives a snapshot in time and this years' iMatter cycle reverted to its original timescale - making it less than one year since the 2021 questionnaire was issued. The national *Health & Social Care Staff Experience Report 2022* was published on 16 November 2022 and a short comparison has been provided for key areas.

2 BACKGROUND

The 2022 iMatter questionnaire was issued on 23 May 2022.

- **72%** of staff responded (i.e. 454 staff out of 627 staff).
- **94%** of teams received a report. Four teams did not achieve a report. This was due to team size and a requirement for those teams to achieve a 100% response rate to protect anonymity.
- The Board's EEI number was 75.
- **65%** of teams completed an iMatter Action Plan within the 8-week target timescale.

Every member of staff received a copy of their team report directly into their e-mail inbox. Team leads can also access reports, and team leaders/managers have been strongly encouraged to actively share and discuss the iMatter reports within their teams.

3 ASSESSMENT

Response rate

The table below provides details of iMatter response rates since 2017 and shows an increase of 3% from last year. Responses to the Everyone Matters survey in 2020 have also been included for comparison. Scores in red show comparison to the national *Health & Social Care Staff Experience Report 2022*.

	2017	2018	2019	Everyone Matters 2020	2021	2022
TSH	78%	77%	79%	48%	69%	72%
NHSScotland	63%	59%	62%	43%	56%	55%

The response rate within the State Hospital was 18% higher than the overall response rate NHS Scotland.

Areas of strength

The five highest scoring areas within the TSH report were:

- I am clear about my duties and responsibilities (Score 89: consistently No 1)
- My direct line manager is sufficiently approachable (Score 88: consistently No 2)
- I feel my direct line manager cares about my health and wellbeing (Score 85: consistently in top 5).
- I would recommend my team as a good one to be part of (Score 85: consistently in top 5)
- I have confidence and trust in my line manager (Score 85: an improvement of 3 points from 2021)

These results are consistent with previous years and highlight particular strengths in relation to role clarity, team cohesion and team leader support within teams. They are also broadly similar to the overall results for Health & Social Care in Scotland where the following were the five highest scoring areas.

- My direct line manager is sufficiently approachable (Score 88)
- I am clear about my duties and responsibilities (Score 87)
- I feel my direct line manager cares about my health and wellbeing (Score 86).
- I have confidence and trust in my line manager (Score 85)
- I would recommend my team as a good one to be part of (Score 84)

Areas of challenge

The five lowest scoring areas were:

- I feel that Board members who are responsible for my organisation are sufficiently visible (Score 50: a decrease of 1 point from 2021 and consistently in bottom 5)
- I feel sufficiently involved in decisions relating to my organisation (Score 54: no change from 2021 and consistently in bottom 5)

- I have confidence and trust in Board members who are responsible for my organisation (Score 57: no change from 2021 and consistently in bottom 5).
- I am confident performance is managed well within my organisation (Score 57: an improvement of 2 points from 2021 and consistently in bottom 5)
- I feel my organisation cares about my health and wellbeing (Score 67 – an improvement of 2 points from 2021)

Scores in the **range 51-66** are considered as important areas to 'monitor to further improve'. The key areas for improvement are consistent with previous years, however, improvements are reported in relation to staffs' confidence that performance is managed well in the organisation, and their perception that the organisation cares about their health and wellbeing.

It is probably not surprising that staff feel more distant from the senior members of the organisation than they do from their teams, and this area has likely been impacted by the reduction in leadership walk-rounds and Board member presence on site over the last few years as a consequence of the Coronavirus pandemic. However, it is still incumbent on senior leaders in the organisation to consider what additional action they might take to ensure visibility, inclusion, openness and transparency in decision-making.

Overall within Health & Social Care in Scotland the five lowest scoring areas were.

- I feel that Board members who are responsible for my organisation are sufficiently visible (Score 55)
- I feel sufficiently involved in decisions relating to my organisation (Score 55)
- I have confidence and trust in Board members who are responsible for my organisation (Score 61).
- I am confident performance is managed well within my organisation (Score 63)
- I get the help and support I need from other teams and services within the organisation to do my job (Score 71)

Performance against the Staff Governance Standard

The following table shows the weighted index scores against the Staff Governance Standards, with comparisons since 2015. Scores in red show comparison to the national *Health & Social Care Staff Experience Report 2022*.

	iMatter 2015 TSH NHSScotland	iMatter 2016 TSH NHSScotland	iMatter 2017 TSH NHSScotland	iMatter 2018 TSH NHSScotland	iMatter 2019 TSH NHSScotland	iMatter 2021 TSH NHSScotland	iMatter 2022 TSH NHSScotland
Performance in Staff Governance Strands							
Well informed	80 (78)	79 (79)	80 (80)	81 (80)	82 (80)	78 (78)	78 (79)
Appropriately trained & developed	75 (71)	74 (72)	76 (73)	77 (74)	79 (74)	76 (73)	76 (75)
Involved in decisions	71 (69)	70 (70)	72 (71)	73 (71)	73 (71)	70 (70)	70 (71)
Treated fairly & consistently	76 (75)	75 (76)	77 (77)	78 (77)	78 (77)	76 (77)	77 (78)
Safe environment	75 (75)	75 (75)	76 (76)	77 (77)	77 (77)	74 (76)	75 (77)

Scores across all areas remain within the green 'strive and celebrate' range of 67-100 and are broadly similar to last year. They are also comparable with the overall scores for Health & Social care in Scotland,

Within the State Hospital, being well informed remains the highest scoring area, and involvement in decisions remains the lowest scoring area. Slight increases in scores are evident in relation to being treated fairly and consistently, and being provided with a safe environment that promotes the health and wellbeing of staff and patients. This is encouraging given the current organisational investment and focus on staff wellbeing and support.

How Directorates Responded

The majority of survey respondents used the online questionnaire. However, there were seven requests for paper copies, and one paper response was submitted. Going forward, we will continue to work to get full online responding as it makes for a faster process with less likelihood of error.

The response rate for each directorate for 2022 (with comparisons from previous years) is as follows:

	Chair	Security	CEO	Psych	HR	DDiT	Medic	N&AHP	Fin&Per
2022	100%	62%	100%	83%	94%	67%	67%	72%	94%
2021	86%	66%	92%	73%	94%	67%	90%	66%	62%
2020	67%	53%	82%	62%	88%	-	72%	39%	69%
2019	67%	82%	87%	92%	88%	-	94%	75%	83%

In summary, compared to response rate in 2021:

- Five directorates saw an increase in their overall response rate.
- Two directorates achieved the same response rate.
- Two directorates saw a decrease in overall response rate.

Employee Engagement Index (EEI numbers)

	2017	2018	2019	2020	2021	2022
TSH	76	77	77	n/a	74	75
NHSScotland	75	No report	76	n/a	75	76

The EEI number for 2022 increased by one point from last year, however, is still lower in comparison with previous years. This is perhaps not surprising, given the ongoing challenges and pressures that staff have faced over recent years due to the Coronavirus pandemic. With the increased focus on wellbeing, and additional resource which is being provided to support the wellbeing agenda, it is hoped that we will see further improvement in the EEI number in the coming year.

Scores in red show comparison to the national *Health & Social Care Staff Experience Report 2022*.

Action Plans

The target date for completion of action plans was 22 August 2022. A total of 44 teams (65%) completed their action plan within the eight-week target timescale (an increase of 6% from 2021), and as of 1 January 2023, completion of team action plans had increased to 83% (57 out of 69 teams).

	2017	2018	2019	2020	2021	2022
TSH	78%	55%	79%	n/a	59%	65%
NHSScotland	43%	56%	58%	n/a	42%	47%

Scores in red show comparison with the national *Health & Social Care Staff Experience Report 2022* and indicate that action plan completion rates within the State Hospital are significantly higher than the national overall %.

Summary

In summary, the iMatter survey results for 2022 are broadly similar to last year.

Overall response rates increased by 3%, and staff continue to report strong satisfaction in relation to team cohesion, role clarity and line manager support. Slight improvements are evident in relation to staff satisfaction with how performance is managed in the organisation, and perceptions regarding organisational commitment and support for staff health and wellbeing.

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

The 2023 iMatter cycle will commence in May 2023 with the following key dates:

- 24 April - Team confirmation begins
- 22 May - Questionnaire distributed to workforce
- 26 June - Team reports are published
- 22 August - Team action plan completion date

The 2023 questionnaire will feature additional questions to capture whistleblowing concerns. These questions will not impact on the employee engagement index (EEI) but will run as a test of change for 2023 with appropriate evaluation of success and impact.

A new IT system/platform is also being developed and tested by Webropol in 2023 and will be launched in time for the 2024 cycle.

4 RECOMMENDATIONS

Board members are invited to note the contents of this report and the update from the National iMatter Reports.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support 2022/23 Workforce Plan, Wellbeing Agenda and iMatter.
Workforce Implications	Considered in this report
Financial Implications	None identified
Route To Board Which groups were involved in contributing to the paper and recommendations.	Staff Governance Partnership Forum
Risk Assessment (Outline any significant risks and associated mitigation)	Fully outlined and considered in the report
Assessment of Impact on Stakeholder Experience	Fully outlined and considered in the report. It is well evidenced that good workforce morale is directly linked to a more positive patient and staff experience
Equality Impact Assessment	Screened and no implications identified for reporting.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	There are no identified impacts.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 February 2023
Agenda Reference:	Item No: 17 (a)
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Whistleblowing Champion - Annual Update
Purpose of Report:	For Noting

1 SITUATION

To provide an annual update on the Non- Executive Whistleblowing Champion's role at The State Hospital.

2 BACKGROUND

On the 13 December 2022, the Cabinet Secretary for Health and Social Care wrote to Health Boards' Whistleblowing Champions.

He requested a short update on the Whistleblowing Champion's role at Board level, and detail of any work to ensure and promote a more positive and engaging culture within the Board.

3 ASSESSMENT

The role of Non-Executive Whistleblowing Champion at The State Hospital has been vacant since July 2021 but was filled on 16 January 2023. The response to the Cabinet Secretary for Health and Social Care advises of this.

In these circumstances, the Board Chair has prepared the update, and this is attached.

4 RECOMMENDATION

The Board are asked to note the draft response

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	As part of 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.	Board awareness - requested by Scottish Government
Risk Assessment (Outline any significant risks and associated mitigation)	No risk identified
Assessment of Impact on Stakeholder Experience	Reporting on supportive mechanisms in place.
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.

APPENDIX A - DRAFT

Dear Mr Yousaf,

Further to your letter of 13 December 2022, I am writing to provide an update regarding Whistleblowing arrangements at the State Hospitals Board for Scotland.

Since July 2021 the position of Non-Executive Director (Whistleblowing Champion) has been vacant. I am pleased to say that as of 16 January 2023 the position has now been filled. As with our response to you last year, I will provide a commentary to you from a Board perspective regarding Whistleblowing issues.

Regarding the specific issues raised in your letter I can provide the following information and assurance.

- The Whistleblowing Standards have also been a standing item on the Staff Governance Standing committee and regular reports are brought to the Board in ensuring compliance with the Governance section of the Whistleblowing standards.
- From 1 April 2022 to 31 January 2023 there were no Whistleblowing concerns raised direct to the Board. No cases have been raised by any other contractors or anyone linked to the Standard during this time. However, there was one anonymous complaint received by the INWO during Quarter 3, which they have reported to us. They have confirmed that this is for our noting and no further action will be taken by them or any expectation on actions from the Board.
- Since the implementation of the standards, The State Hospital have continued to consider how best to provide continuous improvement in processes and support to any individual raising concerns. An Action Plan was developed in line with the outcome of Whistleblowing Concerns raised during 2021/22 and reported in the previous report. The learning points form part of the Action Plan, which is considered at the HR & Wellbeing Group and updated to the Staff Governance Committee and Board.
- The State Hospital participated in the “Speak up Week” which took place on 3-7 October 2022. Staff Bulletins were circulated to the service from the Chair, Chief Executive and Employee Director amongst the updates. Noticeboards provided information to staff on the Standard and the main one was placed in the front reception area. This also provided staff with specially branded pens, notepads and post-it notes, highlighting that “Speaking up is in everyone’s interest”. A Wordsearch competition was also undertaken and the winner of a Fitbit watch was a Catering Assistant. Information relating this to initiative was also highlighted on social media and general feedback to this initiative has been positive.
- The INWO attended a Board Development Session in September 2022 with Executive and Non-Executive members. This provided a presentation on the Standards and expectations of the Board along with an opportunity for questions. This was extremely helpful for those present to understand their role in the Standard.
- Work continues on highlighting the requirement for Staff and Managers to complete the on-line module on the Whistleblowing Standards and update to date is:

Introduction for all Staff – 356 (83% of target group)

Managers Training – 68 (68% of target group)

Despite the vacant position of the Non-Executive Director (Whistleblowing Champion) the Board has been able to fulfil its governance role regarding the standards and has overseen a programme of development and improvement which has contributed to the promotion of a positive organisational culture.

Other related Board actions include, learning from iMatter reports, continuous review of the culture element of the Corporate Governance Improvement action plan and oversight of the delivery of the Boards Workforce and Staff and Volunteer Wellbeing plans.

The content of this response was shared with Board members at the State Hospital Boards for Scotland on 23 February 2023.

Yours sincerely,

BRIAN MOORE
CHAIR

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 February 2023
Agenda Reference:	Item No: 17b
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Whistleblowing Update
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

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

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

3 ASSESSMENT

The Quarter 3 update is for 1st October 2022 to 31st December 2022. No formal Whistleblowing cases were raised during this quarter direct with The State Hospital.

However, the INWO did make contact with us on 30th January 2023 to confirm they had received an anonymous Whistleblowing concern which is for Quarter 3. They confirmed the following:

"*I am writing to let you know that we received one anonymous whistleblowing concern about your organisation in Q3 2022-23. We are informing you so you are aware and can monitor the number of these cases raised with us about your board. We assess all such concerns on receipt, and if there is any need to take action or pass on relevant information we would do so at the time we received the concern. We are therefore sharing this information for monitoring purposes only*"

Contact was made direct to INWO to ascertain if there was any theme or particular issue that The State Hospital to take on board as part of our ongoing action plan and any particular communications to lead on. However, they have confirmed that they will not share the information at this stage and we should note this as part of our quarterly and annual report.

It has been confirmed by the Cabinet Secretary for Health & Social Care, Humza Yousaf MSP, that Shalinary Raghavan has been appointed as Non-Executive Whistleblowing Champion. Work will continue with the new Non-Executive to ensure that the Standards are fully developed / communicated within the Board.

TSH Hospital participated in the "Speak Up Week" which took place on 3-7 October 2022. Staff Bulletins were distributed to the service from the Chair, Chief Executive and Employee Director amongst others providing updates.

Noticeboards continue to provide information to staff on the Standard and a Wellbeing Leaflet has been developed highlighting the support that staff are able to access.

4 RECOMMENDATION

The Board Members are invited to note the Quarter 3 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.	Partnership Forum 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
STAFF GOVERNANCE COMMITTEE

Minutes of the meeting of the Staff Governance Committee held on Thursday 17 November 2022 at 9.45am via MS Teams. SGC(M) 22/04

Chair:

Non-Executive Director	Pam Radage

Present:

Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Board Chair / Non-Executive Director	Brian Moore

In attendance:

Head of HR	Audrey Bevan
POA Staff Side Representative	Alan Blackwood
Professional Nurse Advisor	Josie Clark
Training & Professional Development Manager	Sandra Dunlop
Chief Executive	Gary Jenkins
Director of Workforce	Linda McGovern
UNISON Staff Side Representative	Michelle McKinlay
Head of Planning & Performance	Monica Merson
Board Secretary	Margaret Smith

In attendance (part):

Head of Commercial Services and Principal Occupational Health Advisor	Kay Japp
Consultant Occupational Health Physician	Dr Sergio Vargas-Prada
Occupational Health Secretary	Caron Casey
Occupational Health Advisor	Karen McGurk
Staff Care Specialist	Lorna Fyfe
OD, Learning and Wellbeing Advisor	Gayle Scott
PA to Director of Workforce	Rhona Preston ***(Minutes)***

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Pam Radage welcomed everyone to the meeting, noting formal apologies from Cathy Fallon, Non-Executive Director and Stuart Lammie, Lead Nurse.

2 CONFLICTS OF INTEREST

Due to Item 15, Occupational Health Service Level Agreement, Brian Moore advised the Committee of his position on the Board of NHS Lanarkshire.

3 MINUTES OF THE PREVIOUS MEETING HELD ON 18 AUGUST 2022

The Committee approved the Minutes of the previous meeting held on 18 August 2022 as an accurate record of the meeting.

4 ACTION POINTS AND MATTERS ARISING FROM THE PREVIOUS MEETING

Pam Radage referenced the recent email correspondence issued by Margaret Smith, Board Secretary asking members to complete the self-assessment exercise. The results of this will be presented to the February meeting.

STANDING ITEMS

5 SALUS OCCUPATIONAL HEALTH ANNUAL REPORT AND PRESENTATION

Members received and noted the OHS Annual Report from April 2021 to March 2022 and presentation provided by Kay Japp, Principal Occupational Health Advisor, Head of Commercial Services. The reported highlighted to the following areas:

The current Service Level Agreement is in place until 31st December 2022 with an option to extend for 3 months.

Key Performance Indicators were implemented in April 2019; the report reflects the 3rd full year of this data.

Management referrals have increased slightly (10%) from last year and the Physician and Nurse resource still match the demand.

Cancellations rate is 9.7% and DNAs is 5% which together accounts for 14.7 % of management referral appointments. This is a 6.3% reduction from last year.

The EASY service is provided within the Occupational Health Service Level Agreement at no additional cost to the State Hospital. Utilisation of the Case Management (Mental Health) service remains low at 8 cases a slight increase from 6 last years.

Across the year, sickness absence in the State Hospital averaged 6.63% which is a 1.3% increase since 2020/21 and just under 1% higher than NHS Scotland.

Mental health and musculoskeletal conditions remain the commonest disorders seen and mental health disorders now significantly exceed musculoskeletal as the highest cause of absence and referrals. Volumes are unchanged from last year's report.

There was a 50% increase in Pre-Placement Health Assessments

The amount of PMVA screening has reduced significantly as planned, and only 34 screenings took place against 240 the previous year.

Most staff accessing Physiotherapy are at work. The largest proportion of cases had spinal conditions (34%) down from 48% last year. Waiting times were 2.75 days, a slight increase on last year. Most staff self-refer to the service. Appointments per person is just under 2. 9 staff (6%) stated that there was a work related element in their musculoskeletal condition with 3 saying it was a direct contributor which is the same as the previous year. 78% of those treated, declared a positive outcome from treatment.

The actions identified for 2022/2023 include:

A new version of the Occupational Health IT system was introduced in March 2021, further training will be given to allow data extraction and reporting from the system.

Record keeping aims to move to a paperless system and old files will be scanned or archived.

The OH input to Induction training will be revised with a view to developing online access.

Scheduled vaccination clinics will be reintroduced.

From table 1 – reasons for referral it was recognised that not work related was high against psychological/psychiatric and Gary Jenkins asked whether there was enough targeted support provided in this area. Kay Japp advised of the good work taking place at the Hospital and noted this reason is not uncommon across other Boards and many staff have a combination of personal issues affecting them out with work which can the overspill into their work life.

Alan Blackwood complimented the services provided by SALUS on behalf of many of his members and advised that using the Psychological support service is influenced by GPs and is incredibly limited which results in many staff being seen much sooner utilising the services offered by the Hospital.

Brian Moore raised the issue of the DNA rates for the physiotherapy service and asked if prompts can be used to remind people to ensure maximum uptake. Kay Japp advised these are not currently used however this is an area that could be explored further.

Pam Radage was encouraged with the report and feels this is testament to the work that is ongoing. Kay Japp and her team were thanked for the report and presentation.

The SALUS Team left the meeting.

6 WORKFORCE REPORT

The Committee received the report as summarised by Audrey Bevan, Head of Human Resources, the report provides an update on overall workforce performance to 31st October 2022.

The information available shows that the absence rate for October 2022 is 8.35%. The rolling year average is 6.45%. 46 staff were being managed through the formal stages of the Attendance Policy and 26 staff were off on long term absence. The key reasons for short term absence were cold, cough, flu, anxiety/stress/depression and back problems. For long term absence, the main reasons were anxiety/stress/depression, other musculoskeletal and back problems.

Anxiety, stress and depression is consistently the most significant reason for absence at TSH: 46% of absence in October 2022 was attributed to this. Across NHS Scotland, anxiety, stress and depression is also the most significant reason for absence: 14.2% in September 2022 and 9.7% on average over the year. It should be noted that the reason code 'unknown' accounts for 12.1% and 17.12% respectively. Similar levels of absence are attributed to 'cold, cough, flu' and 'gastrointestinal' both in month and on average across the year, at around 15% each. TSH's rates are above this, therefore a review has been carried out of all long term absence cases and it is noted that the majority of mental health related absences are related to personal issues such as bereavement reaction or stress at home. All long absences continue to be managed in line with the NHS Scotland Attendance Policy.

Eight posts were advertised in October. This includes an advert for 16 staff nurses. There is one individual with a confirmed start dates, 12 individuals with pending start dates and three individuals where the provisional start date has to be agreed. The national KPI for completion of the recruitment process from post approval to start date is 75 days and for individuals who started within September, The State Hospital average was 142.

57.31 WTE supplementary staffing was required through overtime or excess hours for the whole organisation. 40.30 WTE supplementary staffing was required for Nursing.

Six staff ended their employment at The State Hospital in October 2022. This brings the total number of staff who have left within financial year 2022/23 to 49 to date. Exit interviews are offered to all staff when leaving the organisation. These can be done either by the line manager, or the staff member can complete a paper copy issued by and returned to HR. The outcomes of all exit interviews are shared with the Head of HR and the appropriate Director, with contents reviewed

and actions taken as required. Within the month of November, a trial is underway of moving the current TSH paper based exit interview form to an MS Forms, with additional questions added where negative responses are given. Staff can still complete the form with their manager or can request to discuss their experience with someone out with the department. It is hoped that this will improve return rates and enable analysis of the feedback.

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. At 31 October 2022;

The total number of current (i.e. live) reviews was 520 (84.6%) – a decrease of 0.2% from September 2022.

A total of 63 staff (10.2%) had an out-of-date PDPR (i.e. the annual review meeting is overdue), a decrease of 0.7% from September 2022.

A further 32 staff (5.2%) had not had a PDPR meeting – an increase of 0.9% from September 2022. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.

The committee noted the report and update provided.

7 WHISTLEBLOWING UPDATE

The Committee received the Whistleblowing update for Quarter Two, 1 July 2022 to 30 September 2022 as presented by Linda McGovern, Director of Workforce. There were no Whistleblowing cases were raised during this quarter.

An action plan has been developed to further improve understanding, awareness and process in relation to the Whistleblowing Standards and continues to be monitored.

The INWO attended a Board Development Session in September. They provided a helpful update on the Standards and also the responsibilities of the Board and Non-Executives in this process. There has been an appointment to the Non-Executive Whistleblowing Lead and this will be announced over the next week or so with a start date of December.

TSH Hospital participated in the "Speak Up Week" which took place on 3-7 October 2022. Staff Bulletins were emailed to the service from the Chair, Chief Executive and Employee Director amongst the updates.

Noticeboards provided information to staff on the Standard and the main one was placed in the front reception area. This also provided staff with specially branded pens, notepads and post-it notes, highlighting that "Speaking up is in everyone's interest". Information relating this to initiative was also highlighted on social media and general feedback to this initiative has been positive.

The committee noted the report and update provided.

8 STAFF AND VOLUNTEER WELLBEING REPORT

Members received and noted the Staff and Volunteer Wellbeing Report as presented by the OD and Learning Advisor and Staff Care Specialist who provided an update on the progress of the implementation of the strategy and associated action plan together with the work around the key performance indicators.

Members were advised of the Wellbeing Strategy and the eight areas it focuses on;
Mental Health; Environmental; Financial; Personal Growth & Development; Physical Health; Social and Spiritual & Occupational. Implementation ensures support across the following areas; Self-help; Peer; Line Management and Organisational. Members noted the progress listed in the report under these four key areas.

The Wellbeing Centre continues to be available for all staff to access each day as and when required, before, during or after shift. There is a dedicated staff support Monday – Friday, 9am-5pm. One of the KPIs agreed at the October Board meeting is to monitor footfall once in each quarter, to date the following attendance has been recorded:

May 2022 Footfall = 395
October 2022 Footfall = 272

Currently there is a dedicated resource of 0.8 WTE – this is fixed term until March 2023 and consists of two posts.

These posts support the Wellbeing Centre provision, health promotion activities and initiatives and 1:1 and group support offered to our staff and volunteers.

The Healthy Working Lives Group budget is £3000.00 (+£1000 set aside for the Excellence Awards).

There is Charitable Funding (ring fenced funding received from NHS Charities Together in 2020 - £25,000), with a balance remaining as at 31 October of £14,356.00. It has been agreed that quarterly updates on the requests / approvals / spend on these budgets will be undertaken at the HR & Wellbeing Group to ensure openness and transparency of the finance.

There have been a number of external and internal visits to the hospital recently. Those who have visited the wellbeing centre were impressed with what was available for staff and noted the positive intent in providing staff with this facility.

Members of the Committee also noted the Staff Care Specialist 1:1 Referral Report presented. The numbers reported are from the initial 7 months of the service being provided with 31 referrals between April and October. There are currently 17 live cases.

Also for information and noting was the Wellbeing Leaflet recently compiled that will be provided to new starts at their induction. This outlines the various support systems available.

Members thanked Gayle Scott and Lorna Fyfe for the comprehensive report and found the information very helpful.

There was discussion around how the hospital track the effectiveness to justify that these services are being used effectively that will assist in compiling the necessary information to make a case to continue this work.

Lorna Fyfe, Staff Care Specialist expressed her agreement and is very mindful that due to her position being funded to the end of December 2022, feels an overwhelming responsibility for the individuals she is engaging with and is concerned about the timeframes involved, she wants to ensure she is providing a benefit to them and the organization. It was noted that the feedback within the recent iMatter should assist in providing justification for the needs of this service, Gayle Scott, Learning and Wellbeing Advisor also suggested a further survey / questionnaire could be carried out to get a clearer picture of the impact the service is having on staff.

Josie Clarke, Professional Nurse Advisor suggested that the phone line(s) detailed in the leaflet can be promoted further, ensuring all staff are aware of this external support.

Alan Blackwood, POA Representative advised members that this investment of having this skill set that staff can utilize has been very well received and raised his concern that it seems to be unknown at this time whether the Staff Care Specialist service will continue after December 2022, particularly with the live cases ongoing, he raised concerns that discontinuing the support to the affected staff could have a detrimental effect.

Linda McGovern updated the Committee that she met with Gary Jenkins yesterday and the Service Level Agreement for the Staff Care Specialist is being extended to end March 2023. Further discussion will take place via the Scottish Government around Wellbeing Funding which will be communicated further once agreed.

Pam Radage thanked both Gayle and Lorna for their continued service and was pleased to hear about the extension to the Staff Care Specialist role and agreed the Wellbeing Centre is an incredible service.

ITEMS FOR DISCUSSION

9 STATUTORY AND MANDATORY TRAINING COMPLIANCE (APR-SEPT)

Members received and noted the compliance update from April to September 2022 as presented by Sandra Dunlop, Training and Professional Development Manager.

Statutory training is training that the organisation is legally required to provide as defined in law, or where a statutory body has instructed the organisation to provide training on the basis of legislation.

Mandatory training refers to training requirements that have been determined by the organisation as a result of policy requirements, government directives, and/or recognised best practice guidelines. Mandatory training is often concerned with minimising risk and ensuring the Board meets internal or external standards.

The compliance figures are calculated as an average, based on compliance levels for all statutory and mandatory courses within the Corporate Training Plan.

There was 93% compliance for Statutory Training, this is an increase of 1.2% from March 2022 and the compliance for Mandatory Training was 83.7% an increase from March 2022.

Despite the challenges over the last 6 months' members agreed the position is positive. Sandra Dunlop summarized the concern where compliance levels decreased with Manual Handling Practical Skills Training. She advised however this is an area the department are targeting advising of tailored practical manual handling training being delivered currently at ward level to support the care and management of individual patients with mobility and manual handling needs. A cohort of 12 Manual Handling Link Workers have also been identified to provide manual handing guidance and support at ward/departmental level, and training to equip them for this role is scheduled for delivery in December 2022. The Link Worker approach is endorsed by the Scottish Manual Handling Passport Scheme and is widely employed across NHS and social care to support organisational compliance with manual handling regulations and associated legal requirements.

To support an increase in compliance for online refresher training, a new 'Scorecard' function was introduced within LearnPro in September 2022. The Scorecard is linked to an individual's learning plan, which contains core learning modules that are mandatory for all staff, plus online learning modules that are mandatory for the individual's specific job role. Their current completion status is highlighted whenever they log on, with all outstanding modules displayed in a quick access banner that is located directly under the Scorecard.

Gary Jenkins advised he had found the new score card very helpful and user friendly.

Pam Radage thanked Sandra Dunlop and her team for their continued support and efforts in ensuring compliance levels remain a priority.

10 STAFF GOVERNANCE STANDARD MONITORING RETURN 2021/2022

Members received and noted The Staff Governance Monitoring Return 2021/22 attached for review and require approval by the Committee prior to submission to the Scottish Government on the 18 November 2022.

The Staff Governance Monitoring process is two-fold aiming to provide assurance both locally and nationally that: The Staff Governance Standard (the Standard) is being fully and properly applied in all Boards, and where there are areas for concern that support is provided; and, To share good practice to help drive continuous improvement across all NHSScotland Health Boards.

Members endorsed and approved the submission to the Scottish Government.

11 iMATTER REPORT

Members received and noted the iMatter Report that summarises the key themes of the 2022 iMatter reports and provides a short analysis of the findings as they relate to the State Hospital. It is important to note that the survey gives a snapshot in time and this years' iMatter cycle reverted back to its original timescale, making it less than one year since the 2021 questionnaire was issued. Linda McGovern, Director of Workforce thanked Gayle Scott, OD and Learning Advisor for pulling together this report noting that the national report has since been received. This was not expected until January 2023. Further work will be carried out from the National report and a constructive report will come to a future meeting.

The response rate from the National report is 55%, The State Hospital are the highest with 77% which puts the Hospital in a strong position. The National Report will be shared after this meeting for information.

Members noted the report presented noting the overall response rates have increased by 3%, and staff continue to report strong satisfaction in relation to team cohesion, role clarity and line manager support. Slight improvements are evident in relation to staff satisfaction with how performance is managed in the organisation, and perceptions regarding organisational commitment and support for staff health and wellbeing.

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

12 PRACTICE DEVELOPMENT UPDATE

Members received and noted the Nursing Practice Development update report from February to November 2022, as presented by Josie Clark, Professional Nurse Advisor. The report provides a progress update on the work of the Nursing Practice Development (NPD) Service since the last progress report provided in February 2022. The report also briefly outlines an overview of the team's key priorities for 2023.

Following a period of sustained deficits and retirements throughout 2020 and 2021, and a redeployment of priorities to support organisational response to the COVID pandemic, the NPD team are now working towards a full staffing complement for early 2023. Successful appointments to both full-time Senior Nurse posts were completed in May and October 2022 and work is now underway to recruit to the vacant Practice Education Facilitator post. It is anticipated that this post will attract interest both internally and externally and is likely to be filled without concern. On completion the team will be functioning at full complement of; 1 x Professional Nurse Advisor; 2.5 x Senior Nurses (0.5WTE seconded to University of the West of Scotland) and 1 x Practice Education Facilitator (PEF).

Members received and noted the summary of the work streams the team have been continuing to deliver across the course of the year together with the priorities for 2023.

Pam Radage thanked Josie Clark for this update and asked that this report comes to the Committee twice a year.

ACTION: J CLARK

13 RECRUITMENT STRATEGY UPDATE

Audrey Bevan, Head of HR presented the Recruitment Strategy update and action plan. The aim of the Recruitment Strategy is to meet The State Hospital's organisational objective of recruiting and retaining an effective and modern workforce.

The strategy is intended to support the provision of high quality, effective and safe care.

The action plan covers a number of areas of recruitment and related activity;
Recruitment; eESS Self Service/Manager Self Service; Exit Interviews; Tableau Dashboards; On boarding and TSH Profile.

Audrey Bevan updated members on the good work that is taking place and advised the next steps are to be more visible in Universities / Colleges etc.

Linda McGovern advised of rebranding work that is underway with a TSH Logo. It is hoped this is approved allowing The State Hospital to market itself and stand out from other NHS Boards. Members liked the idea of branding and agreed that early contact with Universities is important.

14 DRAFT STAFF GOVERNANCE WORKPLAN 2023-2024

Members received and noted the draft Workplan presented for 2023-24. It was recognised that updates from the Workforce Governance Group which will commence in January should be added for information.

Margaret Smith, Board Secretary advised members that there will be a move in support to the Committee from January 2023 that will provide more cohesion in how the Committee is supported. This will be carried out by the Corporate Team. The workplan across all the will be reviewed and developed further in the coming year.

ACTION: M SMITH/J WARREN

ITEMS FOR INFORMATION

15 SERVICE LEVEL AGREEMENT FOR THE PROVISION OF OCCUPATIONAL HEALTH AND SAFETY SERVICES

The State Hospital Board has in place a Service Level Agreement for the provision of Occupational Health and Safety Services with SALUS, NHS Lanarkshire.

The last service level agreement commenced on 1 August 2018 and was scheduled to end on 31 July 2021. Staff Governance initially agreed in November 2020 that a SLWG should be established to consider the future SLA. Staff Governance further approved an extension to the SLA with SALUS for 9 months, until 31st December 2022 with an agreed additional 3-month extension to 31st March 2023 if required.

Staff Governance Committee agreed that this would allow a short life working group to be established and for the current provision to be reviewed.

It should be noted that there is currently a National Review of Occupational Health Services within NHSScotland and recommendations to be made to the Scottish Government on the future provision. No timescale has been agreed for the final outcome of this review and we continue to be updated by the Scottish Government on this.

A tender style document has been developed and approved by the SLWG and HR & Wellbeing Group and has been circulated to Boards within NHSScotland for consideration. This proposal is initially for 2-year period with an extension clause for a further 2-year period, which will be in line with the national review.

The closing date for submissions is Thursday 24 November 2022 at 5pm. Shortlisting will take place the following week with nominees invited to present to a panel week commencing 5 December. Pam Radage has agreed to be the Non-Executive Lead for this process and the panel will contain members of the HR & Wellbeing Group, including trade union representation.

Thereafter, once the preferred bidder is known, discussion will take place about all handover requirement and further discussions regarding any need to extend the SLA into 2023.

Members of the Committee noted the update and that a paper will be provided to the next Staff Governance Committee on the process undertaken, details of the successful bidder and timescale for implementation.

ACTION: L McGOVERN

16 WORKFORCE PLANNING STRATEGY 2022-2025

Members received and noted the workforce planning strategy 2022-25 as presented by Linda McGovern, Director of Workforce. This provides an update on the National Workforce Planning expectations for The State Hospital described in DL (2022)09.

This was presented to the Board on 27th October with a full breakdown of the amendments to the draft version. This final version was approved by the Board and was published on 31st October 2022 as per the national guidance.

There will be continued stakeholder engagement going forward, to support achievement of the key drivers and action plan. Monitoring and assurance reporting will continue through the Staff Governance Committee at its quarterly meeting, as well as returning to the Board annually.

Members noted the 3-year Workforce Plan has now been approved by the Board and published on 31st October 2022.

17 APPROVED MINUTES FROM PARTNERSHIP FORUM

The Committee received and noted the approved minutes from the meeting that took place on 27 September 2022.

18 APPROVED MINUTES FROM HR AND WELLBEING GROUP

The Committee received the approved minutes from the meeting that took place on 11 October 2022.

19 ANY OTHER BUSINESS

Linda McGovern, Director of Workforce updated members on possible Industrial Action and provided assurance that meetings are taking place with draft guidance being compiled locally. This work is being taking forward in partnership with the Employee Director and Joint Staff Side.

20 DATE AND TIME OF NEXT MEETING

The next meeting will take place on **Thursday 16 February 2023 at 9.45am via MS Teams**.

Paper No. 23/12

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 February 2023
Agenda Reference:	Item No: 19
Sponsoring Director:	Chief Executive Officer
Author(s):	Head of Corporate Governance/ Board Secretary
Title of Report:	Corporate Objectives 2023 - 24
Purpose of Report:	For Decision

1 SITUATION

The Board undertakes a review of its corporate objectives annually. This document sets out the draft Corporate Objectives for The State Hospitals Board for Scotland for the period 1 April 2023 until 31 March 2024.

2 BACKGROUND

The intention of the corporate objectives is to provide a summary of the strategic priorities for the organisation, and to support the key aims and mission.

The Corporate Objectives should align with the operational business model for The State Hospital through the Annual Operating Plan and related Delivery Plan template submitted quarterly to Scottish Government. In addition, it should reflect the three year Workforce Plan.

At today's meeting, the Board will also receive update reporting on the performance framework, which underpins these objectives.

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:

- Individual performance within the senior leadership team, measured against objectives.
- Directorate/ team performance against objectives measured quarterly.
- Board review of performance and accountability of Executive leadership
- Annual Review process

Additionally, the national framework for delivery of forensic mental health services in NHS Scotland is under active review supporting collaborative working.

4 RECOMMENDATION

The Board is asked to review the Draft Corporate Objectives and recommend any changes required before providing approval of these objectives for 2023/24.

MONITORING FORM

How does the proposal support current Policy / Strategy / AOP / 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 Baord Which groups were involved in contributing to the paper and recommendations.	Requested as part of the Board's workplan.
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.

Appendix A	**TSH Draft Corporate Objectives 2023/24**
Better Care	▪ Deliver the Annual Operating Plan (Year 1) within the overall three-year planning framework for 2023/26, and quarterly Delivery Plan updates to government. ▪ Monitor the performance of the Clinical Model, enabling TSH to provide a progressive care approach for patient treatment and recovery ▪ Safe delivery of care within this context with sustained organisational resilience and the ability to identify and respond to risk ▪ Ensure the principles of the rehabilitative care maximizing opportunity for patient activity and ensure delivery 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 objective ▪ Deliver care and treatment within the framework of least restrictive practice ▪ 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 whilst accessing care and treatment ▪ Work with stakeholders and Scottish Government representatives to enhance the reputation and develop the 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 with the Health in Custody Network ▪ Support development of 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 ▪ Align with the aims and ambitions of medium secure provision and other treatment pathways to provide cohesive care and treatment for patients transferring to other services ▪ 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 which supports the sustainability of the organisation ▪ Work collaboratively across public sector bodies to ensure that best value is achieved in service planning, design and delivery as well as procurement for services, including through National Board collaboration. ▪ Deliver programme of sustainable working and progress to net zero recognising the impacts of climate change. ▪ 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 deliver the action plan related to the organisational audit by the UK ICO, and newly formulated Records Management function. ▪ Deliver the actions identified by the NIS audit, and demonstrate improvement in reporting standards. ▪ Finalise delivery of the security upgrade for the safety of staff,

	patients and the general public ▪ 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 delivery of the performance management framework
Better Workforce	▪ Continue Deliver 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 ▪ Demonstrate support of the implementation of the Health and Care (Staffing) (Scotland) Bill (2019) across TSH, following national rollout, through the Workforce Governance Group. ▪ Deliver national e-rostering programme locally within TSH. ▪ Promote and deliver a framework of wellbeing and culture change within the framework of a Staff and Volunteer Wellbeing Strategy ▪ 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 to support to internal and external services for staff who require them, including a cohesive Occupational Health Service. ▪ Review and action absence related issues and staff wellbeing to provide staff and line managers with the support required to help staff return to work where possible. ▪ Continue to support training and development for all staff across the organisation ▪ Support the Independent National Whistleblowing Policy, and support this workstream locally including promoting awareness for staff.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 February 2023
Agenda Reference:	Item No: 20 (a)
Sponsoring Director:	Chief Executive
Author(s):	Head of Planning, Performance and Quality
Title of Report:	The State Hospital's Performance Management Framework
Purpose of Report:	For Noting

1. SITUATION

Performance management is key to ensuring that The State Hospital (TSH) delivers on its range of commitments expressed through the Annual Delivery Plan 2022/23 (ADP) and the corporate objectives. This paper outlines the Performance Management Framework for TSH, which is developed in the context of the Active Governance Work stream of the Board

2. BACKGROUND

Performance is managed across TSH in a number of strategic and managerial forum. Performance management requires collation of data from a range of sources including KPI's, action plans, project milestones and outcomes, clinical audits, management accounts, internal audits actions and recommendations and quality reports. There have been recent developments in the collation and visualisation of data through the RIO and Tableau dashboards, bringing more information and data to teams. The Performance Framework is outlined in Appendix 1

3. ASSESSMENT

This Performance Management Framework sets out the management processes, measures and indicators that will provide assurance and evidence how TSH is delivering on its expected outcomes Appendix 1 is The State Hospital Performance Management Framework, it outlines:

- what performance management is;
- why it is important to TSH;
- explains how performance is monitored and reported in TSH

- the principles of performance management;
- describes the balanced score card approach;

4. RECOMMENDATION

The Board is asked to consider and note the content of this report

The State Hospital's Performance Management Framework APPENDIX 1

February 2023

Introduction

The State Hospital (TSH) has a range of commitments expressed through the Annual Delivery Plan 2022/23 (ADP) and corporate objectives. As we continue to recover from the crisis response of COVID-19 and develop planning for our future state, management of performance is vital in enabling clear communication about what we are aiming to achieve and why, and crucially where we are making progress. Setting out clearly how services are performing is an integral part of our contract with the population that we serve (patients, staff, carers and volunteers)[i]. The Performance Management Framework for TSH is developed in the context of the Active Governance Work stream of the Board.

Purpose of a Performance Framework

This Performance Management Framework sets out the management processes and range or measures and indicators that will provide assurance and evidence how TSH is delivering on its expected outcomes

Performance Management arrangements will demonstrate how TSH is:

1. Meeting its corporate objectives.
2. Meeting, or working towards meeting, government targets.
3. Achieving planned outcomes.
4. Making sure services are performing as expected.
5. Able to identify areas of improvement.
6. Helping staff see how they can contribute to strategic objectives.
7. Managing corporate risks, within a controlled environment.
8. Listening to feedback from service users, stakeholders and partners.
9. Achieving value for money

From the above it is clear that performance management requires collation of data from a range of sources including KPI's, action plans, project milestones and outcomes, clinical audits, management accounts, internal audits actions and recommendations and quality reports. An overview of the delivery commitments TSH has is summarised within the Performance Workbook. The Performance Workbook provides an overview of the range of targets that are set within TSH. It details where these are monitored and reported and who has responsibility for leadership of activities against these.

Principles for TSH Performance Management Framework

1. Strategic focus: provide clarity on TSH aims and objectives.
2. Comprehensive: giving a picture of the main areas of the TSH work and integrated into planning and management processes.
3. Focus on outcomes where possible: this is driven by what is important to staff, patients and stakeholder.
4. Evidence based: based on good quality data and interpretation
5. Support a culture of continuous improvement: learning from good practice both within TSH and elsewhere.
6. Transparent: data is objective and readily accessible.
7. Inclusive and owned: everyone has a role in managing performance and taking action to ensure improvement.
8. Data driven decision making: an efficient systematic approach to gathering and analysis of data to support decision making at the right level.

Balance Scorecard approach

TSH has developed a balanced scorecard approach to performance monitoring. This has been embedded in the Strategic Objectives and in structured in the follow areas:

- **Better care:** 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 heath:** 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 value:** Increase the value from, and financial sustainability of, care by making the most effective use of available resources through efficient and effective service delivery
- **Better workforce:** Improve the engagement of staff and opportunity for development through effective values based leadership resulting in a culture of quality and accountability to support staff wellbeing and effectiveness.

Performance Management Processes

Performance is managed across TSH in a number of forum. Strategic performance is managed through the Corporate Management Team and the Strategic Planning and Performance Group. Operational performance is monitored and reviewed through the Organisational Management Team and the Hub Leadership Teams. Governance of key performance indicators and projects occur through the Board, and its sub committees.

Further managerial overview is gained through the Finance, e-health and Audit Group and the Security, Risk, Resilience and Health and Safety Group. Service specific teams have also responsibility to develop, monitor and report on their own performance measures. TSH Organisational Group Structure and TSH Board and sub-committee / advisory structure are included as appendixes.

To inform leadership and management decisions, progress has been made with the presentation and visulisation of data. Notably, developments of RIO and Tableau dashboards have progressed both the visibility of data to teams and the timely presentation of this. . These dashboards provide a platform for key data items to be available for staff to use in their practice. Tableau dashboards provide an overview of anonymized hospital data such as workforce data and sickness absence. RIO dashboards provide clinical teams with information on patient specific indicators such as physical activity, DASA (Dynamic Appraisal of Situational Aggression) and BMI (Body Mass Index). The Variance Analysis Tool (VAT) also provides clinical teams with an ability to monitor performance on key clinical metrics. Current KPI developments include a workstream of the Activity Oversight Group which aims to redevelop and define performance indicators for patient activity, that will be linked to recovery goals.

The Performance Measurement Blueprint approach (PuMP) has been previously been used as a pilot in 2020/21 with teams in HR and e-health. The aim was to develop performance measures that tracked the results these departments aimed to achieve. This approach, based on continuous improvement, was found to be of value to the teams. When resources allow, this approach will continue to develop across TSH as more teams are on boarded and trained to develop performance measures related to their strategic results they aim to achieve.

The Performance Workbook provides a comprehensive overview of the data collected across TSH, the corporate objectives, a summary of key delivery projects for TSH and 1/4ly reporting on these through the Delivery Plan, the Organisational KPI's, and Equality Outcomes. Performance Workbook 22-23.xlsx

Performance Monitoring and Reporting

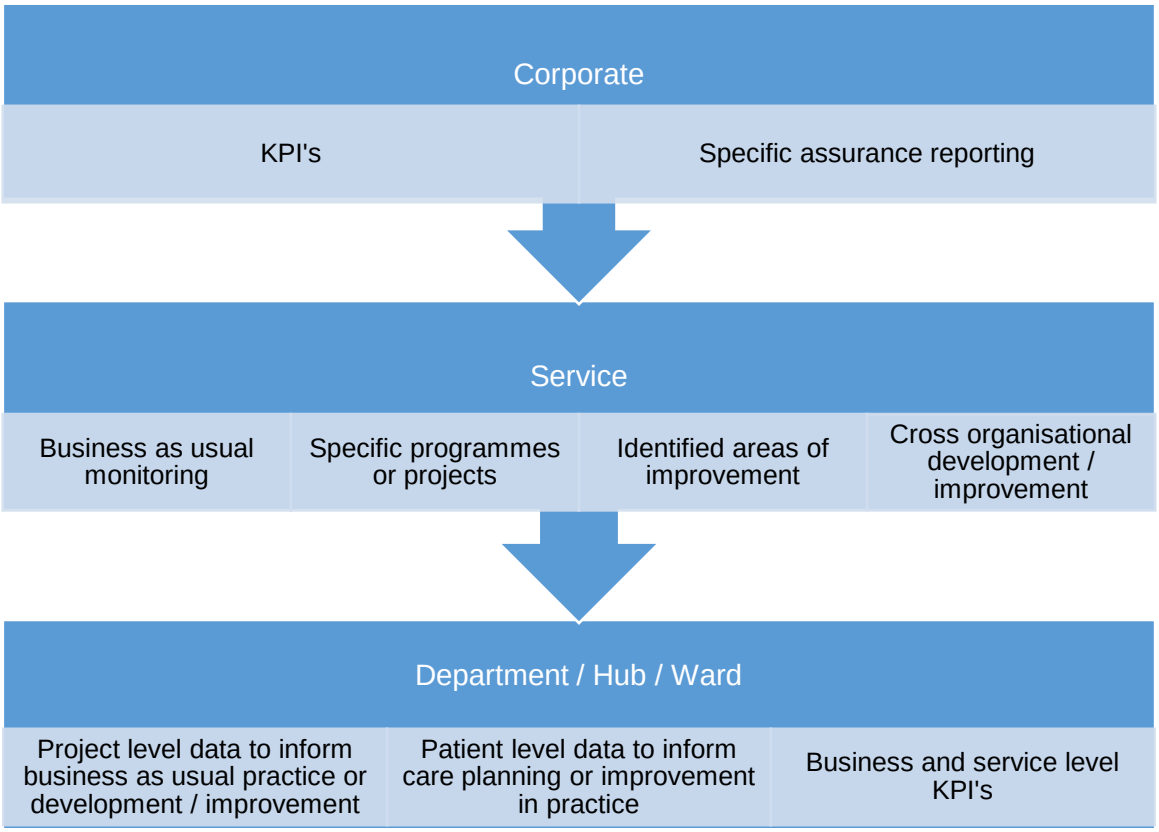
The State Hospital has quarterly Performance Management Meetings with Scottish Government where the quarterly updates to the Delivery Plan are reviewed. There is also an annual review with Scottish Government as part of the NHS Scotland Review process. A draft sponsorship agreement has been developed with Scottish Government, which outlines the roles and responsibilities of each and details the performance management and oversight processes. This document is awaiting review by the Public Bodies Unit.

The State Hospital has both internal and external auditors who provide an objective audit function to monitor both business as usual activities and specific projects. Internal audit cycles are agreed and monitored through the Audit committee and the Board. The external auditor provides an annual review of data and activity to provide an analysis and reporting on TSH functions.

External monitoring is also carried out by the Mental Welfare Commission and the Shared Intelligence for the Health and Care Group (SIHCG). This group provides a central mechanism to share and collaborate on information across the Health and Care systems in Scotland, with a particular focus on NHS Boards.

Internally quarterly Directorate Performance Meetings have been established. These provide an opportunity to review and discuss the performance of each directorate and its unique contribution and challenges. Performance is also reviewed throughout the management group structure of CMT/OMT and Hub leadership teams and corporate governance mechanisms of the Board and sub committees structure.

The Diagram below illustrates the data reporting and analysis that takes place across TSH.



Performance Management Terminology

The following terms are used in performance management and reporting, for ease they are described as:

- Objective: what we want to happen.
- Outcomes: what tangible difference will be made as a result of the activity/ intervention.
- Output: This should help track progress towards reaching the outcome, it can include process measure, timelines, stakeholder satisfaction and measures of efficiency.
- Baseline: where we are starting from.
- Target: by how much or how quickly we expect to achieve the objective.
- Performing measure / indicator: a measure which tells us whether we are improving and / or have reached the target.
- Benchmark – comparison against an external organisations performance or experience

Defining Performance Measurement

Performance measurement is a process that produces performance measures, ready for decision making. It involved choosing measures that link results to strategy and defining the detail of how to calculate them, report them, interpret them and put them to use. A Performance measure is a quantification that provides objective evidence of the degree to which a performance result is

occurring over time. When developing individual measures or indicators, we will consider whether the data is

- Relevant – to the strategic aims and delivery priorities
- Well defined – clear and unambiguous, measure is easy to understand and use.
- Timely - Producing information regularly enough to track progress and quickly enough for the data to still be useful
- Avoids perverse incentives: discourages unwanted behaviour.
- Attributable: clear where accountability for the measure lies.
- Reliable – accurate enough for its intended use and responsive to change
- Comparable - allows comparisons with others over time

A performance measure will have a statistic, performance data item, scope of the data item and a timeframe. e.g. % of orders delivered on time for all customers by month

Performance Objectives

A performance objective should describe what we expect to happen and link to the strategic approach of TSH, where safe effective person centered care is demonstrated. A performance objective should be expressed as a SMART objective (Specific, Measurable, Achievable, Relevant and Time-Bound).

Creating a performance management culture. TSH will promote a performance management culture and will:

- Actively support continuous improvement.
- Monitor and control its overall performance.

Where services:

- Have a broad range of performance measures in pace that covers all key services.
- Actively develop measures to support continuous improvement.
- Learn from others.
- Use trend information to help assess how the services are changing.
- Make sure that staff have the time and opportunity to review their performance and take part in improvement activities.
- Uses evidence from performance measures to change resourcing decisions.

Good performance management motivates people, requires strong and inspirational leadership to create the right environment to allow innovation for teams to excel and where success is celebrated and challenges are tackled in a positive way.

Achieving a culture of performance management is to establish an integrated way of communicating and implementing agreed objectives. This enables the linkage between organizational intention and priorities to actions and ultimately impacts. The management structure of CMT/OMT and linking to

HLT provides a structure where performance objectives and measures can be developed to represent the business each of these management areas has responsibility for leading.

Continuous Improvement approach to Performance Management

The process below outlines an approach to the development and monitoring of performance objectives and KPI's that enables continuous improvement.

PLAN:

- Set out objectives and targets linked to organization and team key results.
- Identify what needs to be done to achieve these.
- Identify how this will be done and what resources will be needed (including contracting / commissioning).
- Identify who is responsible.
- Set clear measures and define these with a data definition template.

DO:

- Ensure necessary systems and processes are in place.
- Take action.
- Identify and manage risks.
- Support staff to achieve their objectives.
- Monitor and record data regularly and notice / analyze changes in the data

REVISE:

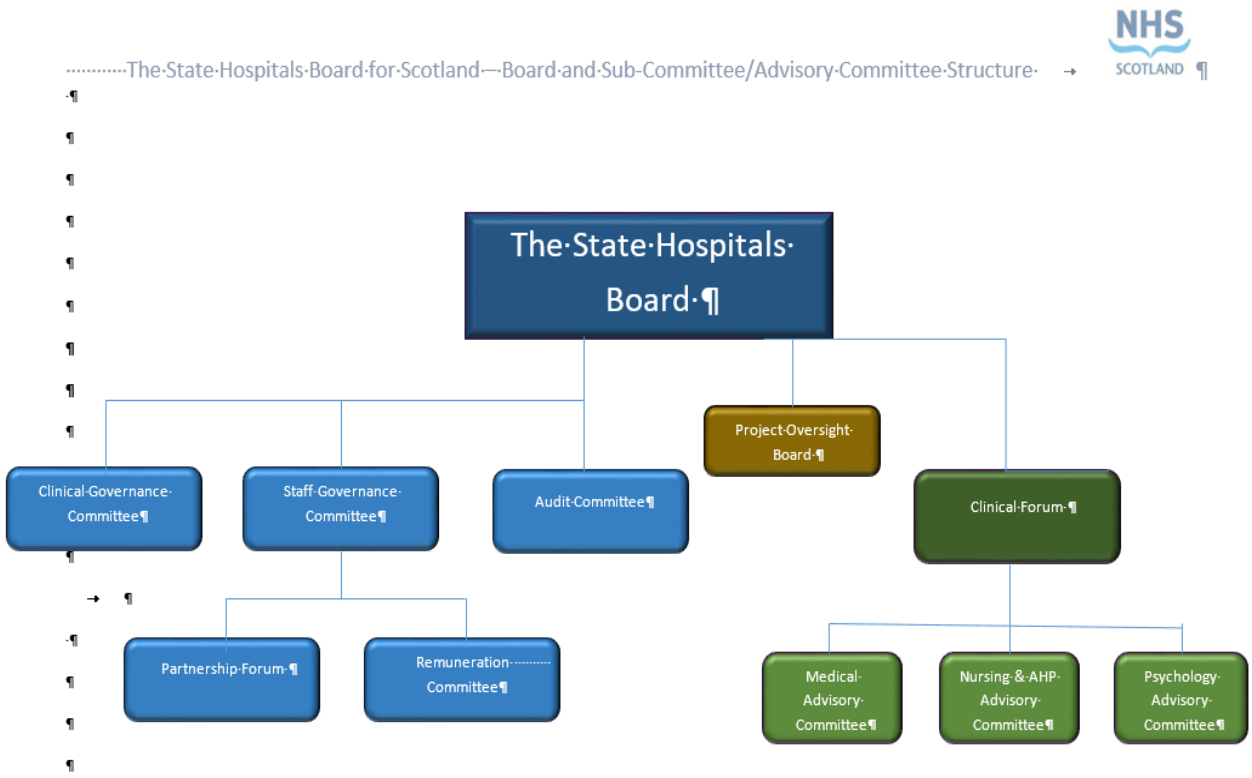
- Incorporate improvements into future planning.
- Revise objectives and targets.
- Update resource planning.
- Continue to monitor data and respond to shifts and significant changes in data

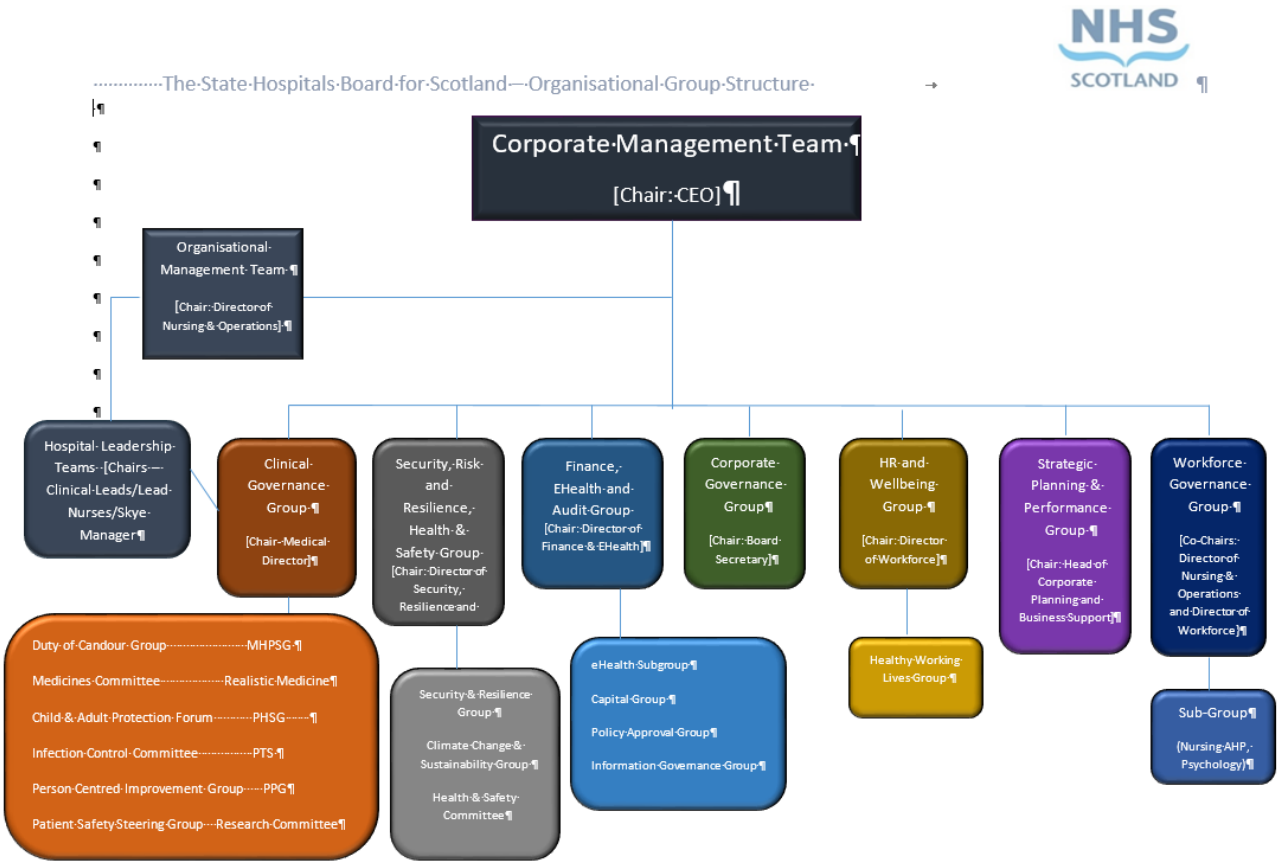
REVIEW:

- Monitor progress regularly.
- Identify what worked well and what could be improved.
- Speak to service users and stakeholders about their experience.
- Scrutinise performance and hold those accountable to account.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of Performance in the TSH meets the corporate priorities.
Workforce Implications	No workforce implications - for information only.
Financial Implications	No finance implications - for information only.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Strategic Planning and Performance Group
Risk Assessment (Outline any significant risks and associated mitigation)	Not formally assessed
Assessment of Impact on Stakeholder Experience	Not formally assessed
Equality Impact Assessment	No equalities implications identified
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One 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 – Board and Sub-Committee/Advisory Committee Structure
NHS SCOTLAND
The State Hospitals Board
Clinical Governance Committee
Staff Governance Committee
Audit Committee
Project Oversight Board
Clinical Forum
Partnership Forum
Remuneration Committee
Medical Advisory Committee
Nursing & AHP Advisory Committee
Psychology Advisory Committee


The State Hospitals Board – Organisational Group Structure
NHS SCOTLAND
Corporate Management Team
[Chair: CEO]
Organisational Management Team
[Chair: Director of Nursing & Operations]
Hospital Leadership Teams – [Chairs – Clinical Leads/Lead Nurses/Skye Manager]
Clinical Governance Group
[Chair: Medical Director]
Security, Risk and Resilience, Health & Safety Group
[Chair: Director of Security, Resilience and
Finance, EHealth and Audit Group
[Chair: Director of Finance & EHealth]
Corporate Governance Group
[Chair: Board Secretary]
HR and Wellbeing Group
[Chair: Director of Workforce]
Strategic Planning & Performance Group
[Chair: Head of Corporate Planning and Business Support]
Workforce Governance Group
[Co-Chairs: Director of Nursing & Operations and Director of Workforce]
Duty of Candour Group – MHPSG
Medicines Committee – Realistic Medicine
Child & Adult Protection Forum – PHSG
Infection Control Committee – PTS
Person Centred Improvement Group – PPG
Patient Safety Steering Group – Research Committee
Security & Resilience Group
Climate Change & Sustainability Group
Health & Safety Committee
eHealth Subgroup
Capital Group
Policy Approval Group
Information Governance Group
Healthy Working Lives Group
Sub-Group
(Nursing AHP, Psychology)

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 February 2023
Agenda Reference:	Item No: 20
Sponsoring Director:	Chief Executive
Author(s):	Head of Corporate Planning and Business Support Head of Clinical Quality
Title of Report:	Performance Report – Quarter 3
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-December 2022. Trend data is also provided to enable comparison with previous performance. The national standards directly relevant to the State Hospital are as follows: Psychological Therapies Waiting Times and Sickness Absence. Additional local Key Performance Indicators (KPIs) are reported to the Board and included in this report. Board planning and performance are monitored by Scottish Government through the Annual Operational Plan for 2022-23 which was submitted to Scottish Government to outline the priority areas of development.

2. BACKGROUND

Members receive quarterly updates on Key Performance Indicator (KPI) performance as well as an Annual Overview of performance and a Year-on-Year comparison each June.

The calculation for a quarterly figure is an average of all three 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 miss their targets.

There are nine KPI's which have reached and / or exceeded their target this quarter.

There are four KPI's which are off target this quarter, these are:

- Patients have their care and treatment plans reviewed at 6 monthly intervals.
- Patients will have a healthier BMI.
- Sickness absence rate (National HEAT standard is 4%).
- Patients will commence psychological therapies <18 weeks from referral date

Performance Indicator	Target	RAG Q4 21/22	RAG Q1 22/23	RAG Q2 22/23	RAG Q3 22/23	Actual	Comment
Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	A	R	A	90%	This indicator moves from the red zone in Q2 to the amber zone in Q3.
Patients will be engaged in psychological treatment	85%	G	G	G	G	83%	This indicator remains green for this quarter.
Patients will be engaged in off-hub activity centers during COVID-19	90%	G	G	G	G	86%	This figure includes drop-in sessions, which took place in hubs, grounds and the Skye Centre.
Patients will undertake an annual physical health review	100%	-	G	G	G	97%	97% compliance. Green compliance for this amended KPI.
Patients will undertake 150 minutes of exercise each week	60%	-	G	G	G	57%	Green zone for this KPI's data collection.
Patients will have a healthier BMI	25%	R	R	R	R	10%	This indicator has remained in the red zone this quarter.
Sickness absence rate (National HEAT standard is 4%)	** 5%	A	G	R	R	8.7%	October's figure was 8.13%, November's figure was 8.57% and December's figure was 9.51%.
Staff have an approved PDR	*80%	G	G	G	G	85%	This indicator has been within the green zone since March 2019.
Patients transferred/discharged using CPA	100%	G	G	G	G	100%	This indicator has been in the green zone since September 2018
Patients requiring primary care services will have access within 48 hours	*100%	G	G	G	G	100%	This indicator remains 100% in Q3.
Patients will commence psychological therapies <18 weeks from referral date	**100%	A	A	G	R	86%	3 instances of patients waiting beyond the specified wait time during Q3.
Patients have their clinical risk assessment reviewed annually.	100%	A	G	G	G	96%	As at 30 December 2022, there were 110 patients in the hospital. Ten were new admissions. Seven patients had an out of date or no risk assessment

Attendance at CPA Reviews (Refer to Appendix 1)							

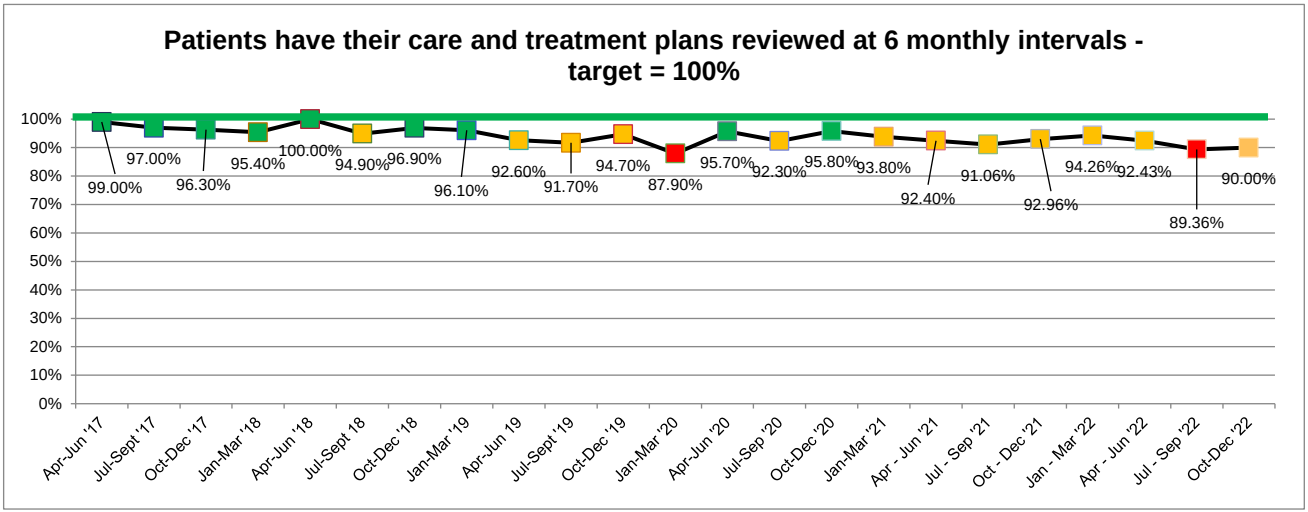
No 1: Patients Have their Care and Treatment Plan Documentation Reviewed and uploaded to RiO at 6 Monthly Intervals

Target: 100%

Data for current quarter: 90%

Performance Zone: Amber

This is a Mental Health Act requirement for any patients within high secure settings. This indicator measures the assurance of patients receiving admission, intermediate and annual case reviews. Care and Treatment Plans are reviewed by the multidisciplinary teams at case reviews and objectives are set for the next 6 months.



This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In October, the compliance was 94%, November was 91% and December was 85% giving a quarterly compliance of 90%, which is a slight increase from last quarter's figure. This indicator now moves into the amber zone.

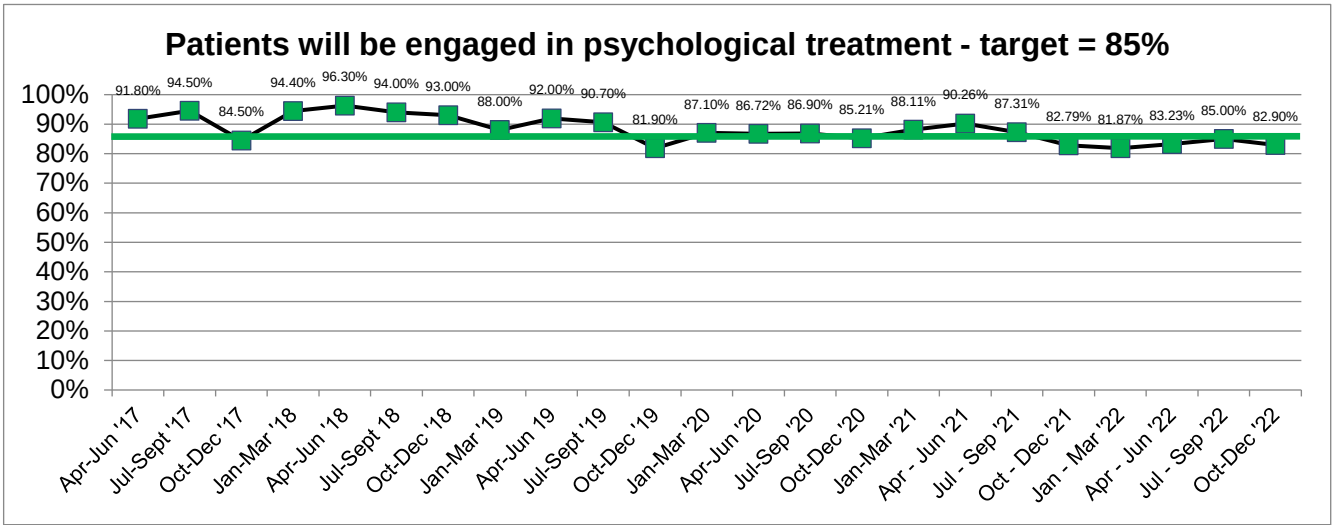
On 31 December 2022 there were 110 patients in the hospital. Ten of these patients were in the admission phase. Fifteen CPA documents had not been reviewed within the 6-month period, or within the agreed admission phase. All of these CPAs have been held with no documents being uploaded to RiO within allocated timescales.

Health Records staff continue to send reminder emails to RMOs and medical secretarial staff to advise that a patient's review or renewal of detention is due. The renewal of detention ties in with the annual CPA document being completed.

No 2: Patients will be Engaged in Psychological Treatment

Target: 85%
Data for current quarter: 83%
Performance Zone: Green

This indictor is a main priority of National Mental Health Indicators. This indicator measures the percentage of patients who are engaged and involved in psychological treatment.

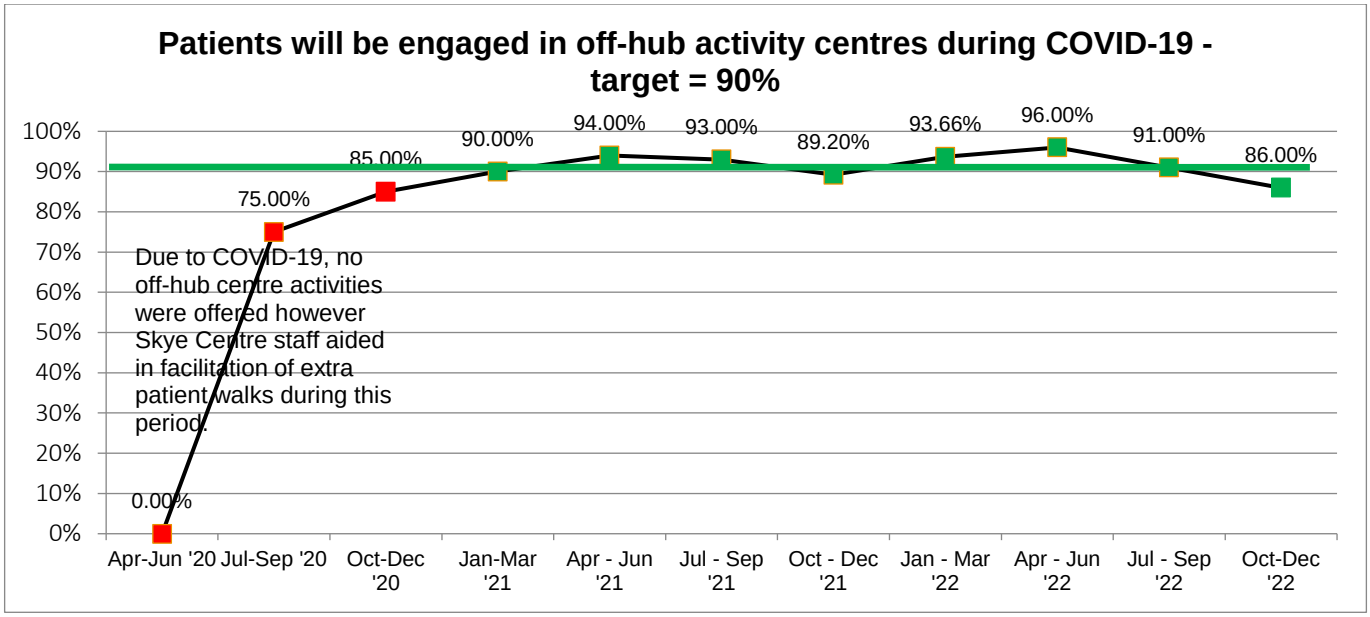


This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In October, the compliance was 83.48%, November was 84.4% and December was 81.1% giving a quarterly compliance of 83%, which is a slight increase from last quarter's figure. This indicator remains with the green zone.

No 3.1: Patients will be Engaged in Off-Hub Activity Centers during COVID-19

Target: 90%
Data for current quarter: 86%
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 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.

This indicator is currently under review to be redeveloped into a more accurate indicator which relates to any timetabled sessions and activity for every patient.

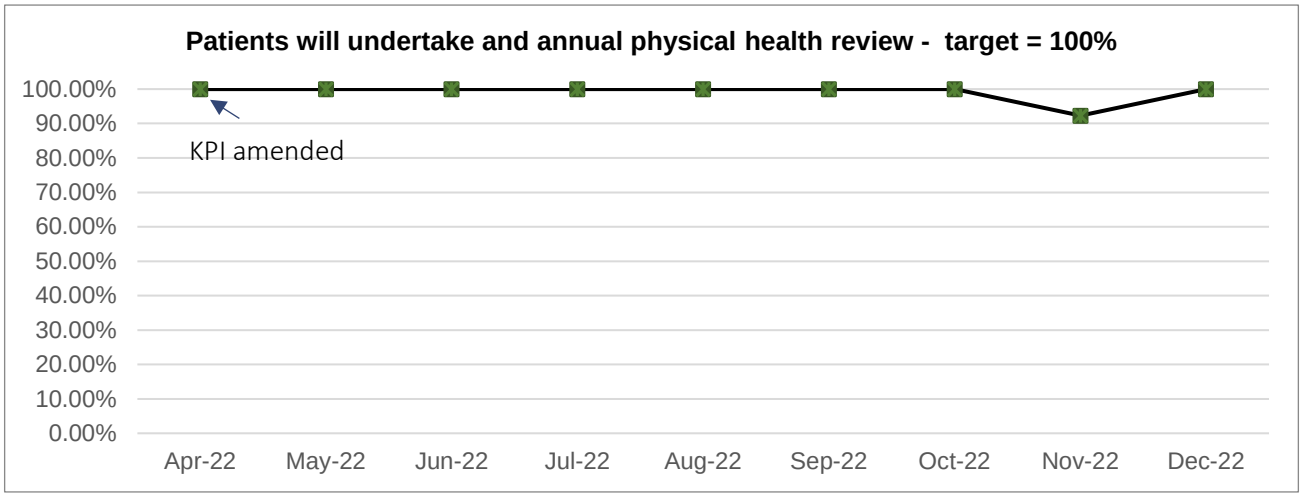
No 4: Patients will Undertake an Annual Physical Health Overview

Target: 100%

Data for current quarter: 97%

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.



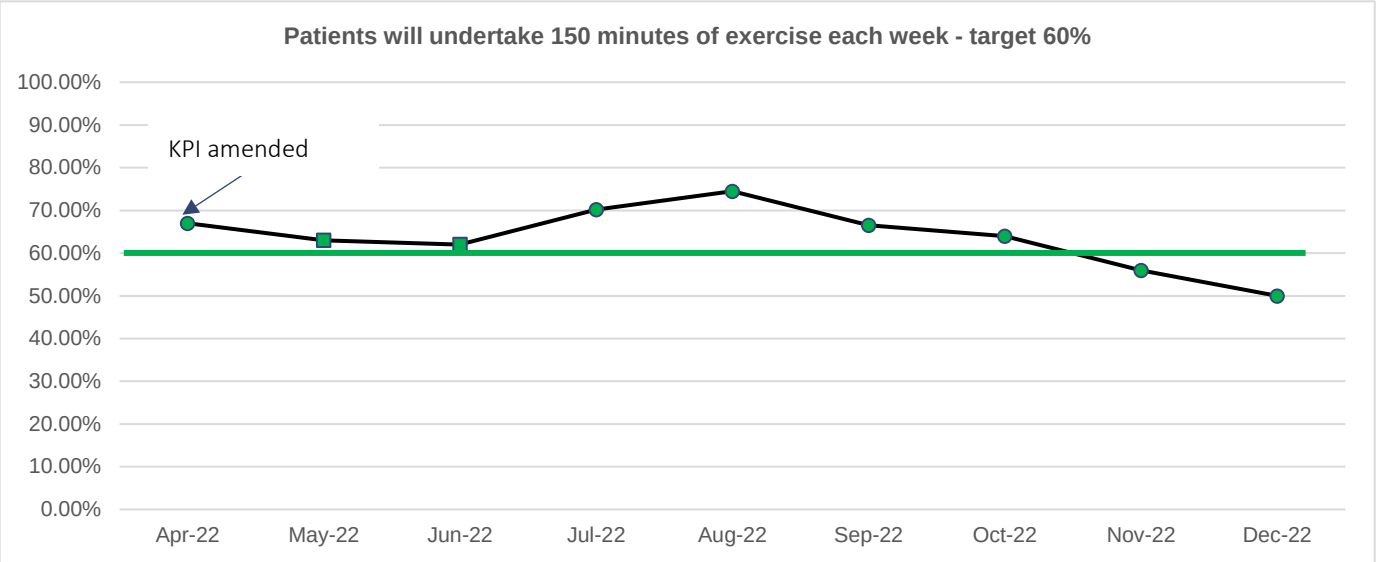
As at 1 April 2022, this KPI was amended to incorporate the uptake of an annual physical health review by all of our patients, rather than the previous data collection of an offering of a review. This KPI now charts the completion of an annual physical health overview by the Practice Nurse. The Practice 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. 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.

During Q3, 97% of patients who were eligible for an annual physical health review were reviewed by the Practice Nurse. Out of these 34, 29 were reviewed in addition by the GP. Five patients did not attend their face-to-face consultations; this was due to two patients suffering from poor mental health, one patient boarding out at UHW, one patient receiving palliative care and the other patient refusing to attend. These reviews have been rescheduled.

No 5: Patients will be Undertake 150 Minutes of Exercise Each Week

Target: 60%
Data for current quarter: 57%
Performance Zone: Green

This links with national activity standards for Scotland. This measures the number of patients who undertake 150 minutes of exercise each week.



At the Board meeting in June 2022, the Board agreed to change the corporate Key Performance Indicator 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 following guidance released by the WHO and reviewed by the PHSG. This change will be effective from 1 April 2022 and will be reviewed after 4 quarters data to assess whether the target should be increased 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.

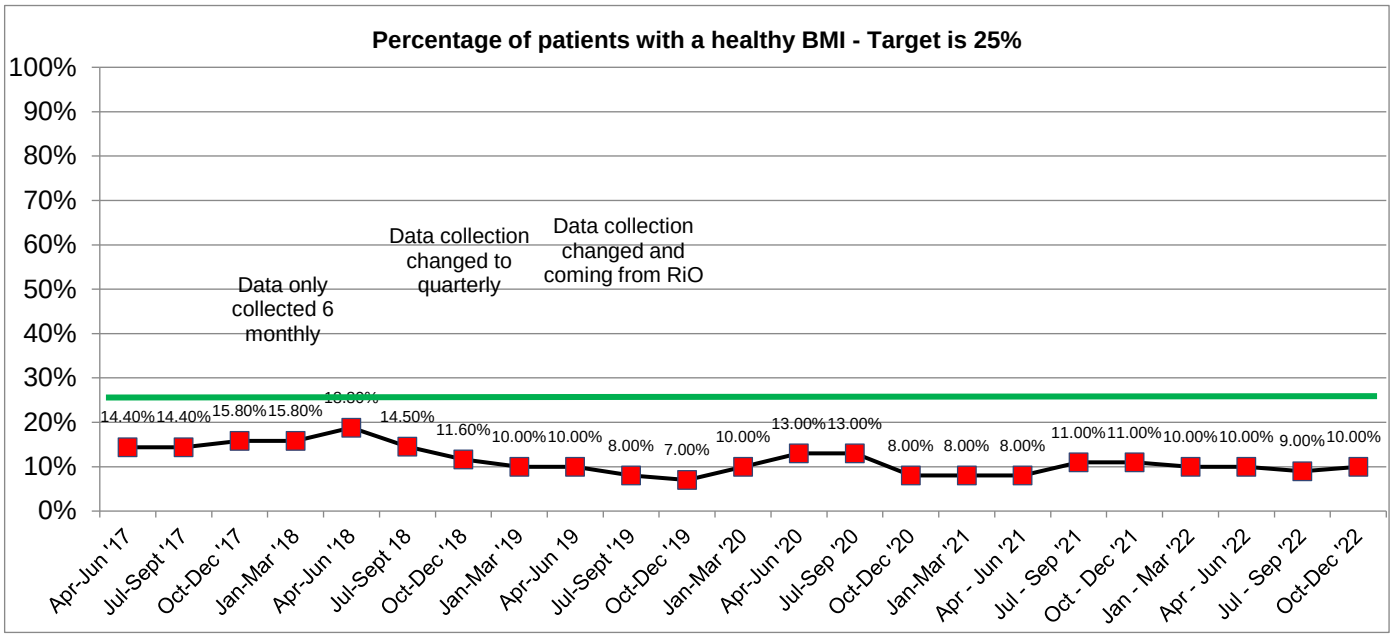
During this quarter, compliance levels have dropped compared to target however remain higher than levels recorded for the same period across both 2020 and 2021 prior to official introduction of the 150 mins KPI in April 2022. This reduction may be attributed to poor weather, resourcing / clinical issues and the festive period.

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.

No 6: Patients will have a Healthy BMI

Target: 25%
Data for current quarter: 10%
Performance Zone: Red

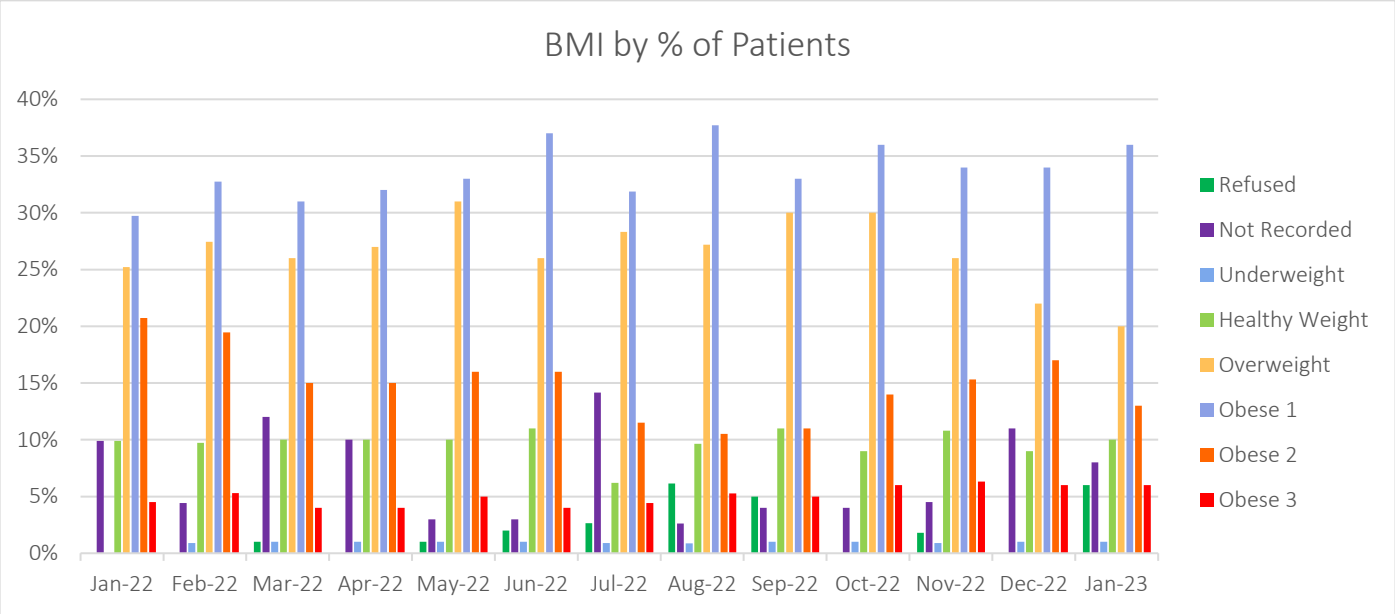
This correlates towards the national target from the care standards as well as a corporate objective of TSH. This is an aspirational target and a local priority due to the obesity issue of our patient group.



During this quarter, 9 patients moved down to a healthier BMI band. Three of them then returned to their original BMI band the following month.

The PHSG are currently reviewing the reporting format of patient weight and BMI movement data in order for more meaningful information to be available and to be shared with Clinical Teams. This also includes review work across a local KPI to limit weight gain of patients from admission to equal to or less than 5% of admission weight over first 12 months following admission.

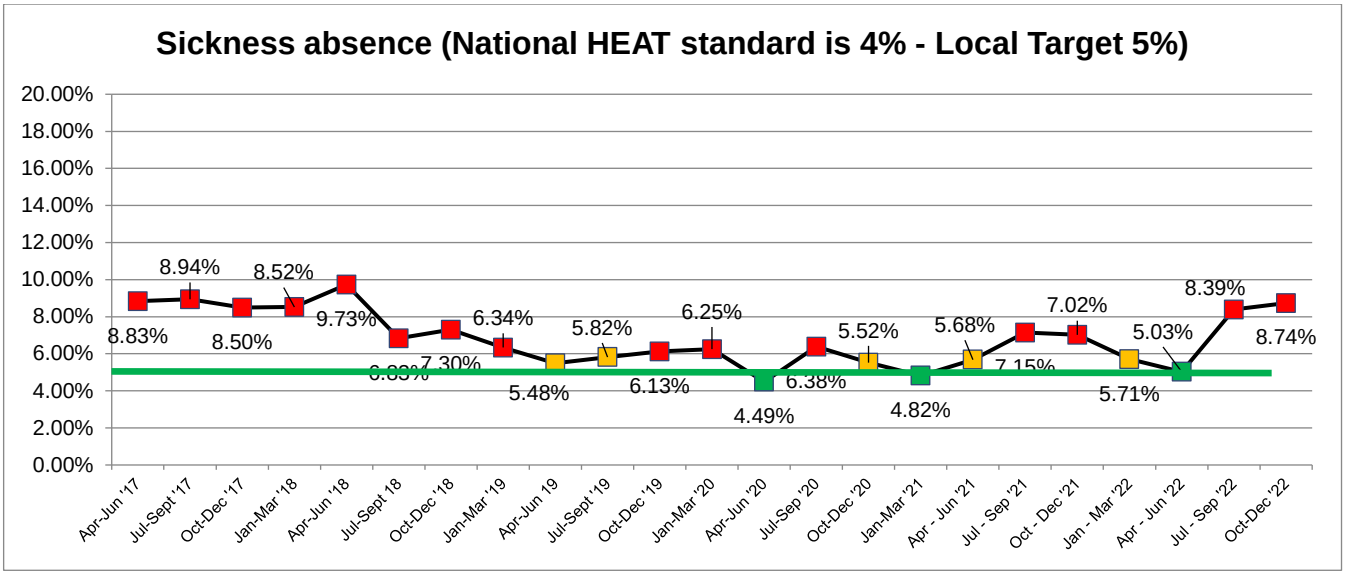
Dietetics are also working to address some recent issues regarding the completion of monthly weight recording by wards which has been impacting data collection.



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

Target: 5%
Data for current quarter: 8.74%
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.



Sickness absence continues to be closely monitored with staff being managed through the formal stages of the Attendance Policy. The key reasons for short term absence are cold, cough, flu, anxiety/stress/depression and back problems. For long term absence, the main reasons are anxiety/stress/depression, other musculoskeletal and back problems. The HR Advisors hold monthly meetings with all departments to look at the staff who have reached trigger points within the Attendance Policy and to ensure that managers address these in line with the policy. The HR team regularly attend the SCN forum providing an opportunity for this group to ask questions on the Attendance Policy and explore common questions such as timeframes for meetings, monitoring periods and follow up meetings. Attendance management training has also been developed for delivery as part of the Charge Nurse Development Programme. This focuses on key aspects of attendance management that Charge Nurses support including communication during periods of absence and how to complete return to work interviews.

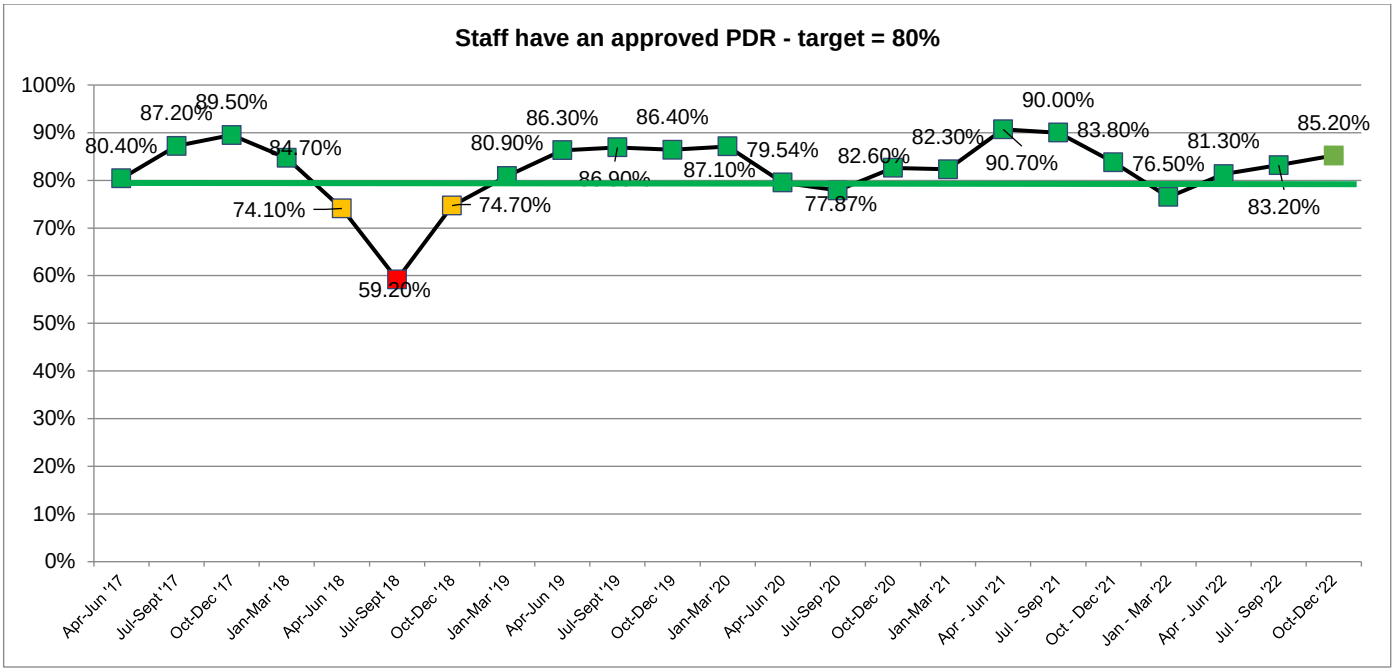
No 8: Staff have an Approved PDR

Target: 80%

Data for current quarter: 85.2%

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 the compliance was 84.6%, November was 86.1% and December was 84.9% giving a quarterly compliance of 85.2%, which is a slight increase from last quarter's figure. This indicator remains with the green zone.

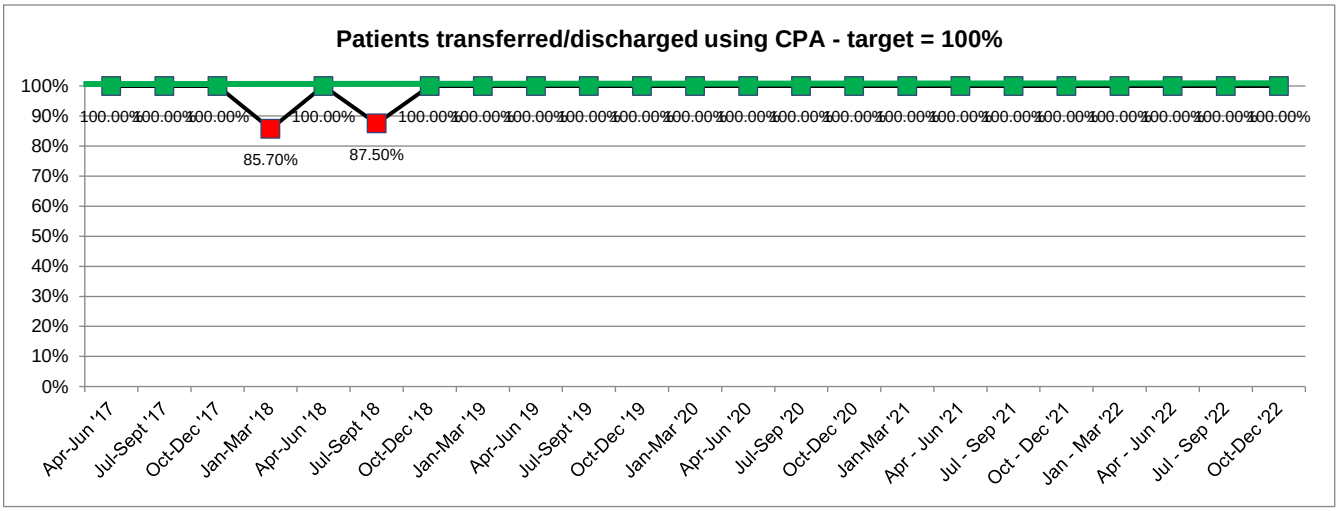
No 9: Patients are Transferred/Discharged using CPA

Target: 100%

Data for current quarter: 100%

Performance Zone: Green

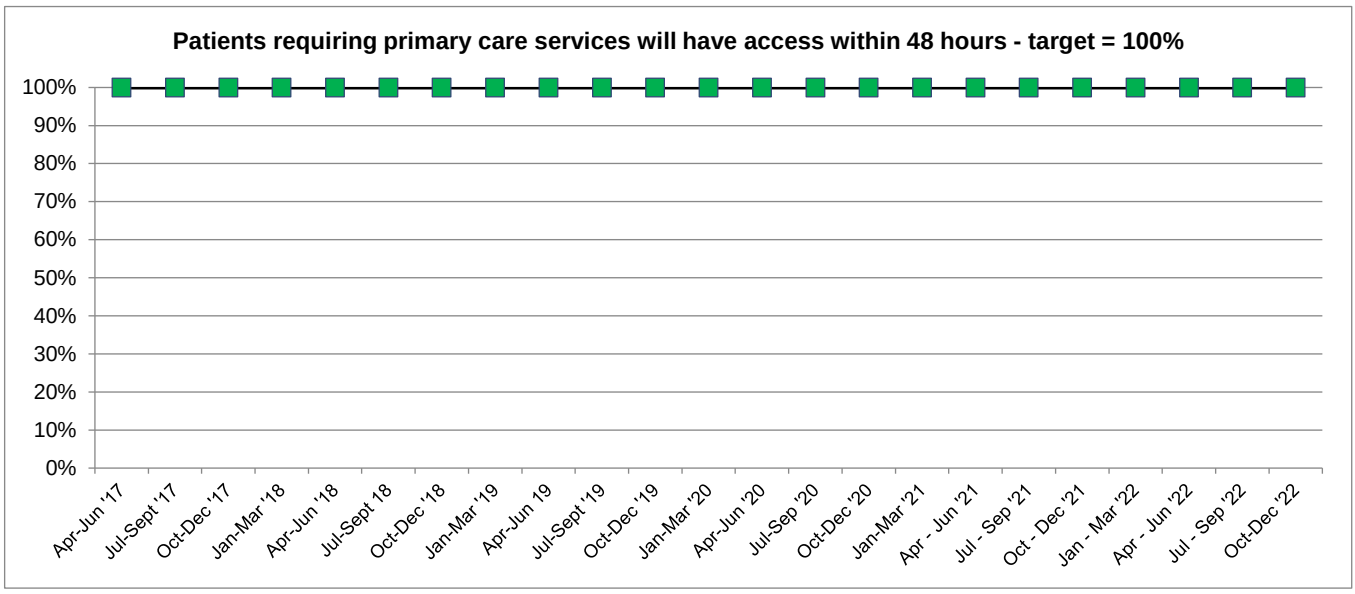
The indicator is linked to the Mental Health Act, 2003 and the streamlining of discharges and transfers. The number of patients transferred out using CPA process are measured through this indicator.



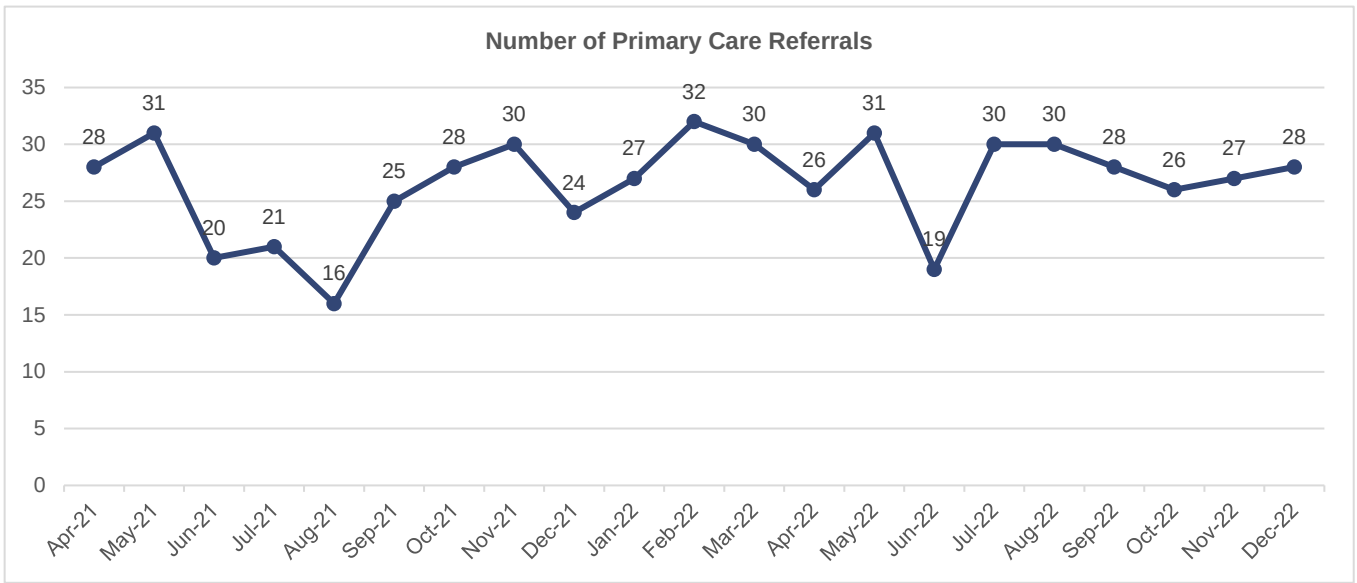
No 10: Patients Requiring Primary Care Services Will Have Access within 48 Hours

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.



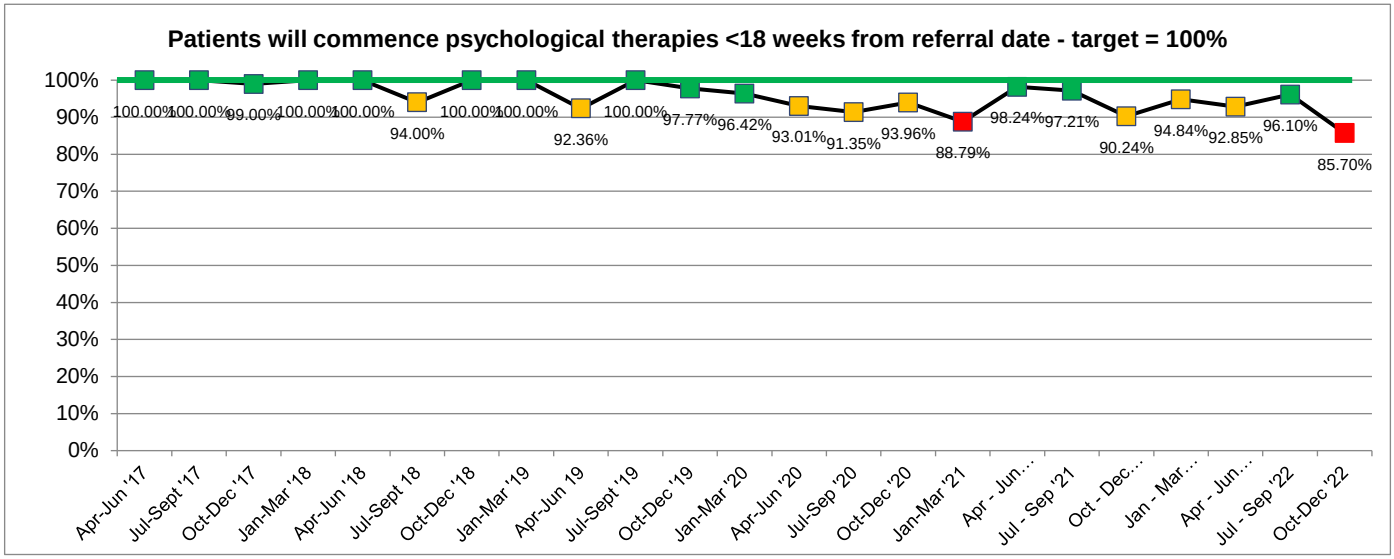
No 11: Patients will Commence Psychological Therapies <18 Weeks from Referral Date

Target: 100%

Data for current quarter: 85.7%

Performance Zone: Red

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.



During Q3, three patients waited beyond the expected referral timeframe to commence their psychological therapies. All patients who are waiting for a therapy should still have regular contact with their psychology team and during their pre-CPA interviews.

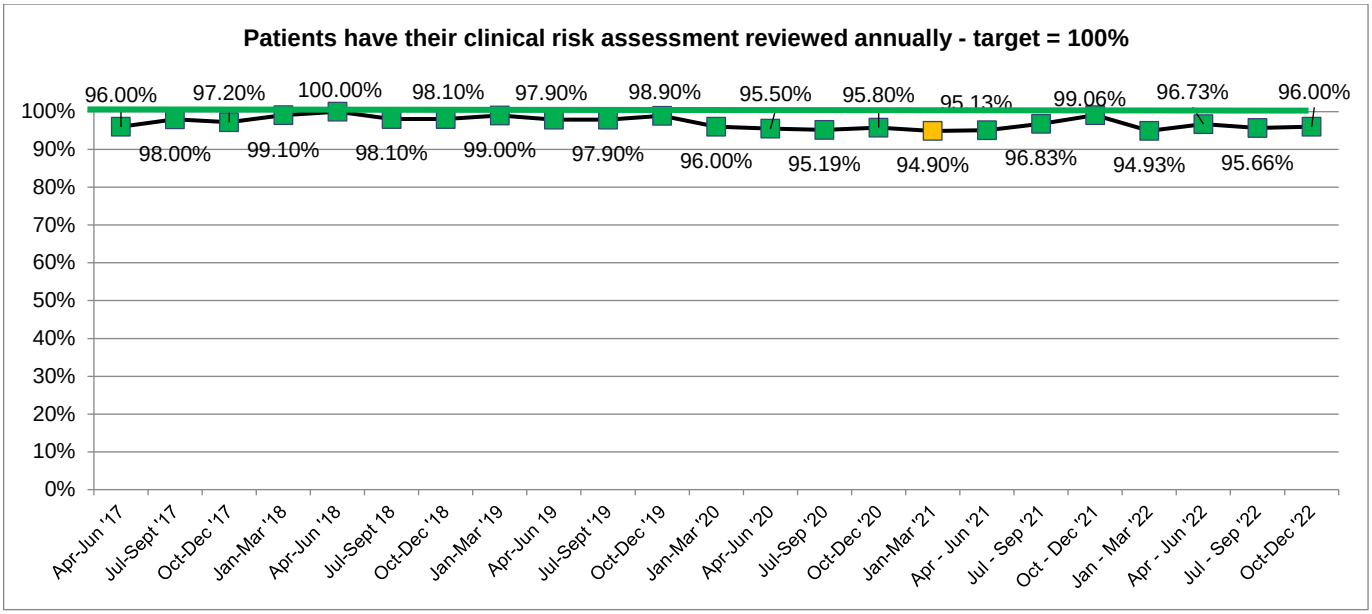
No 13: Patients have their Clinical Risk Assessment Reviewed Annually

Target: 100%

Data for current quarter: 96%

Performance Zone: Green

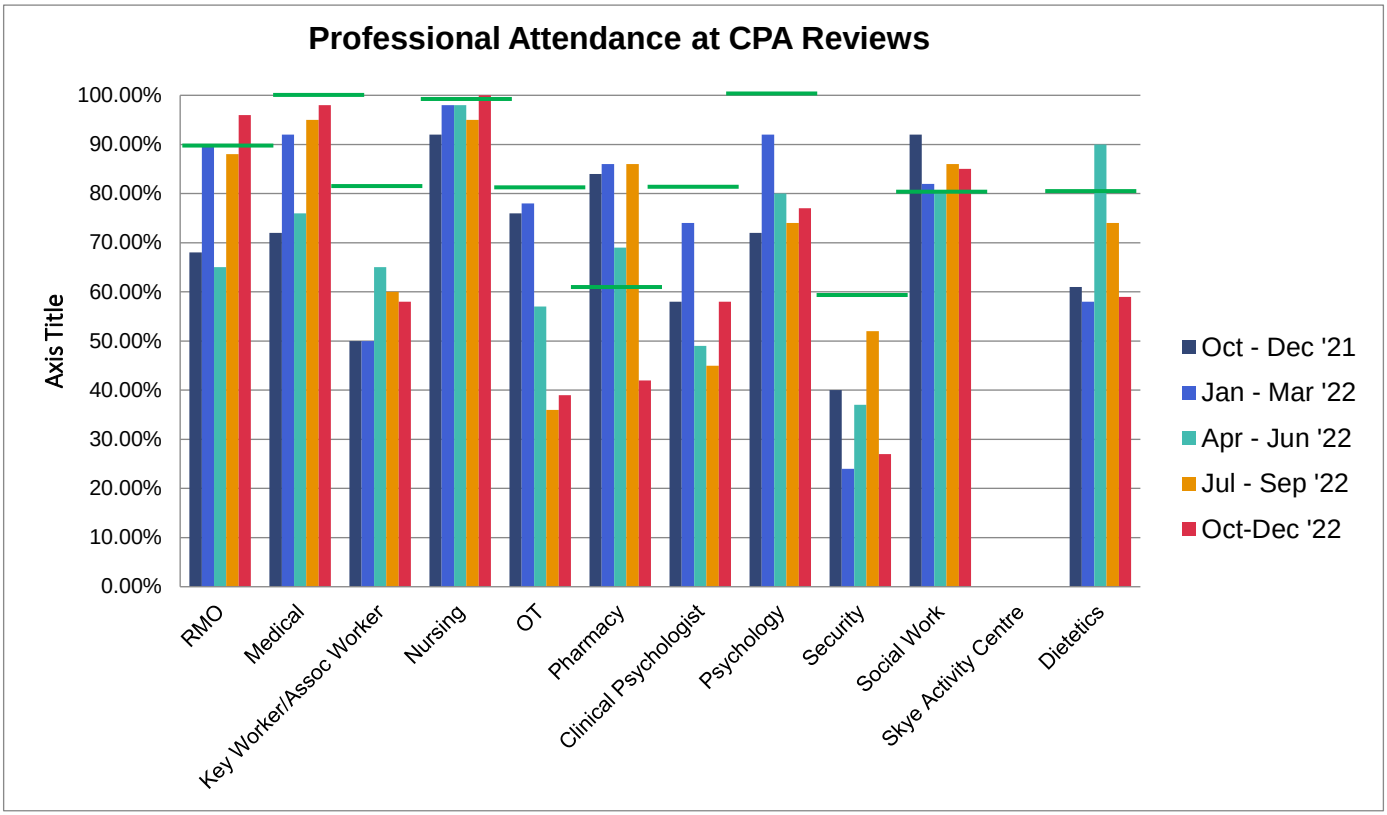
The indicator links with the Mental Health Care and Treatment Act Scotland, 2003. Examples of clinical risk assessments would be a HCR20 / SARA.



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 22 n=14	Nov 22 n=25	Dec 22 n=13
RMO	100%	92%	100%
Medical	100%	96%	100%
KW/AW	57%	48%	77%
Nursing	100%	100%	100%
OT	29%	40%	46%
Pharmacy	86%	32%	15%
Psychologist	50%	44%	62%
Psychology	71%	64%	77%
Security	14%	32%	31%
Social Work	71%	96%	77%
Skye Centre	0%	0%	0%
Dietetics	83%	56%	50%

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 to 96% in Q3. This indicator remains in the green zone for this quarter.

Medical – this profession remains in the green zone for this quarter, with an increase from 95% to 98% in Q3.

Key Worker/Associate Worker – attendance figures decreased to 58% for this quarter. On the 22 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 increased to 100%; this profession remains in the green zone.

OT – attendance has increased slightly during Q3 to 39% from 36%. OT therefore remains into the red zone for this quarter. This can be mainly attributed to staff sickness and staff vacancies within this department.

Pharmacy – attendance for this quarter has decreased from 86% to 42%. This moved this profession from the green zone to red zone. This can be attributed to Staff annual leave, Staff off duty, Workload and staff vacancies.

Clinical Psychologists – this profession's attendance has increased from 45% in Q2 to 58% in Q3. This indicator remains in the red zone. Five instances where the VAT form was not completed and a combination of annual leave, no reason, staff sick leave and staff vacancy made up this percentage.

Psychology – this professions attendance has increased in Q3 to 77%. This profession remains in the red zone. On 10 occasions where the Psychologist was unable to attend, a Psychology representative attended in their place.

Security - attendance from security has decreased in this quarter from 52% to 27%. Security moves into the red zone for this quarter. This can be attributed to staff annual leave and staff off duty.

Social Work – attendance has slightly decreased in Q3 to 85% from 86%. This profession remains in the green zone.

Dietetics – during Q3, attendance from dietetics has decreased to 59% from 74% in Q2. This professions moves into the red zone. This can be attributed to staff annual leave, no reason given, staff off duty and the VAT not being completed.

4. RECOMMENDATION

The Board is asked to **note** the contents of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	
Workforce Implications	
Financial Implications	
Route to Board Which groups were involved in contributing to the paper and recommendations.	
Risk Assessment (Outline any significant risks and associated mitigation)	
Assessment of Impact on Stakeholder Experience	
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).	
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:	23 February 2023
Agenda Reference:	Item No: 21
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 31 January 2023
Purpose of Report:	Update on current financial position

1 SITUATION

The Board is asked to consider the Revenue and Capital Resources spending plans, and monitor financial outturn. This report provides information on the financial performance, which is also issued monthly to Scottish Government (SG) along with the statutory financial reporting template.

2 BACKGROUND

2.1 TSH

SG were ordinarily provided with an Annual Operating Plan (OP) and 3-year financial forecast template. The Operating Plans for 2020/21 and 2021/22 were paused due to Covid and replaced with the Board Remobilisation Plan (BRP); however, we have now once again submitted an Annual Operating Plan for 2022/23 in 2022.

SG notified all Boards of there being no Covid-specific funding guaranteed to be available ongoing into 2022/23 at the levels of the last two years and, while this position will remain under review, there are a number of processes that have been put in place with individual budget-holders so that the pressures of Covid-related costs which have continued to be incurred will to be met within the specific directorates as we continue to return to “business as usual” through 2022/23.

There are delays (attributable to Covid) in the Perimeter Project which are being monitored by the Project Board and for which any delay costs will be reviewed and quantified for consideration (in 2022/23).

The draft base budgets (pending notification of settlement of the final and fully confirmed AFC Pay Circular for 2022/23) currently forecast a breakeven year-end position, set on achieving £0.811m efficiency savings, as referred to in the table in section 4.

This is subject to change once we receive confirmation of SG coverage of final pay circulars but to manage this prudently we are also maintaining an element of contingent reserve until the final pay award levels and reimbursement are known from SG – due in February 2023.

2.2 SG Communication

On 14 July 2022, the NHS Scotland Chief Operating Officer and Director of Finance wrote to all Chief Executives and Directors of Finance highlighting Service Priorities and the "considerable financial challenge" for 2022/23, 2023/24 and beyond. Priorities for 2022/23 were noted as:

- Planned care – reduction in waiting times
- Cancer care – enhanced diagnosis and treatment
- Unscheduled care – taking forward the new "Urgent and Unscheduled Care Collaborative" – funding to be confirmed
- Extended flu and Covid vaccinations
- Reduced drug deaths

The letter referred to the 2022/23 Agenda for Change pay offer, with Boards to assume that funding will be provided based on the additional costs associated, and allocations to be confirmed following conclusion of pay negotiations.

It was also noted that Boards are to focus on reducing remaining Covid costs, with the anticipation of no further COVID consequentially in 2022-23 or in future years and any recurring costs to be met through confirmed recurring allocations where now in place (e.g. sustainable vaccination workforce) or from existing baseline budgets. (Funding is expected towards the Test and Protect programme).

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £41.050m is primarily the forecast Scottish Government Revenue Resource Limit core and non-core allocations, and anticipated additional allocations.

The Board is reporting an overspend of £0.044m to January 2023; with revenue forecast trajectory variance set at £0.223m underspend (per monitoring template for 'SG'). The adverse variance in month is mainly due to utilities overspend – an ongoing risk. Pay pressures including the AFC pay increase also went through in January with additional arrears due in February – further RRL is anticipated to cover the shortfall of the original 2% and the average 7.5%.

PAIAW ("Payment as if at work") funding continues to be held as a reserve for the current year. This continues to be a significant element for the Board regarding our high levels of overtime and high nursing vacancies. There is a small pressure for some who have been identified as having potentially been paid incorrectly for which review is underway and which should be resolved soon.

Some pressure potentially remains re prior years' PAIAW still outstanding – claimants now being in the hand of CLO (some of whom have recently been paid.) This was accrued at March 2022.

Additional, at March 2022, some costs of the project works started in 2021/22 re the eRostering project *(see para 3.2)*, M365 licences, and related pressures have been accrued to fund an element of anticipated costs in 2022/23.

3.2 Key financial pressures / potential benefits.

Revenue (RRL): -

Covid-19
As noted above, because of the late advice from SG that Covid would no longer be funded there are some remaining cost pressures which will be managed within Directorates, and which will be regularly monitored. Some new posts may be reviewed for permanency, and a schedule of such posts is being collated for SG review, further to discussion with SG, Chief Executive and Finance and eHealth Director.

eRostering Project
While provision has been noted for the contractual implementation costs of the eRostering project in 2022/23, this project is now being rescheduled nationally by NSS to implement across 2023/24 and 2024/25. Additionally, currently unfunded are the additional posts expected to be required in order to manage this implementation – being three posts requiring an annual funding of approx.£150k. This pressure has been highlighted to SG, and as it is an issue shared by a number of Boards this has been raised by TSH at both DoF and Chief Exec levels as the project is receiving national attention re confirmation of amended timeframes.

Clinical Model review update
There is risk noted that the updated Clinical Model review's financial position is expected to differ in structure from that which was originally considered and evaluated pre-Covid – current indications being that while this is not expected to give additional costs above current levels, originally anticipated savings will not be realised.

Energy and inflation increases
The rising costs of energy supplies and the knock-on effect on other supply chain deliverables will be closely monitored in 2022/23 as it is expected that there could be significant pressure in 2023/24 – currently estimated at an increase of £300k.

Extra PH for Platinum Jubilee
It is noted that there is the cost of one day's additional holiday in 2022/23.

Benefits
Travel underspend has continued through the year and ongoing budgets will be amended accordingly to reflect changed ways of working. There are also some divisional training underspends noted in-year.

3.3 2023/24 Draft Budget

The 2023/24 draft budget template required by SG has been submitted, noting a forecast break-even position for the revenue outturn, within which there is a savings requirement of £1.3m.

This increase from 2022/23's savings of £0.8m is due principally to cost pressures specifically highlighted of £300k re energy costs anticipated in the coming year due to market price increases, and £180k noted re 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 priorities for spend in the coming year have been notified to CMT – also noting that additional project funding will be considered when appropriate for any priority projects not affordable through the recurring funding.

3.4 Year-to-date position – 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	22,666	18,997	18,945	52	402.10	411.88
Security And Facilities	5,898	4,991	5,036	(45)	121.62	116.02
Utilities (extracted from above)	707	530	629	(99)	0.00	0.00
Medical	3,057	2,536	2,392	144	20.55	20.56
Chief Exec	2,041	1,698	1,696	2	22.96	23.09
Human Resources Directorate	991	826	793	33	15.15	14.50
Finance	2,792	2,328	2,302	27	29.43	31.04
Cap Charges	2,641	2,201	2,190	10	0.00	
Misc Income	(600)	(500)	(464)	(36)	0.00	0.00
Central Reserves	857	68	199	(131)	0.00	0.00
	41,050	**33,674**	**33,718**	**(44)**	**612**	**617**

Nursing – Includes Ward Nursing overtime pressure, and benefit from leavers being replaced by new starts in year which will contribute to the underachieved savings – plus offset with vacancies in other departments which gives a net underspend position.

Security & Facilities – Previously highlighted biomass and electricity overspends are noted, with a focus forward on monitoring energy costs in a pressured market. This has been extracted from Security to show on its own in order not to distract the Security budget from core activity. There are remaining covid pressures for disposable items being used for patient food delivery (budget was released in January to support this), and food price increases are causing pressure in the kitchen and staff restaurant. Pressures also noted regarding essential Estates repairs and Laundry.

Medical – Some Medical recharges have now ceased, resulting in an adverse effect, being offset with post vacancies, underspends in non-pay, and research underspend to date. Pharmacy savings are currently under achieved.

CE – Non-pay expenditure underspends noted.

HR – Vacancy benefits have to date countered staff cost pressures, with benefit noted also from corporate training underspend.

Finance – eHealth cost pressures are noted, with review underway of utilisation/allocation of non-recurring strategic funding received.

Capital Charges – We are awaiting SG confirmation of the required change to the allocation (core to non-core adjustment) – £2.620m being the estimate, with AME provision currently set at 21/22 value.

Miscellaneous Income (MI) – The budget recognises income billed for exceptional circumstance patients, with appropriate provision for boards with whom recoverable balances are being discussed.

Central reserves – The most significant reserves are inflation / estimate for pay awards held centrally awaiting circular (accrued monthly); PAIAW costs reserve; and Apprenticeship Levy reserve.

Some of the anticipated RRL confirmations are awaited for final confirmation in remaining months.

4 ASSESSMENT – SAVINGS

The following table summarises the savings set by Directorate.

Cumulative Savings	Savings - Annual Target	Achieved to date / post base adj'ts	(Still to be achieved) / over achieved
Directorate	**£'k**	**£'k**	**£'k**
Chief Executive	(41)	0	(41)
Finance	(42)	22	(20)
Nursing & AHP's	(347)	365	18
Human Resources	(29)	0	(29)
Medical	(68)	85	17
Security & Facilities	(115)	90	(25)
Unidentified (phased ytd) - so all 'achieved'	(169)	0	(169)
Total	**(811)**	**562**	**(249)**

While an improved level of recurring saving remains a national / audit focus, it should be noted that of the Hospital's budget only 15% of costs are non-pay related while by comparison, many territorial boards have a non-pay cost element of around 65% and other National boards have non-pay costs ranging from around 80% (NSS, NES) to 30/40%.; while certain boards also treat vacancy savings, or a proportion thereof, as recurring savings.

Savings are phased evenly over the year (twelfths). Draft budgets had unidentified savings currently set at £0.169m.

Principle savings achieved to date are from vacancies in various Directorates, including Psychology and Housekeeping.

National Boards Contribution

The eight National Boards (formerly Special Boards) continue to work towards joint efficiencies and collaborative working. The recurring level of contribution to the collective £15m savings challenge which the Board agreed and approved for 2021/22 remained at £0.220m, and this is currently included as forecast for 2022/23.

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation anticipated from Scottish Government for 2022/23 is £0.269m. We also have a brought forward unspent 2021/22 allocated project funding for Key Safes & MSRs – this £0.605m was included in our August Allocation schedule – for which work is well underway and completion expected within 2022/23.

In addition, funding has been applied for and received in-year to support backlog maintenance work required on the Hospital site – a range of Estates and Security work was identified and these areas of work are all now included in the planned programme for the current year. A small element of this is revenue work.

With regard to the Perimeter Security Project allocation, there are elements of unforeseen delays in the project – now likely to be completing in early 2023/24 (Q1) – requiring carry forward of unspent monies. SG are fully up-to-date with the anticipated project outturn and conclusion. Payment to the contractor has been negated in recent months due to offset of agreed due penalties.

CAPITAL CRL 2022/2023 AS AT JANUARY 2023	ANNUAL PLAN £'k	YTD SPEND £'k
PERIMETER SECURITY		
Stanley Security Solutions LTD		166
Thomson Gray LTD		161
TSH Staff Apr - Sep '22		162
DJ Goode		0
PERIMETER SECURITY TOTAL (Yr 2 of 2)	905	489
CAPITAL		
IM&T	4	26
Other	265	64
MSR refurbishment	400	0
Family Centre gardens	0	87
Key-safes refurbishment	205	0
CAPITAL	874	177
Backlog Maintenance (awaiting funding)		50
Total CRL	1,779	717

6 RECOMMENDATION

Revenue

The year to date position is an overspend of £0.044m, with breakeven anticipated for the year-end.

Capital

CRL June 2022 received £0.874m, with the specific perimeter allocation awaitingh the confirmation of the final 2022/23 balance required. We are also awaiting the final confirmed backlog maintenance allocation (previously approved). It is anticipated that our capital allocation will be fully utilised in-year.

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

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of financial position
Workforce Implications	No workforce implications – for information only
Financial Implications	No workforce implications – for information only
Route to SG/Board/CMT/Partnership Forum Which groups were involved in contributing to the paper and recommendations.	Deputy Director of Finance
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:	23 February 2023
Agenda Reference:	Item No: 22
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 assessment and current issues under consideration by the Project Oversight Board.

2. BACKGROUND

The Governance for the project is provided by a Project Oversight Board (POB) co-chaired by the Chief Executive and the Director of Security, Estates and Facilities.

The Project Oversight Board meets monthly. The POB last met on 16th February 2023 and is scheduled to meet again on 16th March 2023.

The Programme Director provided an update on the current status on the project, the Project Risk Register and financial details.

3. ASSESSMENT

a) General Project Update:

Quality targets are being met, project costs are projected to overspend by a small amount and project timescales have been reviewed and adjusted (See “Project Timescale” at point 3b below). A strategic overview of progress during the period from February 2020 to date is below:

- Construction Phase – 45% completed (7 work faces in progress, 18 to be commenced)
- Testing and Commissioning – not yet commenced
- Detailed Design Packages – 96% completed
- Construction Health and Safety documentation – 65% completed (14 to be commenced)

b) Project Timescales & Quality Issues:

Programme revision 41 was accepted with Caveats and an end date of 17 January 2022. Further revisions have been reviewed and rejected. Revision 44 is currently under review with a forecast completion of 23rd May 2023.

A Project Status Review paper was presented to the Project Oversight Board on 19th January 2023. This extraordinary paper detailed the difficulties that Stanley were having dealing with faults and TSH operational problems whilst also trying to make progress against the installation programme. The proposal from Stanley was that installation works were paused while these problems were addressed. Installation works have recommenced. An update was provided to Board members on 9 February 2023.

c) Finance – Project cost

The project is proceeding according to the current projected cost plan.

The key project outline is:

Project Start Date:	April 2020
Planned Completion Date:	May 2023
Contract Completion Date:	April 2022
Main Contractor:	Stanley Security Solutions Limited
Lead Advisor:	ThomsonGray
Programme Director:	Doug Irwin
Total Project Cost Projection (Inc. VAT):	£11,007,888
Total costs to date (Inc. VAT) at 12th February 2023:	£9,836,260

The cash flow schedule planned for the months to come is confirmed on a rolling basis in order to ensure that the Hospital's cash flow forecast is aligned and that our SG funding drawdown is scheduled accordingly. All project payments are processed only once certification is received confirming completion of works to date.

While it is not a prerequisite of the project, regular reports to the SG Capital team are also being provided to notify of progress against total budget.

50% of the 5% retention is due to be paid at completion, with the remaining 50% to be paid at the end of the defects and liability period of 2 years.

A rounded breakdown of actual spend to date at end of January 2023 is below.

Stanley	£ 6.843m (5% retention applied)
Thomson Gray	£ 0.832m
Doig & Smith	£ 0.008m
HVM Design	£ 0.017m
VAT (exc. refund)	£ 1.639m
Staff Costs	£ 0.578m
Income	-£ 0.080m
Total	**£ 9.837m**

4 RECOMMENDATION

That the Board **note** the current status of the Project

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date:	23 February 2023
Agenda Reference:	Item No: 23
Author(s):	Head of Corporate Governance/Board Secretary
Title of Report:	Board and Committee Membership
Purpose of Report:	For Decision

1 SITUATION

To outline the updated membership of the Board, as well as of each of its committees.

2 BACKGROUND

It is confirmed that Mr Brain Moore has been appointed to a four-year term as Board Chair, and that Mr McConnell will continue for a second four-year term.

Ms Shalinay Raghavan has been appointed as Non Executive Whistleblowing Champion (from 16 January 2023) for a four-year term.

In addition, Mr Allan Connor has been elected as Chair of Joint Staff Side, for a four-year term until 31 March 2027, and a recommendation has been made to Scottish Government Ministers that he be re-appointed as Employee Director.

3 ASSESSMENT

In view of these changes, the Board is asked to consider the proposed changes to membership of each of the standing committees as attached.

This adds Ms Shalinay Raghavan to both the Clinical Governance Committee and Staff Governance Committee. It also revises membership of the Remuneration Committee to a smaller cohort, rather than including all of the Non-Executive membership as had previously been the case, to help enable continuity of focus in this area.

The revised Board and Committee membership is noted in Appendix A.

4 RECOMMENDATION

The Board is asked to approve the changes to governance committee membership

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support board business and scrutiny through its standing committee structure. To ensure each committee has appropriate membership.
Workforce Implications	Not applicable
Financial Implications	Not applicable
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board Secretary
Risk Assessment (Outline any significant risks and associated mitigation)	No specific risk assessment required as this ensures appropriate membership and chair appointments to the committee structure
Assessment of Impact on Stakeholder Experience	No specific assessment of this 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 relevant
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Appendix A

THE STATE HOSPiTALS BOARD FOR SCOTLAND

BOARD AND STANDING COMMITTEE MEMBERSHIP

MEETING	MEMBERSHIP
BOARD	**Chair – Brian Moore** **Vice Chair – David McConnell** **Non-Executive Directors:** **Stuart Currie** **Allan Connor (Employee Director)** **Cathy Fallon** **Pam Radage** **Shalinay Raghavan (Whistleblowing Champion)** **Executive Directors:** **CEO: Gary Jenkins** **Director of Nursing and Operations: Karen McCaffrey** **Finance and eHealth Director : Robin McNaught** **Medical Director: Lindsay Thomson**
AUDIT COMMITTEE	**Chair – David McConnell** **Stuart Currie** **Allan Connor** **Pam Radage**
CLINICAL GOVERNANCE COMMITTEE	**Chair – Cathy Fallon** **Stuart Currie** **David McConnell** **Shalinay Raghavan**

STAFF GOVERNANCE COMMITTEE	**Chair – Pam Radage** **Allan Connor** **Stuart Currie** **Cathy Fallon** **Shalinay Raghavan**
REMUNERATION COMMITTEE	**Chair – David McConnell** **Allan Connor** **Cathy Fallon** **Pam Radage**

Updated 1 February 2023 – M Smith

Approved Minutes of the meeting of the Audit Committee held on Thursday 29 September 2022 at 9.15am via Microsoft Teams AC(M) 22/04

PRESENT:

Non-Executive Director	David McConnell ***(Chair)***
Employee Director	Allan Connor
Non-Executive Director	Pam Radage
Non-Executive Director	Stuart Currie

IN ATTENDANCE:

Internal

Director of Finance and eHealth	Robin McNaught
Head of Corporate Planning and Business Support	Monica Merson
Board Chair	Brian Moore
Head of Procurement	Stuart Paterson (up to item 8)
Director of Security, Estates, and Resilience	David Walker
Business Development Manager	Alison Buchanan ***(Minutes)***

External

Internal Audit, RSMUK	Asam Hussain
Internal Audit, RSMUK	Victoria Gauld

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

David McConnell welcomed everyone to the meeting. Apologies for absence were noted from Gary Jenkins and Margaret Smith. Karen Jones, Azets, provided late apologies.

2 CONFLICTS OF INTEREST

Stuart Currie indicated that he has been appointed to the position of Vice Chair, Independent Review of Inspection, Scrutiny and Regulation of Social Care in Scotland by the Scottish Government. This appointment has the potential to be a conflict of interest for all further meetings whilst holding this post. David McConnell advised that this would be kept on the minute as a standing conflict of interest and that Stuart Currie should highlight areas of conflict as appropriate going forward.

No other conflicts of interest were noted.

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 23 June 2022 were approved as an accurate record with amendments to reflect a change in paragraph 6 that addressed an incorrect number.

4a MATTERS ARISING – ACTION PLAN UPDATE

Progress was noted on the Action Plan Update as detailed below:

External Audit – SLA
Robin McNaught advised that discussion with other boards are ongoing. Action plan updated.

Effectiveness of Audit Committee
On agenda.

Cyber Crime Report
On agenda.

Internal Audit Tracking Report 2022-23
On agenda.

INTERNAL AUDIT

5 INTERNAL AUDIT PLAN 2022/23 – PROGRESS REPORT

Victoria Gould, RSMUK, summarised that work on the 2022/23 internal audit plan is underway with a number of audits at the scoping stage. Two audits have been delayed due to external factors with the Security Resilience audit deferred to Spring 2023 due to project delays, and the Workforce Planning audit delayed due to Scottish Government deadlines around submission of workforce plans in October 2022.

It was reported that the audit plan remains in line with the original timetable and the report provided full status updates on actions.

Members raised some concerns around the uncertainties of workforce planning. Current wider national developments could potentially result in amendments to workforce planning by the Scottish Government and there may be potential for significant impact from an audit perspective. Asam Hussain advised that Linda McGovern has written to Scottish Government asking for clarification. RSMUK remain in regular contact with Linda McGovern and will ensure that the audit is able to respond to any emerging change/uncertainties.

ACTION: ASAM HUSSAIN

Monica Merson highlighted that the timescale for audit does not match the timeline for the implementation of the clinical model. Asam Hussain advised that RSMUK would be able to flex their scope accordingly to adjust to clinical model delivery. This will be picked up in regular meetings with Karen McCaffrey and Linda McGovern. How this matter is reported to the committee will be developed as the clinical model implementation progresses.

ACTION: ASAM HUSSAIN

6 INTERNAL AUDIT TRACKING REPORT 2022/23

The Committee received and noted the tracking report from RSMUK in relation to management actions taken forward in response to internal audit recommendations.

Of the 21 actions still live on the tracker: 14 were reviewed and seven have not been reviewed this time as either the original or revised implementation date has not yet passed. 11 actions had been implemented, with 3 remaining ongoing. These three related to actions from the eHealth audit, whereby the eHealth Plan and subsequent IT Strategy are still in the process of being finalised. Full details of the actions and reasons for delays are listed within the report.

It was noted by the auditor that the eHealth department are working well to finalise the 3 outstanding actions, however, the volume of work for this department remains an issue.

Overall good progress has been made. Details are on page 5 of the tracker report.

Stuart Currie intimated that the status update “date not reached” does not provide the committee assurance the action is progressing. It was agreed that it would be helpful for future reports to have an indicator of progress noted for the committee to review.

ACTION: ASAM HUSSAIN

Allan Connor noted that page 12, item 1.21/22 was not accurate. Rosters will not be compiled 6 weeks in advance, this remains at 12 weeks. The report will be amended to reflect this.

ACTION: ASAM HUSSAIN

Allan Connor noted that page 13, item Effective Rostering and Overtime 1.21/22 was not accurate. There is no 100 hours of overtime per month limit. Local protocols are in place to monitor 23 hours per week as it was felt that a weekly cap was more beneficial to staff. The report will be amended to reflect this.

ACTION: ASAM HUSSAIN

Pam Radage noted the positive progress achieved to date but expressed concern regarding the pressured eHealth team and their ability to progress work. Robin McNaught provided an update to indicate that the budget for fixed term posts is presently being funded from the strategic fund however this did not allow recruitment to full time posts. The Scottish Government have been contacted regarding solutions and an outcome is pending. In the meantime, work is being prioritised but challenges remain. Organisationally there needs to be an understanding of volume and considerations for future projects. It was agreed that the November deadlines will be a challenge.

Members noted the update of the internal audit action tracker.

INTERNAL CONTROL AND CORPORATE GOVERNANCE

7 PROPERTY AND ASSET MANAGEMENT STRATEGY ANNUAL REPORT

David Walker provided an update on the position on the property and asset management strategy annual report. Audit committee noted the content.

ACTION: ROBIN MCNAUGHT / DAVID MCCONNELL *to pick up the remit issue outwith the meeting*

8 CORPORATE RISK REGISTER UPDATE

David Walker provided the committee with an update. In terms of assessment (point 3.2 of the report), 3 Corporate Register Risks currently require review within the HR Directorate, they are currently with the Director for review and there is 1 within the Corporate Directorate. Work is being done to address.

Point 3.3 of the report noted that SD54 Climate Change Impact on The State Hospital has been reviewed by the Sustainability Group to better align with DL38: The Climate Emergency and Sustainable Development Policy. There are 68 action points for consideration which are currently out for consultation with the Climate Change and Sustainability Group. An update will be provided at the next board meeting.

Point 3.4 IT Risk Updates
Work has been ongoing to finalise the risks below since the last Audit Committee. The Full Risk Assessment is detailed in Appendices 1 and 2 of the provided report.

Risk	Action
FD91 - IT System Failure	Updates made to Risk Assessment, signed off by Director
FD98 - Failure to Comply with Data Protection Arrangements	Updates made to Risk Assessment, signed off by Director

Covid risk was reviewed in September 2022 with the decision being to leave this risk as high going into the winter period. This will remain under review and be reported via the Corporate Management Team.

Staffing issues continue to affect TSH. Daily meetings takes place to monitor staff resources in real time managed through the 'Safe to Start' Process. Staffing is being monitored daily and continues to be a priority for the Hospital, recruitment is ongoing and modified working/closures being utilised where required.

Members thought the report was helpful to understand and rate risk. Overall, there were thought to be a some patterns that were worth looking at where the initial grading, the current grading, and the target grading are all the same and also HRD112 where the current risk is moderate but the target is major. David Walker advised that there is a piece of work in progress where the directors review risk. A development session is in the process of being planned to allow a better understanding of risk and how the report can be updated.

ACTION: DAVID WALKER

Members noted the position of the report.

9 PROCUREMENT ANNUAL REPORT

The report highlights the main areas of activity in the previous financial year 2021/2022 and is based on the recently updated Procurement Strategy approved by Corporate Management Team. Stuart Paterson advised that he had now been in post for a year and the recent RSM audit supported the reasons for the changes that have been implemented within the department. It was also noted that there had been significant savings to the health care service through the appointment of the new GP Service.

Under section 2.1 of the report, the committee advised that it would be useful to have a reason/explanation code for these procurement items in future reports.

ACTION: STUART PATERSON

The committee welcomed the report.

10 FRAUD UPDATE

The level of fraud allegations and notifications received from Counter Fraud Services remains high although no specific issues have been raised.

One new allegation with date shown was received since the March 2022 report:

- 06/06/22 – however, this case is successfully closed off.
- As at 13th September, no further allegations have been forwarded to TSH from CFS.

The annual meeting with Counter Fraud Services was informative and focussed on specific actions across all boards. The CFS are looking to engage more with the board as the recovery from Covid continues – details on this engagement will be forthcoming.

It was noted that fraud incidents had decreased since 2019. There was consideration given to how either our process are working very well or if as an organisation The State Hospital may not have robust enough measures to report incidents. Robin McNaught advised that due to the hospital's secure nature the site isn't as exposed to fraud such as equipment theft/resale and contract work is limited which both lower risk. Focus remains on the need to appropriately manage the complaints/issues that come in.

The Committee is invited to **note** the alerts circulated by CFS in the last quarter and note the update on fraud allegations within the Hospital.

11 FRAUD ACTION PLAN

See above

12 POLICY UPDATE REPORT

The submitted policy update indicates maintained progress in policy renewals, although it was noted that it will be difficult to drive out further improvements. The committee noted that that the Policy Approval Group was functioning well and asked Robin McNaught to provide positive feedback to the group.

13 CYBER SECURITY REPORT

Risks continue to arise nationally and to date all encountered risks have been managed effectively. The resilience to continue to manage risk in place, however there is a need to ensure that this level is maintained.

A cyber awareness course has been circulated for the non-executive members of the board and it was agreed that attendance would be beneficial.

Brian Moore noted that a possible development session to profile the risks and ensure resilience is being planned for later in the year.

EXTERNAL AUDIT

14 EXTERNAL AUDIT PROGRESS REPORT

Azets have now relinquished their role as the organisation's external auditor. Following submission of their finalised accounts the remaining involvement will be to ensure an effective handover to KMPG who will take over the audit shortly in regards to financial year 2022/23.

Further updates will be provided at the next Audit Committee.

OTHER ISSUES

15 EFFECTIVENESS OF AUDIT COMMITTEE

Robin McNaught thanked everyone for the completion of the Audit Committee Handbook checklist.

Members considered the following points:

1	Review of the need for specific induction material for new members of the Audit Committee, whilst acknowledging the national framework of active governance and that this is an area where further national guidance may become available.
2	Consider and discuss the challenge of independence of the committee from other board governance committees, in a small board. Due to the size of the board, members also sit on other board governance committees. There should be awareness of potential conflicts of interest related to involvement of members in other Committees
3	Consider ongoing the structure of review of the Committee's level of effectiveness, including the potential of specific feedback from the Board and Accountable Officer.

It was agreed that this checklist should be completed and reported on annually.

Members were assured that the breadth of the items discussed at this committee meant no surprises when items reached the Board. It was agreed that it would be of benefit to collate previous checklist results to see a year on year comparison and the report will be updated to include this information.

ACTION: ROBIN MCNAUGHT

A new blueprint for governance is forthcoming from the Scottish Government (due early 2023) and an upcoming Board session will be dedicated to understanding the expectations and how this will impact future audit arrangements.

16 DRAFT AUDIT COMMITTEE WORKPLAN 2023

The Audit Committee is scheduled for four meetings in 2023. No significant changes to the existing work plan were proposed although some duplication of work has been removed and a routine cyber fraud update has been included. It was noted that the work plan should be an evolving document so it can evolve as required.

The 2023 workplan was approved by the committee.

17 FINANCE, eHEALTH AND AUDIT GROUP

The Finance eHealth and Audit Group update was provided for information and to give reassurance that the group is meeting and addressing issues as required.

Members noted the report content.

18 SECURITY, RESILIENCE, HEALTH AND SAFETY GROUP

David Walker noted that the Security, Resilience and Health & Safety is due to meet in October 2022. There were no issues of note and a fuller update will be provided to the next Board meeting.

19 ANY OTHER BUSINESS

There was no other business.

20 DATE AND TIME OF NEXT MEETING

The next meeting will take place on 26 ***January 2023 at 9.45am in the Boardroom***

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 February 2023
Agenda Reference:	Item No: 25
Sponsoring Director:	Chief Executive Officer
Author(s):	Head of Communications
Title of Report:	Communications Service - Update
Purpose of Report:	For Noting

1 SITUATION

The Board is seeking an update in respect of Communications resourcing and digital transformation. This update is provided as at 3 February 2023.

2 BACKGROUND

In 2022, the Board approved the appointment of two Communications posts:

- **PR & Media Communications Officer -** Specific emphasis being placed on raising the profile of the State Hospital by engaging and educating stakeholders through the daily management of social media channels and the creation of content.

- **Digital Communications Officer –** Key areas of responsibility being the Website and Intranet.

Additional work was scoped to assess if an early rapid redesign of the website could be undertaken as a one off project and priority for the Board.

3 ASSESSMENT

PR & Media Communications Officer

The PR & Media Communications Officer took up post on 3 October 2022 and is already proving to be a real asset to the Communications Service. The post has just completed the mandatory three-month induction process, which focuses on important information about the Hospital, its policies and procedures, and relevant training. The aim being to ensure both personal safety and the wellbeing of the organisation.

The next step is for the post to undertake in-depth Communications Service familiarisation training. This is two-fold, firstly to ensure understanding of how we do things in Communications and why, and secondly to explain / agree the expectations of the role. This is critical so new posts understand their responsibilities thoroughly before commencing their duties.

Digital Communications Officer (provisional Band 6)

In July 2022, the post was advertised with interviews taking place in August 2022, however no appointment was made. The post went out to advert a second time in October 2022 with interviews being set for November 2022, however the post was pulled before the closing date as the requirements of the role had changed with the passing of time. For example:

- The plan was for the Digital Communications Officer to have expertise in web development to enable the rebuild of the State Hospital's website to be undertaken in-house.
- The post also required expertise in content management systems, namely 'Sharepoint', to drive forward the redevelopment of the Intranet from a technical aspect. This is no longer required as we have already bought into the national 'Sharepoint online' therefore the role will not require to build the new Intranet site.

To reflect this change / lesser responsibility, we will now be seeking to recruit a PR & Digital Communications Officer (provisional Band 5) post. A new job description and person specification are currently being written, with a view to the post being advertised mid-February 2023.

State Hospital Website

Work to commission a company to develop the website took place during June and July 2022 with the successful company 'Daysix' being commissioned in early August 2022. A first in-person meeting 'discovery session' took place in September 2022 with work accelerating over the following four months (October 2022 to January 2023). The new site was signed-off on Thursday, 2 February 2023.

Scotland's Health on the Web (SHOW) will continue to host our website. SHOW has confirmed that they will commence the 'go-live' process on Monday, 6 February 2023 – this can take up to 72 hours to complete. The current site will still be live and available during the majority of this time.

The Board will receive a short overview of the new website at the February Board meeting. The new site is modern with a simplistic but effective and visually appealing design. It has been specifically designed with our external audiences in mind. All forms on the site are online completion and sent directly to the relevant department. Information within these forms will not be stored on the server – the data will automatically be deleted when the submission email is sent.

State Hospital Intranet

Plans are underway to redevelop the State Hospital Intranet. The Intranet is currently managed by eHealth and will soon be adopted by the Communications service. Our current Sharepoint site (now at end of life) will be replaced with the new 'Sharepoint Online' version which is being led nationally for all Boards by National Services Scotland (NSS). The project is at an early stage pending resources, governance approvals and other necessary requirements to ensure successful implementation across NHS Scotland.

Due to this, we cannot provide an exact timescale for implementation for the State Hospital; however, we could be looking at 12-18 months.

Implementation of the new 'Sharepoint Online' Intranet site across the Hospital will be a huge undertaking for both eHealth and Communications who will work closely together to ensure this is done effectively and quickly when the time comes.

Meantime, staff have been advised to keep updating the current Intranet site to ensure easy transfer of any information in due course.

NHS Scotland National Branding

The Scottish Government is reviewing the NHS Scotland national branding. This provided an opportunity for the State Hospital to put a case forward for a State Hospital variant of the NHS Scotland logo that more clearly identifies the State Hospital as an NHS Scotland organisation. Branding includes both logo and name. All NHS organisations within the family use NHS in their name and so any change is likely to mean that our name would change to NHS State Hospital and NHS State Hospitals Board for Scotland as appropriate. A business case has been submitted to the Scottish Government. The process will take a few months to complete, and we are confident our business case will be successful.

Communications Resource

In the absence of the Digital Communications Officer post, the redevelopment of the external website has been all-consuming for the Head of Communications over the past four months. As a result of this - combined with day-to-day operational duties, providing support to the PR & Media Communications Officer, the reactive nature of the role, and unplanned commitments creating additional workload pressure - outstanding tasks largely remain outstanding due to capacity issues. The appointment of the PR & Media Communications Officer and planned appointment of the PR & Digital Communications Officer, when fully established in their respective roles, will ensure acceleration of the completion of current pressures and backlog.

The Communications Service remains committed to building capacity for the future, with an emphasis on appropriate resilience, succession planning and growth.

<u>Outstanding tasks – now complete</u>

- Update of Communications Strategy, policies and other supporting documentation.
- Produce the State Hospital Annual Report 202021– and on track for 2022/23.
- Produce the Communications Annual Report 2020/21 – and on track for 2022/23.
- Update of ONELAN screens at Reception for Official Visitors.
- Develop GDPR Data Protection Impact Assessments (DPIAs).
- Appoint a PR & Media Communications Officer.
- Redevelop the State Hospital Website.

<u>Priorities – (now to end July 2023)</u>

- Deliver familiarisation training / support for the PR & Media Communications Officer including the setting of tasks / objectives / review.
- Recruit PR & Digital Communications Officer (Band 5) post – lengthy process that could take around four months. This appointment is essential to addressing the backlog, supporting daily operational activity, maintaining the website, and redeveloping the State Hospital Intranet.
- Review and update of the Communications Strategy Action Plan.

- Continue to support the implementation of the new Clinical Model through the delivery of the Clinical Model Communications and Engagement Plan.
- Continue with work to support the Security Refresh Project through the delivery of the CCTV Implementation Communications Plan / community engagement.
- Enhance social media presence with the introduction of LinkedIn.
- Support recruitment and induction initiatives through social media and other channels to raise the profile of the State Hospital.
- Undertake preparatory work for the introduction of the new Intranet site 'Sharepoint Online'.
- State Hospital branding.
- Review and update of State Hospital Corporate Document Standards.

Priorities – (August to December 2023)

- Develop specific social media campaigns that support key actions within the Communications Strategy Action Plan / raise the profile of the State Hospital.
- Review and update of the State Hospital General Presentation / speakers' directory.
- Develop Communication Asset Registers to ensure compliance with Records Management legislative requirements.
- Explore delivery of in-house video production.
- Redevelop the Intranet site 'Sharepoint Online'

Future Priorities

- Review and update of State Hospital publications over three years old, and create a publications directory.
- Review of State Hospital photos and create a photo library.

4 RECOMMENDATION

The Board is asked to note the update.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	In support of the Board's Communications Strategy.
Workforce Implications	N/A as project update.
Financial Implications	N/A as project update.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested.
Risk Assessment (Outline any significant risks and associated mitigation)	N/A as project update.
Assessment of Impact on Stakeholder Experience	Positive impact.
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.