Meeting of The State Hospitals Board for Scotland to be held on Thursday 25 June 2015 at 1.00pm in the Boardroom, The State Hospital, Carstairs.

AGENDA

1 Apologies for absence and Chair’s introductory remarks
   - Chair

2 Conflicts of Interest
   - Chair

3 To approve the Minutes of the previous meeting held on 7 May 2015
   - Chair

4 Action Points and Matters Arising from previous minute
   - Chair

CLINICAL GOVERNANCE

5 Skye Centre Annual Report
   - Report by General Manager

6 Annual Report of the Clinical Governance Committee for year ended March 2015
   - Report by Chair of Committee

7 Clinical Governance Committee meeting held on 21 May 2015
   - Draft Minutes – Chair of Committee

STAFF GOVERNANCE

8 Workforce Data Submission
   - Report by HR Director

9 Annual Report of the Staff Governance Committee for year ended March 2015
   - Report by Chair of Committee

10 Annual Report of the Remuneration Committee for year ended March 2015
    - Report by Chair of Committee

11 Staff Governance Committee meeting held on 4 June 2015
    - Summary of Discussion – Chair of Committee

CORPORATE GOVERNANCE

12 Review of Staff Governance Committee Terms of Reference
    - Report by Chair of Committee

13 Review of Remuneration Committee Terms of Reference
    - Report by Chair of Committee
14 Annual Report of the Audit Committee for year ended March 2015  
   - Report by Chair of Committee  
   Enclosed

15 Report on the Annual Accounts for the year ended 31 March 2015  
   - Report by Finance and Performance Management Director  
   Enclosed

16 Finance Report as at 31 May 2015  
   - Report by Finance and Performance Management Director  
   Enclosed

17 LDP Performance Report as at 31 March 2015  
   - Report by Finance and Performance Director  
   Enclosed

18 Chief Executive’s Report  
   - Report by Chief Executive  
   Enclosed

19 Any Other Business

20 Date and Time of next meeting  
   Thursday 27 August 2015 at 10.00am in the Boardroom, The State Hospital, Carstairs

21 Exclusion of Public and Press  
   To consider whether to approve a motion to exclude the public and press during consideration of the items listed at Part II of the agenda in view of the confidential nature of the business to be transacted.
THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 7 May 2015 at 10.00am in the Boardroom, The State Hospital, Carstairs.

Present:
Chair 
Non-Executive Director 
Non-Executive Director 
Employee Director 
Non Executive Director 
Non Executive Director 
Chief Executive 
Finance and Performance Management Director 
Nursing Director 
Medical Director 

In attendance:
Training and Professional Development Manager 
Security Director 
Patient Learning Manager 
HR Director 
General Manager 
Board Secretary 

Observing:
Head of Estates and Facilities 
Estates Officer 

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Apologies for absence were received from Caroline McCarron. Terry Currie welcomed everyone to the meeting and announced the recent retirement of Annie McGeeney, Social Work Mental Health Manager. The Board joined Terry Currie in acknowledging the professional contribution and support to patients and staff at the Hospital by Annie McGeeney which had been very much appreciated and welcomed.

Members noted a verbal report from Terry Currie on the main issues discussed at the NHS Chairs meeting with the Cabinet Secretary on 3 March 2015. This related to the recent performance statistics and the positive aspects noted in terms of the increase in staffing; the significant improvement in cancer survival rates; and delayed discharges which remained stable. The four hour waiting time target, however, was still of some concern.

The Cabinet Secretary had received the assurance required from all Boards in respect of Healthcare Associated Infection (HAI) issues and underlined her concerns that the same type of issues continued to arise time after time and must be eradicated. It was noted that the assurance given from NHS Boards related to a particular point in time.

The Government’s commitment to Partnership for Change and in particular to achieving gender balance across NHS Boards was noted. She advised that currently, 45% of Non Executive Directors were women.
In terms of the Guiding Coalition’s Change Programme and the welcome news that additional resources were being channelled into specific work streams, the Cabinet Secretary noted the ongoing commitment to the Programme from NHS Chairs and Chief Executives. The NHS Chairs Group expressed some concern about the loss of momentum in progress being made and would welcome some clarity on various issues of the Programme. The Cabinet Secretary suggested that a matrix framework should provide the clarity they required.

Elizabeth Carmichael had attended the NHS Chairs Group meeting, on behalf of Terry Currie, on Monday 27 April 2015 and Members noted her feedback on the issues discussed. This related to the ongoing review of the HEI Assurance Statement; the need for a standard induction process for new Non Executive Directors and recognition of the value of ongoing development of Non Executives. Further discussion on this would take place over the summer; and that a presentation on added value of National Boards would be received at the Chairs Group meeting in September.

There was no meeting with the Cabinet Secretary, however, some Members would meet with her later to discuss the long term vision for the Health Service as well as Guiding Coalition issues.

The next meeting of NHS Chairs and the Cabinet Secretary would take place on Monday 1 June 2015.

Terry Currie advised that the NHS Scotland 2015 event would take place on Tuesday and Wednesday 23 and 24 June and that strong representation from the Hospital was expected again this year. The Chair and Non Executives had been invited to meet with Paul Gray during this year’s event.

2 CONFLICTS OF INTEREST
No conflicts of interest were noted in respect of the business to be discussed.

3 MINUTES OF THE PREVIOUS MEETING
The Minutes of the previous meeting held on 26 February 2015 were approved as an accurate record.

4 ACTION POINTS FROM PREVIOUS MEETING AND MATTERS ARISING
The actions noted from the last meeting were progressing.

5 PATIENT LEARNING REPORT
Stephen Milloy introduced Sandra Dunlop and Julie McDonald who were attending to discuss the Patient Learning Annual Report 2014.

Sandra Dunlop summarised the report which detailed service activity levels and key achievements for the period under review.

Members discussed a number of areas of the report in respect of the significant amount of positive work undertaken over the year; the costs around delivery of patient activities which would be included in next year’s report, with a connection being made on the benefits derived by patients in terms of learning and rehabilitation; the strong links patient learning had with the equalities agenda; the key performance data for the period; the number of unscheduled closures of activity sessions in the year; the importance of recognising and supporting patients’ aspirations and encouraging those who found it difficult to engage; the valuable role of volunteers; and the possibility of introducing the patient’s story and feedback of experiences in future reports.

Members agreed that the report was extremely positive and acknowledged the impressive achievements of patients. Terry Currie thanked Sandra Dunlop and Julie McDonald for presenting their report and wished them well with the continuation of their valuable work.

Sandra Dunlop and Julie McDonald left the meeting at this point.
6  SECTION 22 APPROVED MEDICAL PRACTITIONERS

Members received a report from Lindsay Thomson on the Approval of Medical Practitioners by The State Hospitals Board for Scotland.

Members noted that under the terms of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003, Medical Practitioners having the relevant qualifications and experience and on completion of the relevant training, required Board approval to have their name added to The State Hospital's List of Approved Medical Practitioners.

Members agreed Section 22 approval for Dr Sakib Ahmed and recommended that his name was added to The State Hospital's List of Approved Medical Practitioners as having special experience in the diagnosis and treatment of mental disorder. The appropriate notifications would be made.

Action: Lindsay Thomson

7  PREVENT STRATEGY

Members received a report from Stephen Milloy in respect of the PREVENT Strategy.

It was noted that Scottish Ministers supported PREVENT as it was part of the UK Government’s wider counter-terrorism strategy. This related to a number of initiatives aimed at protecting and supporting individuals, particularly those who were vulnerable, from being drawn into terrorism and recognised that safety was a shared endeavour.

Stephen Milloy summarised the report and the action plan developed following self assessment/review. Members noted that the Hospital was a fairly low risk environment and acknowledged the importance of being proportionate in response to the guidance issued.

A number of areas of the report and action plan were discussed in relation to the involvement of external partners in terms of the initial action plan, organisational learning and future monitoring; and the proportionate, but not complacent, approach taken to the guidance.

Terry Currie confirmed that the Board was assured by the work carried out and treated the issue very seriously.

Members noted the PREVENT Strategy and that updates on progress would be provided at future meetings of the Board.

8  CLINICAL GOVERNANCE COMMITTEE MEETING HELD ON 12 FEBRUARY 2015

Members received and noted the draft Minute of the Clinical Governance Committee meeting held on 12 February 2015 from Nicholas Johnston.

In advance of the draft Minute, the Board had received an update of the business discussed by the Committee at their last meeting on 26 February 2015 from Lindsay Thomson.

Members approved the Minute of the Clinical Governance Committee meeting held on 12 February 2015.

9  STAFF GOVERNANCE COMMITTEE MEETING HELD ON 5 MARCH 2015

Members received and noted the draft Minute of the Staff Governance Committee meeting held on 5 March 2015 from Bill Brackenridge.

Discussions had taken place in relation to progress of Personal Development Plans (PDP). It was noted that a meeting had been convened with Hospital Managers, who were invited to share their personal experiences of the PDP process and a number of learning points had resulted from this discussion. Other matters discussed related to the work underway with the i-Matter staff experience tool; attendance management and the difficulties across NHSScotland with the measuring of data; and the progress made and the different focus taken on the actions from the Internal Audit recommendations.
Jim Crichton provided the Board with an update of progress with i-Matter. Members noted the very positive start that had been made to the initiative at the Hospital with 89% participation of staff across the Hospital in cohort 1. Work was underway with cohort 2 and once complete, it was expected that The State Hospitals Board would be the first Board in Scotland to conclude the process.

Members noted an update from Barbara Anne Nelson on the formal process underway to meet with a number of identified staff to discuss attendance management issues. The matter was being taken forward in partnership and Interviews were scheduled to commence on 28 May 2015.

Terry Currie stated that the Board was seeking assurance that progress was being made to address the attendance management challenges and that the issue was regarded as a top priority.

Jim Crichton advised that the matter was now moving in the right direction with a strong partnership focus and commitment to jointly resolve the issue.

Members approved the draft minutes of the Staff Governance Committee held on 5 March 2015.

10 LOCAL DELIVERY PLAN (LDP) 2015-2018 – FOR HOMOLOGATION

Members received a report from Robin McNaught in respect of the Local Delivery Plan (LDP) 2015-2018. Members had received the draft LDP at its meeting on 26 February 2015.

The Board had agreed that, as in previous years, sign off of the final LDP would be delegated to the Chair, Chief Executive and Finance & Performance Management Director, with the Board being asked to homologate the LDP at its meeting in May 2015.

Robin McNaught advised that the first draft of the LDP was submitted to the Scottish Government in February and the final document by 13 March. At the time of writing the report to the Board, Scottish Government had confirmed verbally that the LDP and the supporting financial plan had been signed off on the basis that they set out a clear programme for delivering the targets in the year ahead, especially with regard to savings and workforce planning.

Robin McNaught tabled the formal letter from Scottish Government confirming sign off of the 2015-18 LDP which had now been received.

Terry Currie stated that the 2015-18 LDP was much improved on previous years and acknowledged the work of Robin McNaught and his team in bringing it all together.

The Board homologated the 2015-18 LDP as agreed at their meeting on 25 February 2015.

11 FINANCE REPORT AS AT 31 MARCH 2015

Members received the Finance Report as at 31 March 2015.

Robin McNaught summarised the report and confirmed an unaudited small underspend of £90k at the financial year end. It was expected that the underspend would be carried forward into the 2015-16 financial year.

Members noted that the savings target had been achieved and expressed his thanks and appreciation to everyone involved in meeting those challenges.

A number of issues of the report were discussed in relation to the possible re-structuring of the General Management budget of £22M; the reasons behind Hub admin overtime; the strict rules around capital budget underspend which could not be carried forward into the following year; the re-design of savings in terms of recurring and non-recurring sums; and the significant savings challenge for the Board of 3.75% in the year ahead. Jim Crichton confirmed that he and Robin McNaught were in discussion to ensure the Board was in a stable sustainable position this year and in the years ahead.

Members noted the Finance Report to 31 March 2015.
12 ANNUAL REVIEW OF STANDING DOCUMENTATION

Members received a report from Robin McNaught in respect of the Annual Review of Standing Documentation and the proposed changes that had been approved by the Audit Committee at their meeting in April. The Committee had recommended their adoption to the Board.

Members noted the changes required to the Standing Financial Instructions and the Scheme of Delegation. There were no amendments proposed to the Standing Orders.

Members approved the changes to the Standing Documentation as recommended by the Audit Committee.

13 PROPERTY AND ASSET MANAGEMENT STRATEGY (PAMS) 2015 – 2020

Members received a report from Doug Irwin in respect of the Hospital’s Property and Asset Management Strategy (PAMS) 2015-20. It was noted that the Board’s assets were approximately £63m in value. Each Health Board was required to submit an annual Board-approved Property and Asset Management Strategy to Scottish Government. In previous years the submission was required at the start of the financial year in April, however, the process had changed this year and submission was due by 6 June 2015.

Doug Irwin summarised the report’s highlights and the new process in respect of the significant changes to the required format made by Health Facilities Scotland (HFS) who lead the PAMS process. The update to the figures on Greenhouse Gas Emissions was noted. Members noted that a report would be submitted to a meeting of the Audit Committee in respect of monitoring of the Board’s assets.

Members discussed issues around efficiencies in terms of available space in the Hospital which would be given careful consideration going forward; backlog maintenance and how it was being addressed in an affordable way in terms of deterioration of furniture, carpets, decoration etc; and the staff alarm and communication systems and the work underway around testing some elements of the overall system. Doug Irwin confirmed that while the issues of testing the alarm system were extremely important, he was confident that the Hospital had a safe alarm system in place.

Members approved the Property and Asset Management Strategy 2015-2020 for submission to Scottish Government Health Directorate by the due date.

Action: Doug Irwin

14 AUDIT COMMITTEE MEETING HELD ON 2 APRIL 2015

Members received and noted the draft Minutes of the Audit Committee meeting held on 2 April 2015 from Maire Whitehead who highlighted some of the discussions that had taken place.

She highlighted two particular points. The ongoing sickness absence issue which she felt was being taken very seriously by all concerned; and the Risk Management Workshop which would take place on the afternoon of Thursday 4 June 2015.

Members approved the draft minutes of the Audit Committee held on 2 April 2015.

15 CHIEF EXECUTIVE’S REPORT

Members received and noted a report from Jim Crichton which reported progress on Healthcare Associated Infection (HAI); progress with the Patient Safety Programme; and the Advocacy Service.

Jim Crichton also provided a verbal update on a range of general issues of note in relation to the Carer Scotland Engaged Award received on 8 April 2015; the Lifetime Achievement award to Professor Lindsay Thomson at the 5th National Medical Education Conference; the Corporate Risk Register Workshop scheduled for Thursday 4 June 2015; the 6th Scottish Forensic Carers’ Event on Saturday 13 June 2015 to be held at The State Hospital and the 2014/15 Annual Review which would take place on Monday 7 September 2015.
It was noted that the contract had been renewed with the existing provider of patient advocacy services. Following discussion, Stephen Milloy agreed to explore any mechanisms whereby the provider could share their experiences with other advocacy services within the NHS and the wider public sector. He would provide an update at the next meeting.

**Action:** Stephen Milloy

Members noted the Chief Executive’s report

16 **ANY OTHER BUSINESS**

There was no other business.

17 **DATE AND TIME OF NEXT MEETING**

The next meeting would take place on Thursday 25 June 2015 at 1.00pm in the Boardroom, The State Hospital, Carstairs.

18 **EXCLUSION OF PUBLIC AND PRESS**

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

ADOPTED BY THE BOARD

CHAIR

(Signed Terry Currie)

DATE 25 June 2015
## MINUTE ACTION POINTS
FROM THE MEETING OF THE STATE HOSPITALS BOARD FOR SCOTLAND HELD ON 7 MAY 2015

<table>
<thead>
<tr>
<th>ACTION NO</th>
<th>AGENDA ITEM NO</th>
<th>ITEM</th>
<th>ACTION POINT</th>
<th>LEAD</th>
<th>TIMESCALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6</td>
<td>Section 22 Approved Medical Practitioners</td>
<td>Appropriate notifications would be made re approval to Dr Sakib Ahmed to the Hospital’s list of Approved Medical Practitioners.</td>
<td>Lindsay Thomson</td>
<td>Immediate</td>
</tr>
<tr>
<td>2</td>
<td>13</td>
<td>Property and Asset Management Strategy (PAMS) 2015-2020</td>
<td>Approved PAMS to be submitted to Scottish Government by the due date.</td>
<td>Doug Irwin</td>
<td>By due date</td>
</tr>
<tr>
<td>3</td>
<td>15</td>
<td>Chief Executive’s Report</td>
<td>Any mechanisms in place for organisations to pool knowledge and resources re advocacy services would be explored.</td>
<td>Stephen Milloy</td>
<td>Next meeting (June 2015)</td>
</tr>
</tbody>
</table>
THE STATE HOSPITALS BOARD FOR SCOTLAND

Agenda Reference: Item 5
Date of Meeting: 26 June 2014
Presented by: General Manager
Title of Report: Skye Centre Annual Report

1 BACKGROUND

This report provides an update on patient activity services within the Skye Centre. It details service activity levels and key achievements for the period June 2014 – May 2015. Current challenges and future developments are also highlighted within the report.

Over the past year the Skye Centre service has embraced the opportunity to be involved and support the ongoing work related to the Patient Day Activity Project. All staff have remained motivated during this transitional period of change and have made concerted efforts towards reviewing and delivering the quality and range of activities offered to patients. The methods for how this is achieved are defined in the Local Delivery Plan targets that relate to patient activity which are also under review. The Skye Centre service continues to be one of the few services which can provide reliable data informing these targets; 90% of patients will be engaged in off hub activities; 60% of patients will be engaged in physical activity 3 times per week.

2 AREAS OF ACTIVITY

2.1 Governance Arrangements.

Formal reports on Skye Centre activity are reported on an annual basis to The State Hospital Board. Strategic aims and priorities for Skye Centre activity levels are monitored on an ongoing basis by the Skye Centre Management Team. Approval for new developments and initiatives are approved by the Senior Management Team at which the Skye Centre service is represented.

2.2 Key Achievements over the last 12 months

- Expanding Range of Activities/Co production model
- Vocational qualifications/courses
- Health Promotion
- Improving Integration
- Social Events
- Skye Centre Professional Nurse Forum
- Volunteers

2.3 Key Performance Indicators

- Referral Information
- Scheduled & Actual Attendance
- Participation in Activity
- Integrated Care Pathway
- Utilisation of the Building
2.4 Challenges/Issues
- Sustainable work force/succession planning
- Outcome Measures
- Development of Electronic Patient Record
- Sickness

2.5 Future Developments
- Curriculum Planning
- Improving Integration
- Patient Feedback
- Workforce Review/Efficiency Savings Targets

3 RECOMMENDATIONS

The State Hospital Board are requested to note the information in this annual report and accept the recommendation that future reports will provide the Board with progress and updates on the Skye Centre Management Team plan of work along with progress on agreed key performance indicators related to the service.
SKYE CENTRE ANNUAL REPORT – 2014-15

1 Introduction

This report provides an update on patient activity services within the Skye Centre. It details service activity levels and key achievements for the period June 2014 – May 2015. Current challenges and future developments are also highlighted within the report.

Over the past year the Skye Centre service has embraced the opportunity to be involved and support the ongoing work related to the Patient Day Activity Project. All staff have remained motivated during this transitional period of change and have made concerted efforts towards reviewing and delivering the quality and range of activities offered to patients. The methods for how this is achieved are defined in the Local Delivery Plan targets that relate to patient activity which are also under review. The Skye Centre service continues to be one of the few services which can provide reliable data informing these targets; 90% of patients will be engaged in off hub activities; 60% of patients will be engaged in physical activity 3 times per week.

2 Governance Arrangements

Formal reports on Skye Centre activity are reported on an annual basis to The State Hospital Board. Strategic aims and priorities for Skye Centre activity levels are monitored on an ongoing basis by the Skye Centre Management Team. Approval for new developments and initiatives are approved by the Senior Management Team at which the Skye Centre service is represented.

3 Key Achievements over the last 12 months

3.1) Expanding Range of Activities/Co production model

This fits with the development of a ‘Recovery College’ approach within the Hospital. This is a co-production model between staff and patients whereby each one brings their knowledge, experience, and expertise to provide education, seminars and workshops to other patients. We will continue to identify and utilise ‘untapped resources’ within our staff and patient group. This will link in with the organisational timetable and will provide a range of activities that patients can opt into. A similar approach is being taken in the three English High Secure hospitals. As part of the Patient Day Activity project an ‘assets’ register will be completed by end of July 2015, which will form the foundation of this approach.

Efforts have been made over the last year to review the range of activities that are on offer to our patients and these are provided on a sessional basis. An overview of these activities includes:

- Patient Access Centre (PAC) – at the start of 2014 the activities within this centre were curtailed due to the implementation of the revised shop timetable and the redeployment of staff to accommodate this. However it was recognised that there was an opportunity to provide a range of activities that would encourage and enable our more chronically unwell or hard to reach patients to engage in a low stimulus environment where a range of structured social and practical activities could be provided. Over the past year the format for the delivery of activity in this area has been tried out and tested and has resulted in the current timetable (Appendix 1).

- Enterprise initiatives – both the Crafts and Woodwork centres have reviewed and implemented a range of new activities which have enabled a wider range of patients regardless of skill and ability to participate in these areas. Both services are far removed from providing the previously held perception that they only offer “industrial based” therapy activities. The creative activities on offer now deliver a more therapeutic and person centred approach ranging from the 12 week ‘Pottery Class’ to involvement in defined enterprise projects e.g. chess boards, wooden planters for the Hub Gardens.
- Gardening Project – patients have been actively engaged in the horticultural project from supporting the initial process of selecting which crops will be grown, to preparing the environment and supporting the growth of a wide range of fruit, vegetables and flowers. Due to the dedication from the Gardens staff and the patients attending this centre the greenhouse environment is now mature enough to sustain an excellent standard of produce for sale.
- Cycling Initiative – for the first time since the Sports service has moved across to the new hospital approval was granted by the Senior Management Team to deliver an outdoor cycling group. This activity has been very well received by patients, who are engaged in obtaining their cycling proficiency certificate and progressing to participating in a range of agreed cycling activities outside in the hospital grounds, located at the rear of the Skye Centre. A series of groups will be run throughout the summer months.

### 3.2) Vocational qualifications/courses

The Patient Learning Centre, supported by the other activity centres such as Gardens and Sports have been instrumental in achieving the objectives set and progress made which was outlined in the recent Patient Learning Annual Board report received in May 2105. The Skye Centre staff have been dedicated to ensuring that patient learning is integrated within each of the activity centres and supports the strategic aim to deliver the core values of Curriculum for Excellence across all activity centres. Work has been ongoing to embed core skills units within the practical vocational units delivered within Gardens & Animal Assisted Therapy, Woodcraft and the Library patient worker role.

Two new vocational programmes were developed and introduced in 2014 within the Garden & Animal Assisted Therapy Centre. The two vocational qualifications (Use of Hand Tools in Horticultural and Maintain Safe & Effective Working Practice) provide patients with the opportunity to learn a wider range of skills related to the horticultural industry and supports the expansion of vocational learning whilst providing them with nationally recognised and transferrable work skills.

Patients have also had the opportunity to participate in other structured learning opportunities such as Sports Leadership Level 1 Award and Elementary Food Hygiene Certificate (REHIS) both of which provide the patients with invaluable skills and knowledge that can also be utilised in supporting them to cope and deal with the challenges of everyday life.

Practical Woodworking Skills (SQA National 4 unit) will be progressed in 2015.

### 3.3 Health Promotion

The Skye Centre service has been involved within the Healthy Choices work that has been recently been underway with a member of Sports staff attends the Steering Group providing a valuable resource in terms of experience and knowledge in the area of physical health and fitness. Along with our Involvement and Equality colleagues, Skye staff have also assisted with facilitating Road Shows. These were successfully held in the Skye Atrium and attended by a number of patients from across the hospital.

The Health Centre staff have organised and held a number of Health Promotion events within the Skye Atrium such as Men’s Health and Safe in the Sun. Which have been very positively received by patients.

The Health Centre has been working towards ensuring that the physical health electronic records system ‘Vision’ is fully operational within the health centre and across the hospital. This will provide healthcare professionals with a current and historical health records which will better inform their practice.

### 3.4) Improving Integration

One of the key recommendations agreed by the SMT following the review of patient activity was to focus on departmental integration. The rationale behind this being that in improving integration of the Hubs and Skye Centre, the practical staffing capacity of the Skye Centre would increase.
The impact of this was anticipated as being twofold; it would minimise risk of departmental closures and it would allow levels of staffing that would maximise use of departments on a session by session basis, to the maximum capacity of 74 patients, which was identified during the review process.

A test of change was introduced which saw a small cohort of staff identified in Mull Hub, who linked specifically with the Sports department in the Skye Centre. A plan, do, study, act approach was employed as a means of testing the impact of change. The defined improvement aims were:

- to maximise the use of the Sports department on a session by session basis
- to minimise departmental closures
- to ensure a positive staff experience

Quantitative data was gathered on a session by session basis each day, and compared with baseline data for the month preceding the pilot. It was initially intended to pilot this for 4 weeks, however, exceptionally high levels of sickness absence during this period in the Skye Centre meant that any benefit from the pilot was largely negated. To allow time to test this approach further, a 12 week pilot was agreed. Data was gathered on:

- Planned activity
- New activity
- Closures across the service impacted on by Sports service delivery
- Staffing Resource
  - Number of Sports staff on duty
  - Sports staff present during session delivery
  - Mull staff presence and start time
  - Additional Skye Centre staff redeployed from other activity centres
  - Sports staff redeployed to other activity centres

Data analysis of the pilot between February and May 2015 demonstrated that the integrated model has led to a modest increase in overall participation in sports activities in the Skye Centre in terms of delivery of planned sessions on a group and individual basis. For example, two areas in the sports department have more regularly been able to open as opposed to one, and there has been more scope for intensive input to our patients who require 1:1 support. The impact of this is well illustrated through one narrative example included in the data collection:

‘The Mull staff ……. he agreed to be the staff that was required for the Skye Atrium. This allowed (for the first time in a long time) all sports staff to create and coach a masters football session. We were able to give individual patients more time and personal coaching. This was a positive experience for both patients and staff.’

There have been no unplanned departmental closures during the period of the Mull pilot. As a direct result of the Mull pilot Sports staff recommended that the range of available sessions could be extended, utilising the increased departmental capacity realised through the pilot. The aim is to open the Sports an additional 2 sessions coinciding with both Lewis and Mull shop sessions. This will enable the patients and ward staff to access the Sports hall for a range of group and team activities whilst the gym can also be opened and available to other patients from across the hospital at the same time.

A qualitative evaluation using a focus group approach was completed at the end of the 12 week period, led by the Clinical Effectiveness department. The Sports Staff team and Mull staff participating in the pilot were involved. The themes from the focus group demonstrated increased job satisfaction, specifically for Hub based Nursing staff, improved cross departmental integration and positive impact of staff patient relationships through seeing patients in a different setting. One important element of this feedback is the fundamental need for consistency within the Hub based staff identified to be involved in the service delivery with the sports department to ensure continuity of staff input.
3.5) Social Events

An important part of the Skye Centre service is the planned social events that are provided and planned to take place throughout the year. The Skye Centre has hosted and planned a number of events over the last 12 months including the Patient Learning and Achievement Ceremony and the Sportsman’s Dinner which both acknowledge the successes and achievements of our patients, the Patient & Carer Christmas lunches and Christmas social and spiritual events. These events are accessed by both patients and their carers. The success of these events can be attributed to the dedication and commitment of the Skye Centre and Involvement and Equality staff group.

The Skye Centre also organised a week long programme of activities to celebrate the Common Wealth Games facilitated by the Sports & Fitness and Patient Learning Centre staff. The vocational centres staff also contributed by supporting patients to create a colourful and decorative display presented throughout and at the awards.

3.6) Skye Centre Professional Nurse Forum

Regular meetings with the Director of Nursing are now established to discuss nursing professional issues and provide direction and support on matters such as the impending Nurse Revalidation process, supervision processes and the extended role for Nurses. A direct outcome from this group is the development of a Reflective Practice supervision group for the Skye Nursing staff which occurs every 6 weeks and is positively embraced by all staff attending.

3.7) Volunteers

The Skye Centre service has continued to work alongside the Involvement & Equality Team to develop the volunteer role within the activity centres. There are 6 volunteers who have continued to support activity within the Patient Learning Centre, Atrium Cafe, and the Multi Faith Centre. There are also five volunteers who help facilitate the Christian Fellowship group within the Skye Centre on a weekly basis.

Within the past 12 months, 3 Skye Centre volunteers have secured part-time employment in mental health roles. The recruitment process for these posts required these individuals to demonstrate proven skills of working with mental health patients and all three were advised that their supporting statements were a key factor for inclusion in the short list of candidates for interview. We are fortunate to still continue to benefit from their input as they embark on their new careers.

An additional 4 volunteers have been successfully recruited and will be placed after finishing exams in the next few weeks; 1 has been placed with the patients’ library service and the remaining 3 have shown an interest in gaining experience and supporting the services in Gardens and Crafts Departments.

Feedback from Skye Centre volunteers indicates that a mutually beneficial relationship exists. This input enables patients to benefit from engaging with a wide range of individuals outwith the staff group, in addition supporting our volunteers to gain valuable skills to enhance career prospects.

Skye Centre staff are very supportive of the process around developing volunteer roles and have truly embraced the opportunity to work with volunteers, incorporating different perspectives within clinical practice.
4 Key Performance Indicators

Key performance indicator data relating to the patient activity centres for the period June 2014 to May 2015 is provided below:

4.1) Referral Information

Induction Programme

The Induction Programme has continued to be developed over the past 12 months. New admission patients and also patients who have not previously accessed the Skye Centre are appropriate for referral to this group. Four weeks after patients are admitted, the patients Key Worker is approached by a member of Skye Nursing staff to discuss patient’s suitability to participate in the Induction Programme. Access to the group can vary from anywhere between 4 weeks to 12 weeks depending on the patient’s mental health and presenting behaviour.

The induction period is provided over 2 sessions per week throughout a 4 week period. As part of the induction programme patients visit and access taster sessions for each of the activity centres, as well as learning more about the wider range of services that the Skye Centre provides i.e. Spiritual Care, Patient Partnership Group (PPG) and activities available in the Atrium.

This allows patients the opportunity to access the service in a structured and focussed manner and as these groups are often small in number some patients find this new experience less daunting. It also provides an excellent opportunity for the Skye Centre staff to contribute to the overall assessment of our patients and provide feedback via the Nurse Key Worker to the clinical team.

Referrals

During the last 12 months the service has received a total of 156 referrals; 29 referrals for the Induction Programme and 127 referrals for existing patients to attend additional placements. One referral form is often received however a patient may be referred to several activity centres. Figure 1 provides a breakdown of these referrals across each of the Hubs.

Figure 1 Breakdown per hub of patients referred to the Skye Centre

<table>
<thead>
<tr>
<th>Hub</th>
<th>No of patients</th>
<th>Number of referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arran Hub</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Iona Hub</td>
<td>10</td>
<td>35</td>
</tr>
<tr>
<td>Lewis Hub</td>
<td>19</td>
<td>49</td>
</tr>
<tr>
<td>Mull Hub</td>
<td>18</td>
<td>48</td>
</tr>
</tbody>
</table>

There were 9 Induction Programmes held over the period of June 2014 and May 2015 with 29 patients from across all 4 Hubs. The attendance at each programme is outlined in Figure 2 below. A further Induction Programme scheduled to commence in June 2015 with a further 5 patients.
<table>
<thead>
<tr>
<th>Course No.</th>
<th>Arran</th>
<th>Iona</th>
<th>Lewis</th>
<th>Mull</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>2.</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>3.</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>5.</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6.</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>8.</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9.</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

On completion of the Induction Programme patients are referred to various activity centres based on the objectives set, the outcome of Clinical Team discussion and interests identified by the patient. They are then generally placed within 7 working days of the referral being received, the exception to this are patients who are referred to one of the Vocational Centres and require to access ‘no tool’ or ‘low tool sessions’. In the interim patients will receive drop in sessions within the Atrium and Patient Access Centre. In conjunction with this the Sports and Fitness staff continue to assess all new admissions on an individual basis in accordance with the Physical Fitness Pathway and admission ICP.

4.2) Scheduled and Actual Attendance

**Access to Activity Centres**

Each Activity Centre is currently planned to be open 8 sessions per week with the capacity of sessions varying depending on the activity being delivered and the identified needs of the patient group.

In the past couple of years the Woodcraft centre experienced a number of ongoing challenges mainly related to staff retirements and long term sickness. This has thankfully been resolved and the centre has within the last 12 months increased its number of open sessions from 4 to 8 sessions and is now on a par with the other activity centres. This in turn has allowed the number of patients on the caseload for the Woodcraft centre to be increased over the last year from 11 to 22 patients.

In order to achieve this change the service model was reviewed and ‘low tool’ sessions were introduced. This has enabled the Woodcraft centre to offer a range of graded sessions which enables wider access to this activity. The centre now offers ‘no tool’, ‘low tool’ and ‘full tool’ access for those patients attending. Discussions have been initiated with Clinical Teams to review the security access levels available for each of the existing patients on the caseload which will allow progression through the different level. For example the creation of a further ‘low tool’ session within the existing timetable will in turn increase capacity and address the current waiting list. (Figure 3)
At present there is no waiting list for new admission patients to attend the Skye Centre. There are however currently 6 patients on the waiting list to attend additional sessions at an Activity Centre at which they presently attend; 2 of these referrals are related to a request to attend the Woodcraft on a first time basis. Both these referrals are for ‘no tool’ sessions which are presently at full capacity but this should be resolved with the review of security access levels as previously indicated.

### 4.3) Participation in Activity

At the time of data collection, week commencing 1st June 2015, 81% (n= 100) of patients had planned sessions at the Skye Activity Centres. Figure 4 shows Mull has the highest number of patients attending the activity centres at 91% with Arran having the lowest number of patients engaged at 73%.

#### Figure 4

<table>
<thead>
<tr>
<th>Hub</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arran</td>
<td>73%</td>
</tr>
<tr>
<td>Iona</td>
<td>75%</td>
</tr>
<tr>
<td>Lewis</td>
<td>82%</td>
</tr>
<tr>
<td>Mull</td>
<td>91%</td>
</tr>
</tbody>
</table>

The number of scheduled sessions offered over the previous 12 months has decreased slightly since the previous annual report by 356 (1.5%). This could be attributed to the falling number of patients, patient transfers and overall review of the activities offered. However the additional sessions being offered in Sports and Crafts should enable the service to demonstrate an increase in capacity over the coming months. It is important to note that the number of sessions attended has increased by 1543 sessions which demonstrates a steady increase in the number of actual attendances achieved.

The future development of the Patient Timetable and prospectus information should ensure this improvement is continued. Figure 5 compares this year’s figures with those reported in the previous year.

#### Figure 5

<table>
<thead>
<tr>
<th></th>
<th>Scheduled Attendance at sessions</th>
<th>Number of sessions attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>22712</td>
<td>16798</td>
</tr>
<tr>
<td>2014/13</td>
<td>23068</td>
<td>15255</td>
</tr>
</tbody>
</table>
Both Figure 6 and Figure 7 provide an overview of the planned/scheduled activity for each activity centre and the actual attendance by patients during the period June 2014 to June 2015.

**Figure 7: % of attendance at Activity Centres**

<table>
<thead>
<tr>
<th>Activity Centre</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAC</td>
<td>65%</td>
</tr>
<tr>
<td>Crafts</td>
<td>80%</td>
</tr>
<tr>
<td>Gardens</td>
<td>74%</td>
</tr>
<tr>
<td>PLC</td>
<td>75%</td>
</tr>
<tr>
<td>Sports</td>
<td>72%</td>
</tr>
<tr>
<td>Woodcraft</td>
<td>71%</td>
</tr>
</tbody>
</table>

A summary of the reasons for non attendance over the past 12 months are detailed in Figure 8 below. The number of sessions affected by closures or reduced service has significantly decreased since the last annual report with a reduction of 67% of sessions reported as being affected. The efforts made so far to review the scheduling of activities across the service has proved successful and other factors such as the Mull Integrated Working pilot has enabled Sports in particular to maintain its number of planned sessions without having to reduce numbers directly related to having an additional consistent staff member.

**Figure 8: Reasons for non attendance at scheduled sessions**

<table>
<thead>
<tr>
<th>Reasons for non attendance at scheduled sessions</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deterioration in Mental Health</td>
<td>679</td>
<td>674</td>
</tr>
<tr>
<td>Physical Health Problem</td>
<td>765</td>
<td>612</td>
</tr>
<tr>
<td>Appointments with other Health Care Professional</td>
<td>517</td>
<td>681</td>
</tr>
<tr>
<td>External appointments</td>
<td>805</td>
<td>116</td>
</tr>
<tr>
<td>Tribunal/CMT/CPA Appointments</td>
<td>65</td>
<td>66</td>
</tr>
<tr>
<td>Patient refuses to attend</td>
<td>501</td>
<td>561</td>
</tr>
<tr>
<td>Service Closed/Reduced Service</td>
<td>1253</td>
<td>3767</td>
</tr>
<tr>
<td>Patient seeing external visitor</td>
<td>94</td>
<td>18</td>
</tr>
<tr>
<td>Visit on ward</td>
<td>315</td>
<td>273</td>
</tr>
<tr>
<td>Discharge/Transfer/rescheduled sessions</td>
<td>101</td>
<td>204</td>
</tr>
<tr>
<td>Bad Weather</td>
<td>69</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>463</td>
<td>728</td>
</tr>
<tr>
<td>Attending other Skye Centre activities using Drop in</td>
<td>287</td>
<td>113</td>
</tr>
<tr>
<td><strong>total</strong></td>
<td><strong>5914</strong></td>
<td><strong>7813</strong></td>
</tr>
</tbody>
</table>
It is anticipated that the ongoing Activity Scheduling work that has been initiated by the Patient Day Activity project will ensure a more consistent and effective method for scheduling activity across all disciplines and will enable the Skye Centre along with the other services to plan out patient activity in a more efficient manner. The potential introduction of an electronic scheduling system such as CELCAT would make a considerable difference to the manner in which we plan and record patient activity across the hospital.

The report so far has concentrated on the overall participation of patients across the service however the information noted below is intended to demonstrate how much time individual patients spend at the Skye Activity Centres. The data presented is reflective of the week commencing 1st June 2015 and does not include the time spent attending the Health Centre which varies or Patient Shop which the majority of patients attend one morning per week.

The numbers of sessions patients attend are recorded over the period 9am – 4pm Monday to Friday. The patients normally attend for a full morning session and the afternoons are currently split into two sessions with patients having the option to stay at the Skye Centre all afternoon. For the purpose of presenting this information one 'split' session is defined as 0.5.

Figure 9

<table>
<thead>
<tr>
<th>Number of Sessions each patient has throughout the a week</th>
<th>Arran</th>
<th>Iona</th>
<th>Lewis</th>
<th>Mull</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>0.5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>1.5</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>2.5</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>3.5</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>4.5</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>5.5</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>6.5</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>7</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>7.5</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>8.5</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>9.5</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total patient numbers</td>
<td>22</td>
<td>32</td>
<td>34</td>
<td>35</td>
<td>123</td>
</tr>
</tbody>
</table>

The number of sessions each patient has varies and is influenced by a number of factors such as the patients' mental/physical health or attendance at other therapies. It is important to note that there are a number of patients (n=23) who do not have scheduled sessions within the Skye Centre mainly due to their presenting mental health and presenting behaviours.
In some cases an outreach service is provided by staff within the Sports, PLC and Gardens Departments providing the opportunity to engage in meaningful activity on ward. This approach has successfully resulted in 3 of these patients commencing 1:1 activity within the Skye Centre providing a tailored approach which supports their care and treatment objectives.

Figure 10 provides an example of an overview of the patients in Arran Hub and their time spent within the Skye Centre. If this information is considered useful it can be developed further for inclusion within future reports.

**Figure 10**

![Graph](image)

**4.4) Integrated Care Pathway (ICP)**

Attendance at case reviews by Skye Centre Nurses has proved a challenge in previous years mainly related to long term sickness and vacancies. The matter of non attendance and the frustrations and concerns related to this were raised by Skye Nursing staff at the Skye Professional Nursing Forum held with the Director of Nursing.

There was commitment from the staff group to support a review of the previous models and they recognise the benefits of attending and directly participating in the clinical team discussions. The attendance figures have steadily increased since February 2015 and are noted in Figure 11. It is an ongoing challenge to balance the competing priorities of ensuring that the activity centres are adequately staffed, against the clinical benefits in nursing staff attending the CPA discussion but these benefits are demonstrated when the patients’ treatment objectives are better informed and they are in turn appropriately placed within the Skye Activity Centres.

Over the last 12 months the service has achieved 100% completion rate for the Annual VAT form

**Figure 11**

![Graph](image)
Efforts have been made to monitor and ensure that Skye Centre annual reports are completed on time and submitted to the relevant clinical team. Since November 2014 the majority of reports have been submitted on time, no reports are sent for patients who do not attend the Skye Centre Service. However, efforts are being made to ensure that Skye Nursing staff are involved in CPA annual review discussions to ensure recommendations are being made for those patients who do not currently attend.

Complaints Information

Over the previous years a number of complaints have been received from patients regarding access to services and centre closures and there were 9 comments received between 2011 and 2012 via community meetings or Patient Partnership Group regarding centre closures. The increased number of complaints that were recorded over the year in 2013 are directly related to the closure of Woodcraft and the staffing resources issues being experienced at that time. On a positive note the number of complaints has reduced since then with no complaints raised so far in 2015 in relation to closures.

<table>
<thead>
<tr>
<th>Year</th>
<th>Upheld</th>
<th>Partly upheld</th>
<th>Not upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>2012</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2013</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2014</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

4.5) Utilisation of the Building

The Skye Centre is utilised for a number of other activities including, on a weekly basis the Patient Partnership Group, Christian Fellowship Group, Multi Faith Service, Psychological Therapy Service Groups, Occupational Therapy groups and Advocacy events and service and strategic meetings which include patient representation.

Patients also attend the Health Centre on a daily basis for a range of Primary Care Services. Every attempt is made to ensure that patients can access these appointments whilst being
supported by the Skye Centre staff to ensure attendance at their planned activity is accommodated.

5 Challenges/Issues

5.1) Sustainable work force/succession planning

The Skye Centre staffing establishment is 40.33 wte, the actual staff in post is 37.33 wte due to vacancies not yet filled. The current Skye Centre is open Monday to Friday 8.30am to 5pm and is also operated on a Saturday and Sunday with evening activities provided within the shift rota on Saturday evenings. The current workforce establishment for the Skye Centre is required to staff all activity centres as well as additional activities detailed in Appendix 1.

There still remains only 4 shift workers within the service and the implications of this are that Skye Centre staff are not self sufficient to provide evening and weekend activities, relying on ward nursing support. This has been the practice for a number of years.

Options for integrated working are being considered within the ongoing work related to the Patient Day project along with a review of current skill mix when considering the grade of staff required to fill current vacancies in accordance with workforce planning arrangements.

There are 3 vacancies within the service at present and discussions are taking place regarding the recruitment process for these posts.

There are 4 staff due to retire within the service over the next 6 to 12 months and consideration is being given to the succession planning and replacement of these long standing and highly experienced technical and clinical staff. Approval will be sought from the SMT to reconfigure the existing staffing. One option is to relocate one of the current vacancies to the Gardens department. This will enable a planned approach to incorporate a new staff member within the existing service under the guidance and mentoring of the skilled and highly experienced staff members that presently provide the horticultural and animal/pet based activities.

5.2) Outcome Measures

Unfortunately the work related to identifying potential standardised outcome measures has not been fully progressed within the last year. The challenge of find a ‘one size fits all’ approach has proved to be a challenge considering the differing needs of each activity area. On reflection it has now been agreed that a more achievable approach will be to focus on specific areas such as the Induction Programme and the Vocational Activity Centres. Staff from the Skye Centre and the Occupational Therapy service have been identified to progress this piece of work and it is anticipated that this will be completed by the end of 2015.

5.3) Development of Electronic Patient Record

Due to the previous staffing issues within the eHealth service ongoing work in relation to RIO and the integration of Skye Centre reports onto the electronic records system were unable to be progressed. This issue has now been resolved and work is underway to ensure the outstanding work is recommenced. This will ensure that all Skye Centre treatment objectives and reporting for CPA reviews will be available electronically and can be accessed by all members of the clinical team.

5.4) Sickness

The staff sickness levels across the service has been particularly high over the past couple of years with long term sickness at one point reaching as high as 17%. This has improved significantly over the past 12 months averaging 7.42% for long sickness and 1.72% for short term sickness. However this remains higher than the national target of 5%. It remains an ongoing challenge to meet the needs of the service and long term sickness tends to impact across all of the activity centres as each area is not self sufficient, and during periods of sickness there is no capacity built into the workforce to compensate and provide backfill replacement for staff. Due to the vacancies created within the service there has been some scope to compensate for hours
lost with the creation of a fixed term contract supported by the Senior Management Team and the utilisation of Zero Hours contract staff that temporarily fill the service gaps and enable the service to continue to meet the needs of our patient group.

6 Future Developments

The main focus for the year ahead will be to continue to review and augment the range of activities and opportunities for our patient group and to adapt and improve the methods in which we deliver these. These key objectives include:-

6.1) Curriculum Planning

The Skye Centre service will continue to support work of the Patient Day Project in particular the Activity Timetabling subgroup. This group aims to support the delivery of meaningful and therapeutic patient activities through development and implementation of an integrated and collaborative approach to the planning and scheduling of programmes and activities across all disciplines and services. The Skye Centre has contributed fully to the work achieved to date within this multidisciplinary scheduling group.

A key task of this group was to plan a six monthly organisational timetable outlining room usage and resourcing. This timetable incorporates the Skye Centre, Hubs, AHP and psychological services, and a multi disciplinary patient activity timetable format has been developed. A comprehensive guide to all therapeutic, educational and vocational activities provided by all disciplines is also nearing completion, and will act as a resource for patients and staff to access. The work related to this part of the Patient Day project is progressing well and it is anticipated that it will be delivered on and implemented by the end of 2015.

6.2) Improving Integration

- The Skye Centre induction programme will be further developed to include more collaboration with our Occupational Therapy colleagues to support a joint assessment service whereby patients are formally assessed and clinical teams are advised with regard to suitable activity for patients.
- Occupational Therapists will develop a variety of life skills groups accessing the facilities within the Skye Centre Atrium. This is envisaged as facilitating a ‘gateway to activity’ whereby OTs will retain a base hub but work in a more integrated way with Skye Centre staff allowing valuable contributions to be made to the clinical teams on patients’ progress within the Skye Centre.

6.3) Patient Feedback

- Discussions have taken place with the Involvement and Equality Manager regarding the development of consistent processes for obtaining patient feedback across all of the Activity Centres. The ‘Emotional Touch Points’ model which has previously been presented to the Board is being explored as one possible option.

6.4) Workforce Review/Efficiency Savings Targets

- Ongoing discussions are taking place with the General Manger regarding the current workforce numbers and skill mix to ensure succession planning is built into future service delivery and that the current service meets the needs of our patients. The importance of ensuring that agreed efficiency targets are achieved is also recognised. The Skye Centre service achieved and in fact exceeded the agreed 4.6% savings target set for 2014/15 on a non recurring basis and the service has identified steps to meet the agreed savings target of £96,300 for this next financial year.

Future developments will give cognisance to the recommendations and outcomes from the Patient Activity Project and future discussions regarding the potential changes to the Clinical Model.
7 Recommendations

The State Hospital Board are requested to note the information in this annual report and accept the recommendation that future reports will provide the Board with progress and updates on the Skye Centre Management Team plan of work along with progress on agreed key performance indicators related to the service.

8 Review Date

The next review date for the Skye Centre annual report is June 2016

Appendix 2

Staffing establishment (wte) available to run patient activity centres

Figure 1

<table>
<thead>
<tr>
<th>Area</th>
<th>Staff wte</th>
<th>RMN</th>
<th>Technical/Specialty/Admin – band 4</th>
<th>Support Worker B3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrium</td>
<td>6.5</td>
<td>2 (1vac)</td>
<td>2.5 (incl. 1 *s/w)</td>
<td>2 (incl.1 admin)</td>
</tr>
<tr>
<td>Patient Learning Centre</td>
<td>4.6</td>
<td>1</td>
<td>3.6 (1 vacancy)</td>
<td></td>
</tr>
<tr>
<td>Sports</td>
<td>6</td>
<td>2**</td>
<td>4 (incl. 2 *s/w) (1 vacancy)</td>
<td></td>
</tr>
<tr>
<td>Woodwork</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Crafts</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Gardens</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>28.1</strong></td>
<td><strong>9</strong></td>
<td><strong>17.1</strong></td>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>
*s/w - shift worker – staff work a 4 days on, 2 days off 6 week roster to cover evening and weekend activities

** RMN works a shift rota Sunday to Thursday. The shift pattern was adapted to support the service demands of the weekend opening times.

Figure 2  Staffing establishment (wte) available to operate “other” patient activities

<table>
<thead>
<tr>
<th>Area</th>
<th>Staff wte</th>
<th>RMN/ R.Nurse</th>
<th>Technical/Speciality /admin - band 4 &gt;</th>
<th>Support Worker B3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skye Centre manager</td>
<td>0.93</td>
<td>0.93</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senior Charge Nurse</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skye centre admin</td>
<td>0.97</td>
<td>0.97</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shop</td>
<td>1</td>
<td>0.5</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Hairdresser</td>
<td>0.4</td>
<td>0.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health centre</td>
<td>6</td>
<td>2</td>
<td>4 (incl.1 admin)</td>
<td></td>
</tr>
<tr>
<td>Tribunal</td>
<td>2</td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Multifaith</td>
<td>0***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>12.3</strong></td>
<td><strong>3</strong></td>
<td><strong>6.8</strong></td>
<td><strong>2.5</strong></td>
</tr>
</tbody>
</table>

*** Gardens activity centre staff help facilitate the weekly multi faith service.
1 BACKGROUND

This report provides an update on patient activity services within the Skye Centre. It details service activity levels and key achievements for the period June 2014 – May 2015. Current challenges and future developments are also highlighted within the report.

Over the past year the Skye Centre service has embraced the opportunity to be involved and support the ongoing work related to the Patient Day Activity Project. All staff have remained motivated during this transitional period of change and have made concerted efforts towards reviewing and delivering the quality and range of activities offered to patients. The methods for how this is achieved are defined in the Local Delivery Plan targets that relate to patient activity which are also under review. The Skye Centre service continues to be one of the few services which can provide reliable data informing these targets; 90% of patients will be engaged in off hub activities; 60% of patients will be engaged in physical activity 3 times per week.

2 AREAS OF ACTIVITY

2.1 Governance Arrangements.

Formal reports on Skye Centre activity are reported on an annual basis to The State Hospital Board. Strategic aims and priorities for Skye Centre activity levels are monitored on an ongoing basis by the Skye Centre Management Team. Approval for new developments and initiatives are approved by the Senior Management Team at which the Skye Centre service is represented.

2.2 Key Achievements over the last 12 months

- Expanding Range of Activities/Co production model
- Vocational qualifications/courses
- Health Promotion
- Improving Integration
- Social Events
- Skye Centre Professional Nurse Forum
- Volunteers

2.3 Key Performance Indicators

- Referral Information
- Scheduled & Actual Attendance
- Participation in Activity
- Integrated Care Pathway
- Utilisation of the Building
2.4 Challenges/Issues
- Sustainable work force/succession planning
- Outcome Measures
- Development of Electronic Patient Record
- Sickness

2.5 Future Developments
- Curriculum Planning
- Improving Integration
- Patient Feedback
- Workforce Review/Efficiency Savings Targets

3 RECOMMENDATIONS

The State Hospital Board are requested to note the information in this annual report and accept the recommendation that future reports will provide the Board with progress and updates on the Skye Centre Management Team plan of work along with progress on agreed key performance indicators related to the service.
SKYE CENTRE ANNUAL REPORT – 2014-15

1 Introduction

This report provides an update on patient activity services within the Skye Centre. It details service activity levels and key achievements for the period June 2014 – May 2015. Current challenges and future developments are also highlighted within the report.

Over the past year the Skye Centre service has embraced the opportunity to be involved and support the ongoing work related to the Patient Day Activity Project. All staff have remained motivated during this transitional period of change and have made concerted efforts towards reviewing and delivering the quality and range of activities offered to patients. The methods for how this is achieved are defined in the Local Delivery Plan targets that relate to patient activity which are also under review. The Skye Centre service continues to be one of the few services which can provide reliable data informing these targets; 90% of patients will be engaged in off hub activities; 60% of patients will be engaged in physical activity 3 times per week.

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3 Key Achievements over the last 12 months

3.1) Expanding Range of Activities/Co production model

This fits with the development of a ‘Recovery College’ approach within the Hospital. This is a co-production model between staff and patients whereby each one brings their knowledge, experience, and expertise to provide education, seminars and workshops to other patients. We will continue to identify and utilise ‘untapped resources’ within our staff and patient group. This will link in with the organisational timetable and will provide a range of activities that patients can opt into. A similar approach is being taken in the three English High Secure hospitals. As part of the Patient Day Activity project an ‘assets’ register will be completed by end of July 2015, which will form the foundation of this approach.

Efforts have been made over the last year to review the range of activities that are on offer to our patients and these are provided on a sessional basis. An overview of these activities includes:

- Patient Access Centre (PAC) – at the start of 2014 the activities within this centre were curtailed due to the implementation of the revised shop timetable and the redeployment of staff to accommodate this. However it was recognised that there was an opportunity to provide a range of activities that would encourage and enable our more chronically unwell or hard to reach patients to engage in a low stimulus environment where a range of structured social and practical activities could be provided. Over the past year the format for the delivery of activity in this area has been tried out and tested and has resulted in the current timetable (Appendix 1).

- Enterprise initiatives – both the Crafts and Woodwork centres have reviewed and implemented a range of new activities which have enabled a wider range of patients regardless of skill and ability to participate in these areas. Both services are far removed from providing the previously held perception that they only offer “industrial based” therapy activities. The creative activities on offer now deliver a more therapeutic and person centred approach ranging from the 12 week ‘Pottery Class’ to involvement in defined enterprise projects e.g. chess boards, wooden planters for the Hub Gardens.
- Gardening Project – patients have been actively engaged in the horticultural project from supporting the initial process of selecting which crops will be grown, to preparing the environment and supporting the growth of a wide range of fruit, vegetables and flowers. Due to the dedication from the Gardens staff and the patients attending this centre the greenhouse environment is now mature enough to sustain an excellent standard of produce for sale.
- Cycling Initiative – for the first time since the Sports service has moved across to the new hospital approval was granted by the Senior Management Team to deliver an outdoor cycling group. This activity has been very well received by patients, who are engaged in obtaining their cycling proficiency certificate and progressing to participating in a range of agreed cycling activities outside in the hospital grounds, located at the rear of the Skye Centre. A series of groups will be run throughout the summer months.

3.2) Vocational qualifications/courses

The Patient Learning Centre, supported by the other activity centres such as Gardens and Sports have been instrumental in achieving the objectives set and progress made which was outlined in the recent Patient Learning Annual Board report received in May 2105. The Skye Centre staff have been dedicated to ensuring that patient learning is integrated within each of the activity centres and supports the strategic aim to deliver the core values of Curriculum for Excellence across all activity centres. Work has been ongoing to embed core skills units within the practical vocational units delivered within Gardens & Animal Assisted Therapy, Woodcraft and the Library patient worker role.

Two new vocational programmes were developed and introduced in 2014 within the Garden & Animal Assisted Therapy Centre. The two vocational qualifications (Use of Hand Tools in Horticultural and Maintain Safe & Effective Working Practice) provide patients with the opportunity to learn a wider range of skills related to the horticultural industry and supports the expansion of vocational learning whilst providing them with nationally recognised and transferrable work skills.

Patients have also had the opportunity to participate in other structured learning opportunities such as Sports Leadership Level 1 Award and Elementary Food Hygiene Certificate (REHIS) both of which provide the patients with invaluable skills and knowledge that can also be utilised in supporting them to cope and deal with the challenges of everyday life.

Practical Woodworking Skills (SQA National 4 unit) will be progressed in 2015.

3.3 Health Promotion

The Skye Centre service has been involved within the Healthy Choices work that has been recently been underway with a member of Sports staff attends the Steering Group providing a valuable resource in terms of experience and knowledge in the area of physical health and fitness. Along with our Involvement and Equality colleagues, Skye staff have also assisted with facilitating Road Shows. These were successfully held in the Skye Atrium and attended by a number of patients from across the hospital.

The Health Centre staff have organised and held a number of Health Promotion events within the Skye Atrium such as Men’s Health and Safe in the Sun. Which have been very positively received by patients.

The Health Centre has been working towards ensuring that the physical health electronic records system ‘Vision’ is fully operational within the health centre and across the hospital. This will provide healthcare professionals with a current and historical health records which will better inform their practice.

3.4) Improving Integration

One of the key recommendations agreed by the SMT following the review of patient activity was to focus on departmental integration. The rationale behind this being that in improving integration of the Hubs and Skye Centre, the practical staffing capacity of the Skye Centre would increase.
The impact of this was anticipated as being twofold; it would minimise risk of departmental closures and it would allow levels of staffing that would maximise use of departments on a session by session basis, to the maximum capacity of 74 patients, which was identified during the review process.

A test of change was introduced which saw a small cohort of staff identified in Mull Hub, who linked specifically with the Sports department in the Skye Centre. A plan, do, study, act approach was employed as a means of testing the impact of change. The defined improvement aims were:

- to maximise the use of the Sports department on a session by session basis
- to minimise departmental closures
- to ensure a positive staff experience

Quantitative data was gathered on a session by session basis each day, and compared with baseline data for the month preceding the pilot. It was initially intended to pilot this for 4 weeks, however, exceptionally high levels of sickness absence during this period in the Skye Centre meant that any benefit from the pilot was largely negated. To allow time to test this approach further, a 12 week pilot was agreed. Data was gathered on:

- Planned activity
- New activity
- Closures across the service impacted on by Sports service delivery
- Staffing Resource
  - Number of Sports staff on duty
  - Sports staff present during session delivery
  - Mull staff presence and start time
  - Additional Skye Centre staff redeployed from other activity centres
  - Sports staff redeployed to other activity centres

Data analysis of the pilot between February and May 2015 demonstrated that the integrated model has led to a modest increase in overall participation in sports activities in the Skye Centre in terms of delivery of planned sessions on a group and individual basis. For example, two areas in the sports department have more regularly been able to open as opposed to one, and there has been more scope for intensive input to our patients who require 1:1 support. The impact of this is well illustrated through one narrative example included in the data collection:

‘The Mull staff ……. he agreed to be the staff that was required for the Skye Atrium. This allowed (for the first time in a long time) all sports staff to create and coach a masters football session. We were able to give individual patients more time and personal coaching. This was a positive experience for both patients and staff.’

There have been no unplanned departmental closures during the period of the Mull pilot. As a direct result of the Mull pilot Sports staff recommended that the range of available sessions could be extended, utilising the increased departmental capacity realised through the pilot. The aim is to open the Sports an additional 2 sessions coinciding with both Lewis and Mull shop sessions. This will enable the patients and ward staff to access the Sports hall for a range of group and team activities whilst the gym can also be opened and available to other patients from across the hospital at the same time.

A qualitative evaluation using a focus group approach was completed at the end of the 12 week period, led by the Clinical Effectiveness department. The Sports Staff team and Mull staff participating in the pilot were involved. The themes from the focus group demonstrated increased job satisfaction, specifically for Hub based Nursing staff, improved cross departmental integration and positive impact of staff patient relationships through seeing patients in a different setting. One important element of this feedback is the fundamental need for consistency within the Hub based staff identified to be involved in the service delivery with the sports department to ensure continuity of staff input.
3.5) **Social Events**

An important part of the Skye Centre service is the planned social events that are provided and planned to take place throughout the year. The Skye Centre has hosted and planned a number of events over the last 12 months including the Patient Learning and Achievement Ceremony and the Sportsman’s Dinner which both acknowledge the successes and achievements of our patients, the Patient & Carer Christmas lunches and Christmas social and spiritual events. These events are accessed by both patients and their carers. The success of these events can be attributed to the dedication and commitment of the Skye Centre and Involvement and Equality staff group.

The Skye Centre also organised a week long programme of activities to celebrate the Common Wealth Games facilitated by the Sports & Fitness and Patient Learning Centre staff. The vocational centres staff also contributed by supporting patients to create a colourful and decorative display presented throughout and at the awards.

3.6) **Skye Centre Professional Nurse Forum**

Regular meetings with the Director of Nursing are now established to discuss nursing professional issues and provide direction and support on matters such as the impending Nurse Revalidation process, supervision processes and the extended role for Nurses. A direct outcome from this group is the development of a Reflective Practice supervision group for the Skye Nursing staff which occurs every 6 weeks and is positively embraced by all staff attending.

3.7) **Volunteers**

The Skye Centre service has continued to work alongside the Involvement & Equality Team to develop the volunteer role within the activity centres. There are 6 volunteers who have continued to support activity within the Patient Learning Centre, Atrium Cafe, and the Multi Faith Centre. There are also five volunteers who help facilitate the Christian Fellowship group within the Skye Centre on a weekly basis.

Within the past 12 months, 3 Skye Centre volunteers have secured part-time employment in mental health roles. The recruitment process for these posts required these individuals to demonstrate proven skills of working with mental health patients and all three were advised that their supporting statements were a key factor for inclusion in the short list of candidates for interview. We are fortunate to still continue to benefit from their input as they embark on their new careers.

An additional 4 volunteers have been successfully recruited and will be placed after finishing exams in the next few weeks; 1 has been placed with the patients’ library service and the remaining 3 have shown an interest in gaining experience and supporting the services in Gardens and Crafts Departments.

Feedback from Skye Centre volunteers indicates that a mutually beneficial relationship exists. This input enables patients to benefit from engaging with a wide range of individuals outwith the staff group, in addition supporting our volunteers to gain valuable skills to enhance career prospects.

Skye Centre staff are very supportive of the process around developing volunteer roles and have truly embraced the opportunity to work with volunteers, incorporating different perspectives within clinical practice.
Key Performance Indicators

Key performance indicator data relating to the patient activity centres for the period June 2014 to May 2015 is provided below:-

4.1) Referral Information

**Induction Programme**

The Induction Programme has continued to be developed over the past 12 months. New admission patients and also patients who have not previously accessed the Skye Centre are appropriate for referral to this group. Four weeks after patients are admitted, the patients Key Worker is approached by a member of Skye Nursing staff to discuss patient’s suitability to participate in the Induction Programme. Access to the group can vary from anywhere between 4 weeks to 12 weeks depending on the patient’s mental health and presenting behaviour.

The induction period is provided over 2 sessions per week throughout a 4 week period. As part of the induction programme patients visit and access taster sessions for each of the activity centres, as well as learning more about the wider range of services that the Skye Centre provides i.e. Spiritual Care, Patient Partnership Group (PPG) and activities available in the Atrium.

This allows patients the opportunity to access the service in a structured and focussed manner and as these groups are often small in number some patients find this new experience less daunting. It also provides an excellent opportunity for the Skye Centre staff to contribute to the overall assessment of our patients and provide feedback via the Nurse Key Worker to the clinical team.

**Referrals**

During the last 12 months the service has received a total of 156 referrals; 29 referrals for the Induction Programme and 127 referrals for existing patients to attend additional placements. One referral form is often received however a patient may be referred to several activity centres. Figure 1 provides a breakdown of these referrals across each of the Hubs.

**Figure 1 Breakdown per hub of patients referred to the Skye Centre**

<table>
<thead>
<tr>
<th>Hub</th>
<th>2014/15 No of patients</th>
<th>Number of referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arran Hub</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Iona Hub</td>
<td>10</td>
<td>35</td>
</tr>
<tr>
<td>Lewis Hub</td>
<td>19</td>
<td>49</td>
</tr>
<tr>
<td>Mull Hub</td>
<td>18</td>
<td>48</td>
</tr>
</tbody>
</table>

There were 9 Induction Programmes held over the period of June 2014 and May 2015 with 29 patients from across all 4 Hubs. The attendance at each programme is outlined in Figure 2 below. A further Induction Programme scheduled to commence in June 2015 with a further 5 patients.
Figure 2 Number of Patients who completed Induction Programme 2014/15

<table>
<thead>
<tr>
<th>Course No.</th>
<th>Arran</th>
<th>Iona</th>
<th>Lewis</th>
<th>Mull</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>2.</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>3.</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>5.</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6.</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>8.</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9.</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

On completion of the Induction Programme patients are referred to various activity centres based on the objectives set, the outcome of Clinical Team discussion and interests identified by the patient. They are then generally placed within 7 working days of the referral being received, the exception to this are patients who are referred to one of the Vocational Centres and require to access 'no tool' or 'low tool sessions'. In the interim patients will receive drop in sessions within the Atrium and Patient Access Centre. In conjunction with this the Sports and Fitness staff continue to assess all new admissions on an individual basis in accordance with the Physical Fitness Pathway and admission ICP.

4.2) Scheduled and Actual Attendance

Access to Activity Centres

Each Activity Centre is currently planned to be open 8 sessions per week with the capacity of sessions varying depending on the activity being delivered and the identified needs of the patient group.

In the past couple of years the Woodcraft centre experienced a number of ongoing challenges mainly related to staff retirements and long term sickness. This has thankfully been resolved and the centre has within the last 12 months increased its number of open sessions from 4 to 8 sessions and is now on a par with the other activity centres. This in turn has allowed the number of patients on the caseload for the Woodcraft centre to be increased over the last year from 11 to 22 patients.

In order to achieve this change the service model was reviewed and ‘low tool’ sessions were introduced. This has enabled the Woodcraft centre to offer a range of graded sessions which enables wider access to this activity. The centre now offers ‘no tool’, ‘low tool’ and ‘full tool’ access for those patients attending. Discussions have been initiated with Clinical Teams to review the security access levels available for each of the existing patients on the caseload which will allow progression through the different level. For example the creation of a further ‘low tool’ session within the existing timetable will in turn increase capacity and address the current waiting list. (Figure 3)
**Figure 3 Activity Centre Caseload Nos. & Waiting List**

<table>
<thead>
<tr>
<th>Activity Centre</th>
<th>No. of patients participating in activity with activity centre</th>
<th>No. of patient on waiting list to attend activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLC</td>
<td>37</td>
<td>0</td>
</tr>
<tr>
<td>Sports</td>
<td>73</td>
<td>3*</td>
</tr>
<tr>
<td>Woodcraft</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>Crafts</td>
<td>37</td>
<td>0</td>
</tr>
<tr>
<td>Gardens</td>
<td>60</td>
<td>3*</td>
</tr>
<tr>
<td>PAC</td>
<td>37</td>
<td>0</td>
</tr>
</tbody>
</table>

*patients have allocated sessions within the activity centre and are requesting additional sessions*

At present there is no waiting list for new admission patients to attend the Skye Centre. There are however currently 6 patients on the waiting list to attend additional sessions at an Activity Centre at which they presently attend; 2 of these referrals are related to a request to attend the Woodcraft on a first time basis. Both these referrals are for ‘no tool’ sessions which are presently at full capacity but this should be resolved with the review of security access levels as previously indicated.

4.3) Participation in Activity

At the time of data collection, week commencing 1st June 2015, 81% (n= 100) of patients had planned sessions at the Skye Activity Centres. Figure 4 shows Mull has the highest number of patients attending the activity centres at 91% with Arran having the lowest number of patients engaged at 73%.

**Figure 4**

<table>
<thead>
<tr>
<th>Hub</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arran</td>
<td>73%</td>
</tr>
<tr>
<td>Iona</td>
<td>75%</td>
</tr>
<tr>
<td>Lewis</td>
<td>82%</td>
</tr>
<tr>
<td>Mull</td>
<td>91%</td>
</tr>
</tbody>
</table>

The number of scheduled sessions offered over the previous 12 months has decreased slightly since the previous annual report by 356 (1.5%). This could be attributed to the falling number of patients, patient transfers and overall review of the activities offered. However the additional sessions being offered in Sports and Crafts should enable the service to demonstrate an increase in capacity over the coming months. It is important to note that the number of sessions attended has increased by 1543 sessions which demonstrates a steady increase in the number of actual attendances achieved.

The future development of the Patient Timetable and prospectus information should ensure this improvement is continued. Figure 5 compares this year’s figures with those reported in the previous year.

**Figure 5**

<table>
<thead>
<tr>
<th>Year</th>
<th>Scheduled Attendance at sessions</th>
<th>Number of sessions attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>22712</td>
<td>16798</td>
</tr>
<tr>
<td>2014/13</td>
<td>23068</td>
<td>15255</td>
</tr>
</tbody>
</table>
Both Figure 6 and Figure 7 provide an overview of the planned/scheduled activity for each activity centre and the actual attendance by patients during the period June 2014 to June 2015.

**Figure 7: % of attendance at Activity Centres**

<table>
<thead>
<tr>
<th>Activity Centre</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAC</td>
<td>65%</td>
</tr>
<tr>
<td>Crafts</td>
<td>80%</td>
</tr>
<tr>
<td>Gardens</td>
<td>74%</td>
</tr>
<tr>
<td>PLC</td>
<td>75%</td>
</tr>
<tr>
<td>Sports</td>
<td>72%</td>
</tr>
<tr>
<td>Woodcraft</td>
<td>71%</td>
</tr>
</tbody>
</table>

A summary of the reasons for non attendance over the past 12 months are detailed in Figure 8 below. The number of sessions affected by closures or reduced service has significantly decreased since the last annual report with a reduction of 67% of sessions reported as being affected. The efforts made so far to review the scheduling of activities across the service has proved successful and other factors such as the Mull Integrated Working pilot has enabled Sports in particular to maintain its number of planned sessions without having to reduce numbers directly related to having an additional consistent staff member.

**Figure 8: Reasons for non attendance at scheduled sessions**

<table>
<thead>
<tr>
<th>Reasons for non attendance at scheduled sessions</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deterioration in Mental Health</td>
<td>679</td>
<td>674</td>
</tr>
<tr>
<td>Physical Health Problem</td>
<td>765</td>
<td>612</td>
</tr>
<tr>
<td>Appointments with other Health Care Professional</td>
<td>517</td>
<td>681</td>
</tr>
<tr>
<td>External appointments</td>
<td>805</td>
<td>116</td>
</tr>
<tr>
<td>Tribunal/CMT/CPA Appointments</td>
<td>65</td>
<td>66</td>
</tr>
<tr>
<td>Patient refuses to attend</td>
<td>501</td>
<td>561</td>
</tr>
<tr>
<td>Service Closed/Reduced Service</td>
<td>1253</td>
<td>3767</td>
</tr>
<tr>
<td>Patient seeing external visitor</td>
<td>94</td>
<td>18</td>
</tr>
<tr>
<td>Visit on ward</td>
<td>315</td>
<td>273</td>
</tr>
<tr>
<td>Discharge/Transfer/rescheduled sessions</td>
<td>101</td>
<td>204</td>
</tr>
<tr>
<td>Bad Weather</td>
<td>69</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>463</td>
<td>728</td>
</tr>
<tr>
<td>Attending other Skye Centre activities using Drop in</td>
<td>287</td>
<td>113</td>
</tr>
<tr>
<td><strong>total</strong></td>
<td><strong>5914</strong></td>
<td><strong>7813</strong></td>
</tr>
</tbody>
</table>
It is anticipated that the ongoing Activity Scheduling work that has been initiated by the Patient Day Activity project will ensure a more consistent and effective method for scheduling activity across all disciplines and will enable the Skye Centre along with the other services to plan out patient activity in a more efficient manner. The potential introduction of an electronic scheduling system such as CELCAT would make a considerable difference to the manner in which we plan and record patient activity across the hospital.

The report so far has concentrated on the overall participation of patients across the service however the information noted below is intended to demonstrate how much time individual patients spend at the Skye Activity Centres. The data presented is reflective of the week commencing 1st June 2015 and does not include the time spent attending the Health Centre which varies or Patient Shop which the majority of patients attend one morning per week.

The numbers of sessions patients attend are recorded over the period 9am – 4pm Monday to Friday. The patients normally attend for a full morning session and the afternoons are currently split into two sessions with patients having the option to stay at the Skye Centre all afternoon. For the purpose of presenting this information one ‘split’ session is defined as 0.5.

Figure 9

<table>
<thead>
<tr>
<th>Number of Sessions each patient has throughout the a week</th>
<th>Arran</th>
<th>Iona</th>
<th>Lewis</th>
<th>Mull</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>0.5</td>
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<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>1.5</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>2.5</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>3.5</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>4.5</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>5.5</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>6.5</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>7</td>
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<td>1</td>
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<td>8</td>
<td>1</td>
<td>3</td>
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<td>2</td>
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<td>8.5</td>
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<td>9</td>
<td>2</td>
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<td>1</td>
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<td>3</td>
</tr>
<tr>
<td>9.5</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total patient numbers</td>
<td>22</td>
<td>32</td>
<td>34</td>
<td>35</td>
<td>123</td>
</tr>
</tbody>
</table>

The number of sessions each patient has varies and is influenced by a number of factors such as the patients' mental/physical health or attendance at other therapies. It is important to note that there are a number of patients (n=23) who do not have scheduled sessions within the Skye Centre mainly due to their presenting mental health and presenting behaviours.
In some cases an outreach service is provided by staff within the Sports, PLC and Gardens Departments providing the opportunity to engage in meaningful activity on ward. This approach has successfully resulted in 3 of these patients commencing 1:1 activity within the Skye Centre providing a tailored approach which supports their care and treatment objectives.

Figure 10 provides an example of an overview of the patients in Arran Hub and their time spent within the Skye Centre. If this information is considered useful it can be developed further for inclusion within future reports.

**Figure 10**

![Graph showing Arran Hub off-ward attendance at Skye Centre](image)

**4.4) Integrated Care Pathway (ICP)**

Attendance at case reviews by Skye Centre Nurses has proved a challenge in previous years mainly related to long term sickness and vacancies. The matter of non-attendance and the frustrations and concerns related to this were raised by Skye Nursing staff at the Skye Professional Nursing Forum held with the Director of Nursing.

There was commitment from the staff group to support a review of the previous models and they recognise the benefits of attending and directly participating in the clinical team discussions. The attendance figures have steadily increased since February 2015 and are noted in Figure 11. It is an ongoing challenge to balance the competing priorities of ensuring that the activity centres are adequately staffed, against the clinical benefits in nursing staff attending the CPA discussion but these benefits are demonstrated when the patients’ treatment objectives are better informed and they are in turn appropriately placed within the Skye Activity Centres.

Over the last 12 months the service has achieved 100% completion rate for the Annual VAT form

**Figure 11**

![Graph showing Skye Activity Centre staff attend Case Review](image)
Efforts have been made to monitor and ensure that Skye Centre annual reports are completed on time and submitted to the relevant clinical team. Since November 2014 the majority of reports have been submitted on time, no reports are sent for patients who do not attend the Skye Centre Service. However, efforts are being made to ensure that Skye Nursing staff are involved in CPA annual review discussions to ensure recommendations are being made for those patients who do not currently attend.

Complaints Information

Over the previous years a number of complaints have been received from patients regarding access to services and centre closures and there were 9 comments received between 2011 and 2012 via community meetings or Patient Partnership Group regarding centre closures. The increased number of complaints that were recorded over the year in 2013 are directly related to the closure of Woodcraft and the staffing resources issues being experienced at that time. On a positive note the number of complaints has reduced since then with no complaints raised so far in 2015 in relation to closures.

Figure 13 Complaints received in relation to centre closures

<table>
<thead>
<tr>
<th>Year</th>
<th>Upheld</th>
<th>Partly upheld</th>
<th>Not upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>2012</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2013</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2014</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

4.5) Utilisation of the Building
The Skye Centre is utilised for a number of other activities including, on a weekly basis the Patient Partnership Group, Christian Fellowship Group, Multi Faith Service, Psychological Therapy Service Groups, Occupational Therapy groups and Advocacy events and service and strategic meetings which include patient representation.

Patients also attend the Health Centre on a daily basis for a range of Primary Care Services. Every attempt is made to ensure that patients can access these appointments whilst being
supported by the Skye Centre staff to ensure attendance at their planned activity is accommodated.

5 Challenges/Issues

5.1) Sustainable work force/succession planning

The Skye Centre staffing establishment is 40.33 wte, the actual staff in post is 37.33 wte due to vacancies not yet filled. The current Skye Centre is open Monday to Friday 8.30am to 5pm and is also operated on a Saturday and Sunday with evening activities provided within the shift rota on Saturday evenings. The current workforce establishment for the Skye Centre is required to staff all activity centres as well as additional activities detailed in Appendix 1.

There still remains only 4 shift workers within the service and the implications of this are that Skye Centre staff are not self sufficient to provide evening and weekend activities, relying on ward nursing support. This has been the practice for a number of years.

Options for integrated working are being considered within the ongoing work related to the Patient Day project along with a review of current skill mix when considering the grade of staff required to fill current vacancies in accordance with workforce planning arrangements.

There are 3 vacancies within the service at present and discussions are taking place regarding the recruitment process for these posts.

There are 4 staff due to retire within the service over the next 6 to 12 months and consideration is being given to the succession planning and replacement of these long standing and highly experienced technical and clinical staff. Approval will be sought from the SMT to reconfigure the existing staffing. One option is to relocate one of the current vacancies to the Gardens department. This will enable a planned approach to incorporate a new staff member within the existing service under the guidance and mentoring of the skilled and highly experienced staff members that presently provide the horticultural and animal/pet based activities.

5.2) Outcome Measures

Unfortunately the work related to identifying potential standardised outcome measures has not been fully progressed within the last year. The challenge of find a ‘one size fits all’ approach has proved to be a challenge considering the differing needs of each activity area. On reflection it has now been agreed that a more achievable approach will be to focus on specific areas such as the Induction Programme and the Vocational Activity Centres. Staff from the Skye Centre and the Occupational Therapy service have been identified to progress this piece of work and it is anticipated that this will be completed by the end of 2015.

5.3) Development of Electronic Patient Record

Due to the previous staffing issues within the eHealth service ongoing work in relation to RIO and the integration of Skye Centre reports onto the electronic records system were unable to be progressed. This issue has now been resolved and work is underway to ensure the outstanding work is recommenced. This will ensure that all Skye Centre treatment objectives and reporting for CPA reviews will be available electronically and can be accessed by all members of the clinical team.

5.4) Sickness

The staff sickness levels across the service has been particularly high over the past couple of years with long term sickness at one point reaching as high as 17%. This has improved significantly over the past 12 months averaging 7.42% for long sickness and 1.72% for short term sickness. However this remains higher than the national target of 5%. It remains an ongoing challenge to meet the needs of the service and long term sickness tends to impact across all of the activity centres as each area is not self sufficient, and during periods of sickness there is no capacity built into the workforce to compensate and provide backfill replacement for staff. Due to the vacancies created within the service there has been some scope to compensate for hours
lost with the creation of a fixed term contract supported by the Senior Management Team and the utilisation of Zero Hours contract staff that temporarily fill the service gaps and enable the service to continue to meet the needs of our patient group.

6 Future Developments

The main focus for the year ahead will be to continue to review and augment the range of activities and opportunities for our patient group and to adapt and improve the methods in which we deliver these. These key objectives include:-

6.1) Curriculum Planning

The Skye Centre service will continue to support work of the Patient Day Project in particular the Activity Timetabling subgroup. This group aims to support the delivery of meaningful and therapeutic patient activities through development and implementation of an integrated and collaborative approach to the planning and scheduling of programmes and activities across all disciplines and services. The Skye Centre has contributed fully to the work achieved to date within this multidisciplinary scheduling group.

A key task of this group was to plan a six monthly organisational timetable outlining room usage and resourcing. This timetable incorporates the Skye Centre, Hubs, AHP and psychological services, and a multi disciplinary patient activity timetable format has been developed. A comprehensive guide to all therapeutic, educational and vocational activities provided by all disciplines is also nearing completion, and will act as a resource for patients and staff to access. The work related to this part of the Patient Day project is progressing well and it is anticipated that it will be delivered on and implemented by the end of 2015.

6.2) Improving Integration

- The Skye Centre induction programme will be further developed to include more collaboration with our Occupational Therapy colleagues to support a joint assessment service whereby patients are formally assessed and clinical teams are advised with regard to suitable activity for patients.
- Occupational Therapists will develop a variety of life skills groups accessing the facilities within the Skye Centre Atrium. This is envisaged as facilitating a ‘gateway to activity’ whereby OTs will retain a base hub but work in a more integrated way with Skye Centre staff allowing valuable contributions to be made to the clinical teams on patients’ progress within the Skye Centre.

6.3) Patient Feedback

- Discussions have taken place with the Involvement and Equality Manager regarding the development of consistent processes for obtaining patient feedback across all of the Activity Centres. The ‘Emotional Touch Points’ model which has previously been presented to the Board is being explored as one possible option.

6.4) Workforce Review/Efficiency Savings Targets

- Ongoing discussions are taking place with the General Manager regarding the current workforce numbers and skill mix to ensure succession planning is built into future service delivery and that the current service meets the needs of our patients. The importance of ensuring that agreed efficiency targets are achieved is also recognised. The Skye Centre service achieved and in fact exceeded the agreed 4.6% savings target set for 2014/15 on a non recurring basis and the service has identified steps to meet the agreed savings target of £96,300 for this next financial year.

Future developments will give cognisance to the recommendations and outcomes from the Patient Activity Project and future discussions regarding the potential changes to the Clinical Model.
7 Recommendations

The State Hospital Board are requested to note the information in this annual report and accept the recommendation that future reports will provide the Board with progress and updates on the Skye Centre Management Team plan of work along with progress on agreed key performance indicators related to the service.

8 Review Date

The next review date for the Skye Centre annual report is June 2016

Appendix 2

Staffing establishment (wte) available to run patient activity centres

Figure 1

<table>
<thead>
<tr>
<th>Area</th>
<th>Staff wte</th>
<th>RMN</th>
<th>Technical/Specialty/Admin – band 4</th>
<th>Support Worker B3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrium</td>
<td>6.5</td>
<td>2 (1vac)</td>
<td>2.5 (incl. 1 *s/w)</td>
<td>2 (incl. 1 admin)</td>
</tr>
<tr>
<td>Patient Learning Centre</td>
<td>4.6</td>
<td>1</td>
<td>3.6 (1 vacancy)</td>
<td></td>
</tr>
<tr>
<td>Sports</td>
<td>6</td>
<td>2**</td>
<td>4 (incl. 2 *s/w)</td>
<td></td>
</tr>
<tr>
<td>Woodwork</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Crafts</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Gardens</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td><strong>28.1</strong></td>
<td><strong>9</strong></td>
<td><strong>17.1</strong></td>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>
*s/w - shift worker – staff work a 4 days on, 2 days off 6 week roster to cover evening and weekend activities

** RMN works a shift rota Sunday to Thursday. The shift pattern was adapted to support the service demands of the weekend opening times.

Figure 2 Staffing establishment (wte) available to operate “other” patient activities

<table>
<thead>
<tr>
<th>Area</th>
<th>Staff wte</th>
<th>RMN / R.Nurse</th>
<th>Technical/Speciality /admin - band 4</th>
<th>Support Worker B3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skye Centre manager</td>
<td>0.93</td>
<td></td>
<td>0.93</td>
<td></td>
</tr>
<tr>
<td>Senior Charge Nurse</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skye centre admin</td>
<td>0.97</td>
<td></td>
<td>0.97</td>
<td></td>
</tr>
<tr>
<td>Shop</td>
<td>1</td>
<td></td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Hairdresser</td>
<td>0.4</td>
<td></td>
<td>0.4</td>
<td></td>
</tr>
<tr>
<td>Health centre</td>
<td>6</td>
<td>2</td>
<td>4 (incl.1 admin)</td>
<td></td>
</tr>
<tr>
<td>Tribunal</td>
<td>2</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Multifaith</td>
<td>0***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>12.3</strong></td>
<td><strong>3</strong></td>
<td><strong>6.8</strong></td>
<td><strong>2.5</strong></td>
</tr>
</tbody>
</table>

*** Gardens activity centre staff help facilitate the weekly multi faith service.
1 INTRODUCTION

The Report is presented to meet the requirements within the Committee’s Terms of Reference to submit an annual report of the work of the Committee to the Board.

The report also supports the Governance Statement in providing periodic reports to the Board from the Committee in respect of Internal Control containing the key achievements, key learning and key developments for Clinical Governance for the period under review in order that the Board can be assured that all elements of Clinical Governance activity are operating effectively and complying with national guidelines.

2 BACKGROUND

Clinical Governance is a statutory obligation to Scottish Government for The State Hospitals Board for Scotland. It is a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.

Clinical Governance establishes the need to focus on the activities involved in achieving effective, high quality care; improving patient experience; and patient safety.

3 SUMMARY

The Clinical Governance Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with the assurance that clinical governance mechanisms are in place and effective within The State Hospital.

The provision of an Annual Report by the Clinical Governance Committee is an important assurance process to the Board in considering the effectiveness of internal controls in order that The State Hospitals Board for Scotland can be assured that all elements of Clinical Governance activity are operating effectively and complying with national guidelines.

The report outlines the work of the Committee, including:

- Frequency of meetings
- The activities of the Committee
- Progress in Clinical Governance

4 CONSULTATION ON DEVELOPMENT OF THIS REPORT

The contents of this report arise from the quarterly Clinical Governance Committee meetings during the year.

5 RESOURCE IMPLICATIONS

Nil to note.
6 IMPACT ASSESSMENT AND CONSEQUENTIAL CHANGES PROPOSED TO MITIGATE ADVERSE IMPACTS IDENTIFIED.

Nil to note

7 RECOMMENDATION

The Board is asked to receive and note the Clinical Governance Committee Annual Report 2014/15.
1 DEFINITION OF CLINICAL GOVERNANCE

Clinical Governance is a statutory obligation and is a framework through which The State Hospitals Board for Scotland is accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

2 REMIT

This committee’s terms of reference are detailed in Appendix A.

Members of the Clinical Governance Committee during 2014-15 were as follows:

- Elizabeth Carmichael, Non-Executive Director
- Nicholas Johnston, Non-Executive Director (Chair)
- Maire Whitehead, Non-Executive Director

Ex-officio Members:

- Terry Currie, Chair, The State Hospitals Board for Scotland
- George Brechin, Interim Chief Executive – until March 2015
- Jim Crichton, Chief Executive – from March 2015

In attendance at meetings:

- Lindsay Thomson, Medical Director (Lead Executive)
- Stephen Milloy, Nursing Director
- Robin McNaught, Finance & Performance Management Director
- Morag Slesser, Head of Psychology
- Robert Gibb, Chair of the Medical Advisory Committee
- Sheila Smith, Clinical Effectiveness Team Leader
- Jean Wade, Board Secretary

3 MEETINGS

The Clinical Governance Committee met on four occasions in 2014/15

- 22 May 2014
- 14 August 2014
- 13 November 2014
- 12 February 2015

4 CONTINUOUS CLINICAL IMPROVEMENT

Committee meetings are divided into sections which reflect the various functions of the Clinical Governance Committee. The sections are as follows:

- Standing Agenda Items
- Annual Monitoring Reports
- Interim Reports (as required)
- Special Topics and Items for Approval

In addition to the planned schedule of reports, the committee is proactive in requesting additional reports and information in order that they receive appropriate assurance that any emerging issues are being addressed. Only when the committee is satisfied that issues have been resolved is the frequency of reporting reduced. Special Topic discussion led items on the Clinical Model and the Patients’ Voice were featured in November 2014 and February 2015 respectively.
5 RISK MANAGEMENT

There are four main delivery areas in relation to Risk Management:

- **Proactive risk identification and minimisation:** This includes the corporate risk register, business continuity and emergency planning and Health and Safety Control Book audits.

- **Incident Reporting and Organisational Learning:** This is delivered through Datix which is the Hospital’s electronic incident reporting system, and is accessible to all staff in the Hospital via the Hospital’s intranet site and a link from each computer desktop in the Hospital. Each reported incident is investigated locally to ensure appropriate remedial and preventative steps have been taken. There are clear processes in place to identify incident trends or significant single incidents. There has also been a review of the Datix codes following the move to the new Hospital. Organisational learning is through the Hospital’s Enhanced Incident Reviews.

- **Supporting a safe culture:** This is delivered through training and risk awareness

- **Developing and reviewing policies:**

There are various risk key performance indicators that include:

- Total incidents reported
- Types of incidents

Other additional areas of good practice during 2014/15 in relation to risk management across the Hospital include:

- Effective monitoring of risk information by groups and committees.
- Regular monitoring of patient-specific risks by hub management teams.
- Proactive engagement by staff of risk specialists within the organisation.
- Strong evidence on learning from incidents, with local action being taken to minimise recurrences.

6 EXTERNAL REPORTS


The Committee noted that from January to April 2014, Health Improvement Scotland (HIS) undertook a baseline scoping exercise to determine governance arrangements in place and inform the methodology, frequency and scale of their future scrutiny and assurance activity in this area.

Duncan Alcock advised that a self-assessment on the requirements of the scoping exercise had been submitted to HIS and generally positive feedback had been received.

The Committee noted the two matters HIS had raised and received confirmation that one had been addressed and the other was in process.

7 CLINICAL GOVERNANCE REPORTS

- Standing agenda items:
- Complaints and Incidents Monitoring Report
- Admission, Transfer/Discharge Monitoring Report (6 monthly)
- Critical Incident Review Reports
The following reports were discussed at the Clinical Governance Committee in 2014/15:

*May 2014:*
- Research Committee Annual Report
- Fitness to Practice Annual Report
- Leadership Walkrounds

*August 2014:*
- Corporate Risk Register Annual Report
- Infection Control Annual Report
- Patient Safety Annual Report
- Clinical Governance Annual Report and Stock Take
- Medium and High Secure Care Standards

*November 2014:*
- Physical Health Steering Group Annual Report
- Medicines Committee Annual Report
- CPA/MAPPA Annual Report
- Mental Health Practice Steering Group update
- Rehabilitation Therapies Annual Report
- Clinical Model – Special Topic

*February 2015:*
- Clinical Forum Annual Report
- Department of Psychological Therapies Annual Report
- The Patients’ Voice – Special Topic
- Medium and High Secure Care Standards Action Plan Update

8 **NHS BOARD REPORTING**

The Committee has provided minutes of each meeting to the Board and the Clinical Governance Committee Chair has highlighted specific areas of concern or good practice to prompt Board debate.

It had been agreed during 2013/14 that the following annual reports would be reported to the Board rather than Clinical Governance Committee:

- Patient Focus Public Involvement (PFPI)
- Equality and Diversity
- Patient Learning
- Skye Centre Activity
- Advocacy
- Clinical Records and Data Protection including Caldicott

9 **CONCLUSION**

It is concluded that the Clinical Governance Committee has fulfilled its remit and it considers that there are adequate and effective Clinical Governance (including Information Governance) arrangements in place to assure the Board of its Clinical Governance duties.
1 PURPOSE

The Clinical Governance Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with the assurance that clinical governance mechanisms are in place and effective within The State Hospital.

2 COMPOSITION

2.1 Membership:

The Clinical Governance Committee is appointed by the Board and shall be composed of at least three Non-executive Board members, one of whom shall act as Chair.

The Chairperson of the Board, and the Chief Executive, shall both be ex-officio members.

The Clinical Governance Committee will have the authority to co-opt up to two members from outwith the Board in order to carry out its remit. These members will act in an ex-officio capacity.

An ex-officio member is a member of a body who is part of it by virtue of holding another office. Such members shall have the power to vote in the Committee’s decisions. Membership will be reviewed annually.

Members of the Clinical Governance Committee during 2014-15 were as follows:

- Elizabeth Carmichael, Non-Executive Director
- Nicholas Johnston, Non-Executive Director (Chair)
- Maire Whitehead, Non-Executive Director

Ex-officio Members:

- Terry Currie, Chair, The State Hospitals Board for Scotland
- George Brechin, Interim Chief Executive to 13 March 2015
- Jim Crichton, Chief Executive from March 2015

In attendance at meetings:

- Lindsay Thomson, Medical Director (Lead Executive)
- Stephen Milloy, Nursing Director
- Robin McNaught, Finance & Performance Management Director
- Morag Slessor, Head of Psychology
- Robert Gibb, Chair of the Medical Advisory Committee
- Sheila Smith, Clinical Effectiveness Team Leader
- Jean Wade, Board Secretary

2.2 Appointment of Chair:

The Chair of the Committee shall be appointed in accordance with Standing Orders.

2.3 Attendance:

Members shall normally attend meetings and receive all relevant papers. All Board Members, the Chair of the Medical Advisory Committee and the Chair of the Research Committee, will have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.
If attendance at the meeting is only required on a periodic basis, this should be agreed with the Committee Chair in advance. Apologies should be tendered to the Chair of the Committee via the minute secretary at least two working days prior to the meeting, unless an exceptional event prevents this level of notice.

Where a member who is due to present a paper is not able to attend they should ensure that another person is suitably briefed in order to deal with this item. The arrangement made should be discussed and approved by the Committee Chair.

To fulfil its remit, the group may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of Hospital staff to attend meetings. If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

Others may attend the Committee on the approval of the Committee Chair.

3 MEETINGS

3.1 Frequency:

The Clinical Governance Committee will meet quarterly to fulfil its remit and shall report to the Board following each meeting.

The Chair of the Committee may convene additional meetings as necessary. The Accountable Officer of the Board may ask the Chair of the Committee to convene further meetings to discuss particular issues on which they want the Committee’s advice.

3.2 Agenda and Papers:

The agenda and supporting papers will be sent out at least five working days in advance to allow time for consideration of issues.

The format of agendas and papers will be in line with corporate document standards. The lead Executive for co-ordinating agendas and papers is the Medical Director.

All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken. Cover papers should be prepared in the format set out in Corporate Document Standards, to draw out the main issues for the Committee. Annual Reports of reporting committees should follow the format set out in Corporate Document Standards.

Documents will be watermarked as Confidential or Draft as required. Documents which are watermarked as Confidential should not be shared outwith the Committee membership. Guidance on confidentiality and openness can be sought from the Health Records Manager.

The secretary for this Committee will maintain a master file of documents, in line with Policy for Management, Retention and Disposal of Administrative Records.

3.3 Quorum:

In the event of the Committee making decisions, two members need to be in attendance to be quorate.

3.4 Minutes:

Formal minutes will be kept of the proceedings and submitted for approval at the next Board meeting. The Board Secretary is responsible for minute taking arrangements. The draft minutes will be cleared by the Chair of the Committee and the nominated lead Executive (Medical Director) prior to submission to the Board.

Following approval, minutes will be placed on the Hospital’s website.
4 REMIT

4.1 Objectives:

The main objectives of the Clinical Governance Committee are to provide the Board with the assurance that clinical governance mechanisms are in place and effective within The State Hospital; and that the principles of clinical governance are applied to the health improvement activities of the Board.

Existence and effective operation of this committee will be demonstrated in continuous improvement and compliance with clinical standards, in delivery of improved services for patients, and ultimately in improved outcomes for patients as evidenced through the clinical key performance indicators reported in the Local Delivery Plan.

4.2 Systems and Accountability

- To ensure that appropriate clinical governance mechanisms are in place throughout the Hospital in line with national standards.
- To ensure that clinical risks are managed in accordance with the corporate risk management strategy, policies and procedures.
- To ensure that staff governance issues which impact on service delivery and quality of service are appropriately managed through clinical governance mechanisms.
- To ensure that systems are in place to meet information governance standards.
- To ensure that systems are in place to meet research governance standards.

4.3 Safe and Effective Care

To provide assurance to the Board in respect of clinical risk management arrangements, that:

- Structures are in place to minimise potential problems such as effective risk assessment and management, incident reporting, critical incident reviews, and complaint procedures.
- Lessons are being learned from adverse events and near misses.
- Complaints are handled in accordance with national guidance and lessons will be learned from their investigation and resolution (including reports of the Scottish Public Services Ombudsman and the Mental Welfare Commission).
- Arrangements are in place to support child and adult protection obligations.

4.4 Health, Wellbeing and Care Experience

- To ensure that the environment supports delivery of high quality care with a culture and appropriate mechanism to allow staff and others to raise concerns on the service of care provided, including the performance of clinical colleagues, in the knowledge they will be addressed without detriment to themselves or prejudice to the principles of confidentiality.
- To ensure that arrangements are in place to embed Patient Focus and Public Involvement activities, including equality and diversity issues pertinent to clinical governance.
- To ensure that care is provided by appropriately trained and skilled professionals with the competencies required to deliver the required care.
- To ensure that clinical policies and procedures are developed, implemented and reviewed.
- To ensure that poor performance of clinical care will be identified and remedial action taken.

4.5 Control Assurance

- To ensure that quality of clinical care drives decision making and that clinicians are involved in planning, organising and managing services.
- To ensure that the planning and delivery of services has taken full account of the perspective of patients and the general public.
• To ensure that systems are in place to measure and monitor performance to foster a culture of quality and continuous improvement.
• To ensure that research and development programmes are initiated, monitored and reviewed.
• To ensure a comprehensive information governance framework is in place which ensures the Codes of Practice on Openness and on Confidentiality of Personal Health Information are fully applied.
• The Committee will manage its business through a workplan, agreed by the Chair of the Committee. This will ensure that the full remit is covered on a rolling basis.

5 AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6 PERFORMANCE OF THE COMMITTEE

The Committee shall annually review and report on:

• Its own performance, effectiveness, and the level of input of members to the Committee relative to added value achieved.
• Proposed changes, if any, to the terms of reference.

7 REPORTING FORMAT AND FREQUENCY

The Chair of the Committee will report to the Board following each meeting of the Clinical Governance Committee, by presenting the minutes of the Committee for approval.

The Chair of the Committee shall submit an Annual Report on the work of the Committee to the Board.

8 COMMUNICATION AND LINKS

The Chair of the Committee will ensure that relevant issues are shared with the Staff Governance Committee.

The Chair of the Committee will be available to the Board as required to answer questions about its work.

The Chair of the Committee will ensure arrangements are in place to provide information to the Scottish Government as required to meet their reporting requirements.
1 PURPOSE

The Clinical Governance Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with the assurance that clinical governance mechanisms are in place and effective within The State Hospital.

2 COMPOSITION

2.1 Membership:

The Clinical Governance Committee is appointed by the Board and shall be composed of at least three Non-executive Board members, one of whom shall act as Chair.

The Chairperson of the Board, and the Chief Executive, shall both be ex-officio members.

The Clinical Governance Committee will have the authority to co-opt up to two members from outwith the Board in order to carry out its remit. These members will act in an ex-officio capacity.

An ex-officio member is a member of a body who is part of it by virtue of holding another office. Such members shall have the power to vote in the Committee’s decisions. Membership will be reviewed annually.

Members of the Clinical Governance Committee during 2014-15 were as follows:
- Elizabeth Carmichael, Non-Executive Director
- Nicholas Johnston, Non-Executive Director (Chair)
- Maire Whitehead, Non-Executive Director

Ex-officio Members:
- Terry Currie, Chair, The State Hospitals Board for Scotland
- George Brechin, Interim Chief Executive to 13 March 2015
- Jim Crichton, Chief Executive from March 2015

In attendance at meetings:
- Lindsay Thomson, Medical Director (Lead Executive)
- Stephen Milloy, Nursing Director
- Robin McNaught, Finance & Performance Management Director
- Morag Slessor, Head of Psychology
- Robert Gibb, Chair of the Medical Advisory Committee
- Sheila Smith, Clinical Effectiveness Team Leader
- Jean Wade, Board Secretary

2.2 Appointment of Chair:

The Chair of the Committee shall be appointed in accordance with Standing Orders.

2.3 Attendance:

Members shall normally attend meetings and receive all relevant papers. All Board Members, the Chair of the Medical Advisory Committee and the Chair of the Research Committee, will have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.
If attendance at the meeting is only required on a periodic basis, this should be agreed with the Committee Chair in advance. Apologies should be tendered to the Chair of the Committee via the minute secretary at least two working days prior to the meeting, unless an exceptional event prevents this level of notice.

Where a member who is due to present a paper is not able to attend they should ensure that another person is suitably briefed in order to deal with this item. The arrangement made should be discussed and approved by the Committee Chair.

To fulfil its remit, the group may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of Hospital staff to attend meetings. If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

Others may attend the Committee on the approval of the Committee Chair.

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THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the Clinical Governance Committee Meeting held on Thursday 21 May 2015 at 10.00am in the boardroom, The State Hospital, Carstairs.

Present:
Elizabeth Carmichael        Non Executive Director
Terry Currie               Board Chair
Nicholas Johnston          Non Executive Director (Chair)
Maire Whitehead            Non Executive Director

In Attendance:
Jim Crichton               Chief Executive
Peter Di Mascio            Social Work Team Leader
Doug Irwin                 Security Director (part)
Robin McNaught             Finance and Performance Management Director
Alex Mallon                HR Manager (part)
Jamie Pitcairn             Research and Development Manager
Morag Slessor              Head of Psychology
Lindsay Thomson            Medical Director
Jean Wade                  Board Secretary

1 APOLOGIES AND INTRODUCTORY REMARKS

Apologies were received from Robert Gibb, Stephen Milloy and Sheila Smith. Nicholas Johnston welcomed everyone to the meeting.

2 CONFLICTS OF INTEREST

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

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 12 February 2015 had been approved by the Board at their meeting on 7 May 2015.

4 PROGRESS ON ACTION NOTES

All actions were completed or progressing satisfactorily. Members noted the following updates:

Action No 8:
Doug Irwin attended the meeting to provide the committee with re-assurance in connection with the number of PAA malfunctions recorded and reported in the 4Cs report discussed at the last meeting of the Committee.

Members noted Doug Irwin’s explanation of the technicalities of the system and the range of safety mechanisms in place. The current issues of concern related to the pager component of the system. Staff had been informed that radio coverage was inconsistent across the site and of the number of layers of the system which supported overall safety. Testing was currently underway and any faulty pagers would be replaced if required. Doug Irwin advised that the system would tolerate faults and would still be safe and that pagers in isolation would not stop the system from working and all incidents have had a safe response.

Doug Irwin acknowledged that safety across the site was of paramount importance and that the testing of the system and increasing staff confidence was being carried out in partnership.

Members noted that an update on the PAA system would be provided at the next meeting of the Board in June 2015.

Action: Doug Irwin
5 MATTERS ARISING

There were no matters arising from the previous minute of the meeting held on 12 February 2015 that were not included in the actions or included on the agenda. However, the following update was received from Morag Slesser in respect of actions from a previous meeting.

a) Actions from the meeting on 13 November 2014:

Morag Slesser provided the following update.

CPA/MAPPA Annual Report:
Peter Di Mascio would be taking forward a project on enhanced feedback from patients.

Rehabilitation Therapies Report:
Morag Slesser and Jacqueline Garrity had discussed the work to be done to provide a more integrated report to the Committee in future.

Lindsay Thomson would work with Jacqueline Garrity on the next report to cover the specific issues to be included.

b) Update on Patients Day Workstream:

Members received a report from Mark Richards which provided an update of progress to date of the recommendations made and accepted as part of the review of patient activity in the Hospital. An evaluation of the service improvement approach employed for this project was included.

Mark Richards summarised the report and the key issues of note in respect of Planning, Monitoring and Reporting Outcomes; Improving Integration; and Revised Framework for Activities.

A number of issues were discussed in relation to the progress made since the report was written; the value of qualitative measurements; the benefits of increased job satisfaction and the subsequent impact this may have on outcomes from the NHS Staff Survey and i-Matter experience tool; the patient/staff relationship and the value this had in terms of patients engaging in therapeutic activity; the key learning points from similar work undertaken in Ashworth Hospital in England; the affordability of rolling out the model and the savings and adjustments that would be required elsewhere; and the early discussion between Lindsay Thomson and Mark Richards of a model in respect of staff and patient involvement in Skye Centre activities.

Members would continue to receive updates on the Patients Day Workstream.

6 PATIENT MOVEMENT – STATISTICAL INFORMATION

Lindsay Thomson outlined the Policy and Procedure around referrals and admissions criteria and the very clear standards in place on transfer monitoring and reporting arrangements which the Committee could be assured were rigorously applied. The Mental Health (Scotland) Bill was currently being considered in the Scottish Parliament and will apply to Care and Treatment in Medium Secure facilities as well as the Forensic High Security of The State Hospital. As a result, there was likely to be a significant impact in respect of patient transfers in the future.

Members noted that all admissions to the Hospital continued to be totally appropriate and necessary. Members were assured that all patients in the Hospital required high secure care.

Discussions related to patient movement and capacity issues in the future in light of the new Mental Health (Scotland) Bill; in terms of efficiencies the potential in future for combining, high, medium and low secure care; the role of the Forensic Network; and the potential impact in future of the Integration of Health and Social Care.
Following the discussions, Lindsay Thomson which provided an overview of the activity across Admissions, Discharges and Transfers as of 31 March 2015. The report was a discussion led item and was a regular feature of various issues discussed by the Committee.

Of the 42 admissions during the period under review, the majority had been admitted from court and prison. In terms of geographical source, the admissions were fairly evenly spread, largely in keeping with what would be expected socio-demographically.

Up to 31 March 2015, eight patients were admitted within the six week time limit between referral and admission; and one patient had been admitted outwith the six week period due to discussions around the need for admission to the Hospital as opposed to prison. There was currently one patient awaiting admission to the Hospital.

Members noted that no patients under the age of 18 had been admitted to the Hospital.

In respect of Exceptional Circumstances Admissions, no patients had been admitted to the Hospital under this category during the period.

There were seven patients who had their appeal against excessive security upheld and 35 patients were discharged to various NHS Boards over the period.

There were currently 16 patients on the transfer list, two more than the position recorded at the end of September 2014; the majority of patients on the list continued to be from Greater Glasgow and Clyde. It was noted that there were 10 patients overall who were awaiting transfer and had been fully assessed/agreed with the local service.

Members noted the report on Patient Movement – Statistical Information as at 31 March 2015.

7 FITNESS TO PRACTISE

Alex Mallon joined the meeting.

Members received a report from Alex Mallon in relation to Fitness to Practise which outlined the process for monitoring professional registration status at The State Hospital. The report also provided assurance to the Clinical Governance Committee that members of staff held current professional registration where required.

Alex Mallon outlined the registration process and Members noted that the Staff Governance Committee also received a report on Fitness to Practise on an annual basis.

Members discussed a range of issues in relation to the sanctions that would be applied if a member of staff failed to register; and the robust system in place for Responsible Medical Officers (RMOs), by way of monthly checks by the General Medical Council (GMC).

Alex Mallon confirmed that the Committee should be assured that all necessary checks were diligently made by HR and there were no concerns.

Members noted the Fitness to Practise report.

Alex Mallon left the meeting at this point.

Following the meeting an error was noted in the report which stated that Human Resources Department checked professional registrations of staff groups working in the Hospital through a Service Level Agreement. However, it should be noted that registration checks of those professional staff were processed through their employer.

The Human Resources Director was informed and would make the necessary correction to the report.

Action: Barbara Anne Nelson
Members received the 2014-15 Research Committee Annual Report from Jamie Pitcairn. Members noted the wide range of research activity undertaken within the Hospital and the summary of work conducted within both the Research Committee and the Research Funding Committee. Members noted the key issues around the Local Delivery Plan; Policy and Strategy; Clinical/Service Delivery; Staffing; Finance; Risk Assessment; Equality and Diversity; and the challenges of the Forensic Network Inpatient Database.

Members discussed a number of issues of the report in respect of the valuable work that had been undertaken over the period, the Service Evaluation of the Healthy Living Programme; the financial allocation and slippage in the year under review and the complex permissions required around various research projects which could result in lost opportunities.

Members noted that the Annual Research and Clinical Effectiveness Conference would take place later that afternoon and that it was expected to be well attended.

Members noted and approved the Research Committee/Research Governance and Funding Annual Report.

9 CHILD AND ADULT PROTECTION ANNUAL REPORT

Members received the Child and Adult Protection Annual Report from Peter Di Mascio, on behalf of Stephen Milloy. It was noted that the reporting period had changed from the previous calendar year format to the financial year and now covered the period from 1 January 2015 to 31 March 2015.

Peter Di Mascio summarised the activity across the Hospital as part of a framework that ensured the Hospital not only met its legal obligations in this area of work but went beyond that in demonstrating best practice in some areas.

Members noted the main areas of the report which confirmed a wide range of activity that had taken place over the period under review.

A number of issues were discussed in relation to any research on children’s performance at school in respect of the level of contact with their fathers. It was noted that no research had been undertaken on this issue and Lindsay Thomson outlined the difficulties of undertaking such a project. Adult Protection referrals were discussed and it was agreed that for the next report, more information would be provided on the outcomes.

Action: Peter Di Mascio/Stephen Milloy

Members noted the Child and Adult Protection Annual Report, the progress made, supported the future areas of work identified, and agreed to receive further reports and updates.

10 CRITICAL INCIDENT REVIEW (CIR) REPORT

Members received redacted reports from Lindsay Thomson in respect of the following Critical Incident Reviews:

(CIR) Ref: 14/04:

Members discussed a number of areas of the CIR in relation to the delay in concluding the report and the improvements required. The Committee noted that the Senior Management Team continued to monitor the priorities and progress of all CIRs at their fortnightly meetings and overall, the timing of completions had improved but there was more to be done in this respect. The due process and potential for a management investigation was also discussed. Lindsay Thomson provided further information and confirmed that a management investigation had not been required.

Members noted CIR Report: 14/04; and the recommendations and actions agreed.
Members discussed a number of areas of the CIR in relation to the length of time taken to conclude the report; the responsibility for redacting CIRs and that the guidance used was being consistently applied. Lindsay Thomson confirmed that she would discuss the matter with Caldicott Guardian, Duncan Alcock and provide the Committee with more information at their next meeting in August 2015.

Action: Lindsay Thomson

Members noted CIR Report: 14/06; and the recommendations and actions agreed.

(CIR) Ref: 14/07:

Members discussed a number of areas of the report in respect of the response by staff which they commended; the learning from the incident; and the training required.

Members noted CIR Report: 14/07; and the recommendations and actions agreed.

11 CLINICAL GOVERNANCE COMMITTEE MONITORING REPORT: 4Cs AND PATIENT SAFETY

Members received the Clinical Governance Committee Monitoring Report: 4Cs and Patient Safety from Lindsay Thomson. It was noted that the title of the report had been changed as it was felt it more accurately reflected the purpose and content of the information provided.

The report provided the Committee with an overview of the activity across the 4Cs and incident reporting system for the fourth quarter of the financial year covering the months of January, February and March 2015.

Lindsay Thomson summarised the report and provided more information on the statistics presented in respect of the sources of feedback, the issues raised, formal complaints including the timeliness of responses, outcomes and actions taken; Scottish Public Services Ombudsman (SPSO) contact; and Patient Safety.

Members noted that the main source of feedback this quarter continued to be from suggestion boxes; 11 formal complaints were received over the period, one of which were fully upheld and one partially upheld; the average number of days taken to respond to complaints within the quarter was 14 days; and one complaint response exceeded the 20 day target in the quarter under review.

Lindsay Thomson provided more information in respect of the Patient Safety issues outlined in the report and Members noted that there had been no very high grade incidents or positive drug tests recorded this quarter.

One complaint had been referred to the Scottish Public Services Ombudsman (SPSO) in the period of the report.

Members also noted the types of issues raised via the ‘Complaint Issues and Outcome’.

A number of areas of the report were discussed in relation to the issue referred to SPSO and the lessons learned; the ‘face down’ restraint technique which Lindsay Thomson explained; the research project underway in respect of the use of seclusion, restraint and emergency medication and the differences in practice; and seclusion trends which were very low in The State Hospital in comparison to the high secure hospitals in England.

Members noted the Clinical Governance Committee Monitoring Report: 4Cs and Patient Safety.
12 **WORKPLAN**

Members received and noted the Clinical Governance Committee Plan of Work to November 2015.

13 **ANY OTHER BUSINESS**

*Consideration of information to be shared with the Staff Governance Committee:*

The issues arising from the report on Fitness to Practise would be shared with Staff Governance Committee.  

**Action:** Lindsay Thomson

14 **DATE AND TIME OF NEXT MEETING**

The next meeting would take place on Thursday 13 August 2015 at 9.45am in the Boardroom, The State Hospital, Carstairs.
1 WORKFORCE DATA SUBMISSION

We are currently preparing the Annual Workforce Projection numbers for submission to Scottish Government. As part of this exercise Managers are being asked to consider their current baseline staffing and project ahead for 2 years in terms of their staffing requirements going forward.

The information provided in Appendix 1 is intended to provide Board Members with a snapshot of workforce data. The data provided as “in post” at 31 March 2015 does not include vacancies whilst the data provided as Year 1 is based upon the currently funded establishment.

This data will inform the preparation of the Annual Workforce Projection numbers which are submitted to the Scottish Government.

2 WORKFORCE REVIEW

Work has begun on profiling the Nursing Workforce requirements going forward based upon service delivery needs in the short, medium and long term and also the demographic profile of this element of the workforce. Current discussion regarding the patient day and clinically led discussion about the possibility of making changes to the detail of the clinical model will underpin the development of the Workforce Strategy. These discussions do need to be concluded in order to ensure that fully informed decisions are made about numbers and skill mix going forward.

This is a significant piece of work which will be taken forward in 2015/16 and will involve a review of the previous Workforce Development Plan based upon the required 6 step methodology, involvement of all key stakeholders including Managers and the Partnership Forum as any Workforce Strategy must also fit within the financial resources available.

3 RECOMMENDATION

The Board is asked to note the data contained within Appendix 1 and the broader workforce planning work which is being taken forward.
### WORKFORCE PLAN

#### Payroll ISD Return due June 15 (15/16 Budgets)

#### Gross of recharges and savings target

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<th>Cost Centre Description</th>
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<tbody>
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<tr>
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<td><strong>Total CE (plus Psychology below)</strong></td>
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<td>11.00</td>
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<tr>
<td><strong>Finance:-</strong></td>
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<td>Finance</td>
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<td><strong>TOTAL Finances</strong></td>
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<tr>
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1 PURPOSE

To provide a report containing the key achievements and key developments for Staff Governance for the period 2014/15.

2 BACKGROUND

The Staff Governance Standard sets out what each NHS Scotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met and that all policies and agreements are implemented.

3 CURRENT SITUATION

Staff, Corporate and Clinical Governance make up the governance framework for NHS Scotland.

This report outlines the work of the Staff Governance Committee as it seeks to support the State Hospitals Board for Scotland’s aim to be an exemplar employer with systems of corporate accountability for the fair and effective management of all staff.

4 PROPOSAL

The Board is asked to consider and make any comment on the contents of the 2014/15 Annual Report.

5 ENGAGEMENT AND CONSULTATION ON DEVELOPMENT OF THIS REPORT

Not applicable.

6 RESOURCE IMPLICATIONS AND IDENTIFIED SOURCES OF FUNDING

Not applicable.

7 RISK ASSESSMENT AND MITIGATION

Not applicable.

8 IMPACT ASSESSMENT AND CONSEQUENTIAL CHANGES PROPOSED TO MITIGATE ADVERSE IMPACTS IDENTIFIED

Not applicable.

9 RECOMMENDATION

The Board is asked to note and agree the Staff Governance Committee Annual Report.
1 INTRODUCTION

Staff Governance is defined as ‘a system of corporate accountability for the fair and effective management of all staff.’

The Staff Governance Standard (4th Edition) sets out what each NHSScotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met, and that all policies and agreements are implemented. In addition to this, the Standard specifies that staff are entitled to be:

- well informed;
- appropriately trained and developed;
- involved in decisions;
- treated fairly and consistently; with dignity and respect, in an environment where diversity is valued;
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

In the performance year 2014/15, The State Hospitals Board for Scotland’s Staff Governance Committee continued to focus its monitoring activities in respect of the above. The Committee members recognised their obligations to support a culture within The State Hospitals Board for Scotland where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the organisation and is built upon the principles of partnership.

Members of the Staff Governance Committee are appointed annually by the NHS Board. Membership details of the Committee during 2014/15 are detailed below.

2 REMIT

The Committee’s current Terms of Reference are detailed at Appendix 1 to this report.

3 MEMBERSHIP

The membership of the Committee during 2014/15 is given below:

Bill Brackenridge (Chair of Committee, Non Executive Director)
Nicholas Johnston (Non Executive Director)
Elizabeth Carmichael (Non Executive Director)
Anne Gillan (Employee Director)
Jacqueline McQueen (lay member, Royal College of Nursing)
Alan Blackwood (lay member, Prison Officers’ Association)

Ex-officio members:

Terry Currie (Chairman)
George Brechin (Interim Chief Executive until 15 March 2015)
Jim Crichton (Chief Executive from 16 March 2015)
Rebecca Chalmers (Human Resources Director until 30 June 2014)
Barbara Anne Nelson (Interim Human Resources Director from 1 July 2014 to 31 March 2015)

Where required by the Chair or by other members of the Committee, appropriate members of staff were invited to be in attendance for the purposes of verbal updates, information sharing, presentations etc.
4 MEETINGS
The Committee met on four occasions between 1 April 2014 and 31 March 2015:
10 April 2014, 5 June 2014, 4 December 2014 and 5 March 2015.

5 COMMITTEE ACTIVITIES
The work of the Committee was set around key elements of the Staff Governance organisational agenda:

5.1 STAFF GOVERNANCE DEVELOPMENT
The Committee received reports and monitored areas as follows:

- Staff Governance Action Plan submission for 2014/15;
- Staff Governance Action Plan 2015/16;
- Monitoring of Knowledge and Skills Framework performance
- Annual Submission to Scottish Government of mandatory workforce statistics.
- Monitoring of Attendance Management performance
- Implementation of the 2020 workforce vision
- Completion of the NHS Scotland staff survey and the results for The State Hospital
- Monitoring the content and actions relating to Audit Reports covering Staff Governance matters
- Monitor the implementation of iMatter, the NHSScotland Staff Engagement Tool

5.1.1 Staff Governance Action Plan submission 2013/14
The Staff Governance Action Plan return for 2013/14 provided assurance that The State Hospitals Board for Scotland had met its obligations under the Staff Governance Standards, as described in item 5.1 above.

There were no issues raised by Scottish Government as feedback on the return.

5.1.2 Staff Governance Action Plan 2014/15
The Action Plan for 2014/15 focused on outcomes relating to improving partnership working, implementation of PIN policies, and progressing the Dignity at Work action plan, as well as corporate priorities related to the workforce. These included:

- Tackling bullying and harassment within the workplace and ensuring all staff are treated with dignity and respect:
- Ensuring effectiveness of communication with staff and involvement in changes which affect them within the organisation.
- Meeting targets within the Organisational Development and Learning Strategy
- Addressing issues relating to Health, Safety and Wellbeing of staff

With particular reference to the work undertaken for the Staff Governance statutory requirements, all processes were undertaken within the necessary timescales.

The Human Resources and Partnership Working Group, comprising a range of operational managers, staff side representatives and HR staff, continued to work closely with Partnership Forum colleagues to develop and approve policies relating to staff governance.

5.2 MANDATORY WORKFORCE STANDARDS
The committee received regular update reports and monitored issues relating to the following issues:

- Knowledge and Skills Framework
- Attendance Management
5.2.1 Knowledge and Skills Framework

Monitoring of the completion rates for Personal Development Plans for staff was kept under scrutiny all year. The completion rate was per month an average of 72.53%, a significant reduction on the previous year’s performance of 85%.

5.2.3 Attendance Management

The State Hospitals Board for Scotland did not achieve the absence management standard of 5% in 2014/15. The end of year average absence percentage was 6.01%. This represented a small decrease from the 2013/14 average of 6.50%.

The principal reasons for absence remained consistent with the previous year, with the two most common reasons for absence being anxiety/stress/depression and musculoskeletal conditions.

5.3 OTHER PRIORITY TOPICS

5.3.1 Workforce Plan

The Committee monitored progress in the achievement of workforce plan targets. Work commenced on development of the workforce plan following a specific workshop to discuss this topic.

5.3.2 Fitness to Practise

A report was provided to assure the Staff Governance Committee that all professional staff were registered and fit to practise.

The Committee also considered the External Quality Assurance Review of Medical Revalidation.

5.3.3 Occupational Health Service Annual Report

The annual report was presented by the Occupational Health Clinical Team from SALUS, current provider of the OHS service level agreement.

5.3.4 Dignity at Work

Training for managers was carried out in line with the corporate training plan on the Prevention and Management of Bullying and Harassment. This involved the provision of Emotional Intelligence training which was well received by staff.

5.3.5 2020 Workforce Vision

The implementation plan for 2020 workforce vision generated much debate, and informed the planning process for the Staff Governance Action plan 2014/15.

The Committee received and noted minutes of the following committee meetings:

- Partnership Forum;
- Health and Safety Committee;
- Clinical Governance papers (as appropriate and where related to a Staff Governance issue);

5.3.6 Staff Survey 2014

The annual staff survey was conducted between 25 August 2015 and 6 October 2014. Whilst there was a very substantial fall in participation from the previous year’s total of 61% to 46% this level was still among the highest rates achieved within NHS Scotland.
The local results recognise the commitment of everyone at The State Hospital to patient care. It should be noted that scores have increased across each and every one of the areas covered by the Survey.

Areas identified for improvement include:

- Staff feeling that they are consulted about changes
- Staff being clear about how the changes will work in practice
- Staff feeling confident that their ideas and suggestions are listened to
- Staff feeling that they are able to speak up and challenge
- Staff feeling that they have a choice in what to do at work

Areas where an increased positive response rate was received included:

- Staff feeling that they get help and support from colleagues
- Staff being clear about their duties and responsibilities
- Staff confirming that they are happy to go the “extra mile”
- Staff acknowledging that the Board’s top priority is the care of patients
- Staff being clear about how their role fits into the overall aims of the hospital

Along with the Staff Governance Committee the Partnership Forum will continue to drive for improvement within the areas identified by the survey and by internal discussion on the results themselves.

6 CHAIRMAN’S COMMENTS

The performance year 2014/15 has underlined the continuing need to focus our attention on key Staff Governance issues. As common with last year the results of the national Staff Survey towards the end of the reporting period, presented the committee with a number of issues to debate, in terms of improving communication, enhancing partnership working, and continuing to tackle perceptions of bullying and harassment within the organisation. The staff survey results form the basis of the staff governance action plan for the coming year, 2015/16, which will be kept under close scrutiny.

During 2014/15, there was still an Interim Chief Executive in post with a substantive appointment being made with effect from 16 March 2015. In addition the Human Resources Director post was filled by a secondment arrangement from 1 July 2014 to 31 March 2015. This has impacted upon the ability to progress and take forward the issues identified in the same manner which would be achieved by substantive postholders.

The priority areas in terms of Staff Governance performance management continue to be the completion of Personal Development Plans, and the pursuit of the Attendance Management target of 5% absence. Performance in these two areas will continue to be monitored rigorously by the Committee in the coming year against the background of the new approaches which have been developed and are being adopted to address these priorities.

The terms of reference for the Staff Governance Committee will be revised in 2015/16 to reflect current membership and submitted to Audit Committee for approval.

I offer my thanks for the continuing support and encouragement of Committee members and also to those members of staff who have worked on the Committee’s behalf during 2014/15.
1 PURPOSE

The Staff Governance Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with the assurance that staff governance mechanisms are in place and effective within The State Hospital.

2 COMPOSITION

2.1 Membership

The Staff Governance Committee is appointed by the Board and shall be composed of the Employee Director and three other Non-executive Board Members one of whom shall act as Chair. The Chairperson of the Board, and the Chief Executive, shall both be ex-officio members.

There will be two lay representatives identified by the staff side organisations and nominated by the Partnership Forum. The lay representatives will not act in an ex officio capacity.

An ex-officio member is a member of a body who is part of it by virtue of holding another office. Such members shall have the power to vote in the Committee's decisions.

Membership will be reviewed annually.

The Staff Governance Committee will have the authority to co-opt other attendees from outwith the Board in order to carry out its remit.

2.2 Appointment of Chair

The Chair of the Committee shall be appointed at meeting of the Board in accordance with Standing Orders.

2.3 Attendance

Members shall normally attend meetings and receive all relevant papers. All Board Members will have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

Executive Directors of the Board are not eligible for membership of the Committee. The Accountable Officer (Chief Executive) and Human Resources Director shall be invited to attend meetings and receive all relevant papers. Other Directors and staff may also be invited by the Chair of the Committee to attend meetings as required.

3 MEETINGS

3.1 Frequency

The Staff Governance Committee will meet quarterly to fulfil its remit and shall report to the Board following each meeting.

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least five working days in advance of the meetings to allow time for members’ due consideration of issues. All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken. The format of agendas and papers will be in line with corporate document standards. The lead Executive for co-ordinating agendas and papers is the Human Resources Director.
3.3 **Quorum**
Two members of the Committee will constitute a quorum.

3.4 **Minutes**
Formal minutes will be kept of the proceedings and submitted for approval at the next Board meeting. The Chief Executive’s personal assistant is responsible for minute taking arrangements.

Following approval by the Board, minutes of the Staff Governance Committee will be presented to the next Staff Governance Committee meeting to ensure actions have been followed up.

The draft minutes will be cleared by the Chair of the Committee and the nominated lead Executive prior to submission to the Board.

3.5 **Other**
In order to fulfil its remit, the Staff Governance Committee may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of hospital staff to attend meetings.

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

4 **REMIT**

4.1 **Objectives**
The main objectives of the Staff Governance Committee are to provide the Board with the assurance that staff governance mechanisms are in place and effective within The State Hospital; and that the principles of the national Staff Governance Standards and The State Hospital’s Staff Charter are applied equitably and fairly to all staff.

Existence and effective operation of this committee will be demonstrated in continuous improvement and compliance with staff governance standards, in delivery of improved working arrangements for staff, and ultimately in achievement of outcome targets as evidenced through the staff related key performance indicators reported in the Local Delivery Plan.

4.2 **Systems and accountability**

4.2.1 To ensure that appropriate staff governance mechanisms are in place throughout the hospital in line with national standards.

4.2.2 To ensure that people management risks are managed in accordance with the corporate risk management strategy, policies and procedures.

4.2.3 To ensure that staff governance issues which impact on service delivery and quality of service are appropriately managed.

4.2.4 To review the Staff Governance Action Plan and ensure that the Partnership Forum is performance managing the action plan.

4.3 **People management**
To provide assurance to the Board in respect of people management arrangements, that:

4.3.1 Culture is maintained within the hospital where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the hospital and is built upon partnership and collaboration.
4.3.2 Structures are in place to monitor the outcome of strategies and implementation plans relating to people management.

4.3.3 Structures are in place to monitor the outcome of strategies and implementation plans relating to knowledge management.

4.3.4 Propose policy amendment, funding or resource submission to achieve the Staff Governance Standards.

4.3.5 Support is given for any policy amendment, funding or resource submission to achieve the Staff Governance Standards.

4.3.6 There is timely submission of all staff governance data required by the Scottish Executive Health Department and in respect of the Local Delivery Plan.

4.3.7 Pay modernisation processes are monitored and that the Boards Pay Benefits Realisation Plans are signed off.

4.3.8 Workforce planning and development is monitored and to sign off the Boards Workforce Plan and the Boards Development Plan and ensure they support the Local Delivery Plan.

4.3.9 Policies and procedures are developed, implemented and reviewed.

4.4 Controls assurance

To ensure that:

4.4.1 The information governance framework provides appropriate mechanisms for Codes of Practice on Data Protection and Freedom of Information to be applied to all staff.

4.4.2 The planning and delivery of services has fully involved partnership working.

4.4.3 Systems are in place to measure and monitor performance to foster a culture of quality and continuous improvement.

4.4.4 Staff governance information is provided to support the statement of internal control.

5 AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised to establish a Remuneration Committee to cover staff under executive and senior manager pay arrangements and to validate the work of that committee. The Remuneration Committee must include, as a minimum, three non executive Directors of the Board. The Remuneration Committee will be a closed committee and shall sign off its own minutes. The Staff Governance Committee will require to be provided with assurance that systems and procedures are in place to appropriately manage the pay of this group of staff. This will not include detailed confidential employment issues that are considered by the Remuneration Committee: these can only be considered by non executive Directors of the Board.

6 PERFORMANCE OF THE COMMITTEE

The Committee shall annually review and report on:

- Its own performance and effectiveness in meeting the terms of reference; including its running costs, and level of input of members relative to the added value achieved
- Proposed changes, if any, to the terms of reference.
7 REPORTING FORMAT AND FREQUENCY

The Chair of the Committee will report to the Board following each meeting of the Staff Governance Committee, by presenting the minutes of the Committee for approval.

The Chair of the Committee shall submit an Annual Report on the work of the Committee to the Board.

8 COMMUNICATION AND LINKS

The Chair of the Committee will be available to the Board as required to answer questions about its work.

The Chair of the Committee will ensure arrangements are in place to provide information to the Scottish Government as required to meet their reporting requirements.

This revision: 15 January 2009
1  PURPOSE
To provide a report containing a summary of the work overseen by the Remuneration Committee.

2  BACKGROUND
The Staff Governance Standard sets out what each NHS Scotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met and that all policies and agreements are implemented.

3  CURRENT SITUATION
This report outlines the work of the Remuneration Committee as it seeks to support the State Hospitals Board for Scotland’s aim to be an exemplar employer with systems of corporate accountability for the fair and effective management of all staff, with particular regard to the pay, performance and terms and conditions of Executive and Senior Managers.

4  PROPOSAL
The Committee is asked to consider and make any comment on the contents of the 2014-15 Annual Report.

5  ENGAGEMENT AND CONSULTATION ON DEVELOPMENT OF THIS REPORT
Not applicable.

6  RESOURCE IMPLICATIONS AND IDENTIFIED SOURCES OF FUNDING
Not applicable.

7  RISK ASSESSMENT AND MITIGATION
Not applicable.

8  IMPACT ASSESSMENT AND CONSEQUENTIAL CHANGES PROPOSED TO MITIGATE ADVERSE IMPACTS IDENTIFIED
Not applicable.

9  RECOMMENDATION
The Board is asked to receive and note the Remuneration Committee Annual Report.
1 INTRODUCTION

Staff Governance is defined as ‘a system of corporate accountability for the fair and effective management of all staff.’

The Staff Governance Standard (4th Edition) sets out what each NHSScotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met, and that all policies and agreements are implemented. In addition to this, the Standard specifies that staff are entitled to:

- well informed;
- appropriately trained and developed;
- involved in decisions;
- treated fairly and consistently; with dignity and respect, in an environment where diversity is valued;
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

In the performance year 2014/15, The State Hospitals Board for Scotland’s Remuneration Committee continued to focus its monitoring activities in respect of the above, with particular regard to the performance, pay and terms and conditions of Executive and Senior managers.

Membership details of the Committee during 2014/15 are detailed below.

2 REMIT

The Committee’s Terms of Reference are detailed at Appendix 1 to this report.

3 MEMBERSHIP

The membership of the Committee during 2014/15 is given below:

Terry Currie Chair of Committee and Board Chair
Bill Brackenridge Non Executive Director
Nicholas Johnston Non Executive Director
Maire Whitehead Non Executive Director
Elizabeth Carmichael Non Executive Director
Anne Gillan Non Executive Director / Employee Director

Ex-officio members:

George Brechin Interim Chief Executive until 15 March 2015
Jim Crichton Chief Executive from 16 March 2015
Rebecca Chalmers HR Director until 30 June 2014
Barbara Anne Nelson Interim HR Director from 1 July 2014 to 31 March 2015
Jean Wade Board Secretary
4 MEETINGS

The Committee met on four occasions between 1 April 2014 and 31 March 2015:

5 COMMITTEE ACTIVITIES

The Committee’s activities included:

- MHO Status of a Senior Manager
- Overseeing the implementation of an Executive On-call Rota subject to remuneration in line with the Agenda for Change terms and conditions of service
- Approval of the Performance Management arrangements and Performance Appraisals for Executive Directors for the performance year 2013-14.
- Agreement that the Appraisal outcomes for Executive Directors be submitted to the National Performance Management Committee. Also consideration of the National Performance Management Committee’s appraisal analysis.
- Agreement of the Executive Directors Performance Planning and Review (Objectives) for the year 2014/15.
- Consultants discretionary points were reported on and approved.
- Oversight of the Interim HR Director and substantive HR Director appointment and terms and conditions of service.
- Approval of the recruitment process for the substantive Chief Executive and remuneration arrangements.

6 CHAIRMAN’S COMMENTS

The Remuneration Committee discharged its responsibilities with regard to the oversight of Executive and Senior Managers’ performance management and remuneration. The Committee also reviewed a range of other issues as described above during the reporting period.

The Terms of Reference for the Remuneration Committee will be revised in 2015/16 and submitted to the Board for approval.

I would like to thank the Committee members for their contribution to the meetings in 2014/15.
THE STATE HOSPITALS BOARD FOR SCOTLAND

REMUNERATION COMMITTEE

TERMS OF REFERENCE

PURPOSE

1. The Committee shall be known as the Remuneration Committee of The State Hospitals Board for Scotland. It will be a standing Committee of The State Hospitals Board for Scotland and will make decisions on behalf of The State Hospitals Board for Scotland.

COMPOSITION

2. The Remuneration Committee members will be appointed by The State Hospitals Board for Scotland and will consist of:
   - The Committee Chair
   - The Chair of The State Hospitals Board for Scotland
   - The Chairs of the three Governance Committees

   In addition there will be in attendance:
   - Chief Executive
   - Human Resources Director
   - Board Secretary

   No employee of the Board shall be present when any issue relating to their employment is being discussed.

3. The Human Resources Director will be the Executive Director Lead and will attend meetings of the Remuneration Committee as Advisor and to provide administrative support.

Executive Director Lead

Generally, the designated Executive Lead will support the Chair of the Committee in ensuring that the Committee operates according to / in fulfilment of its agreed Terms of Reference. Specifically, they will:

- Support the Chair in ensuring that the Committee Remit is based on the latest guidance and relevant legislation.
- Liaise with the Chair in agreeing a programme of meetings for the business year, as required by its remit.
- Oversee the development of an Annual Workplan for the Committee which is congruent with its remit and the need to provide appropriate assurance at the year-end, for endorsement by the Committee and approval by the Board.
- Agree with the Chair an agenda for each meeting, having regard to the Committee's Remit and Workplan.
• Oversee the production of an Annual Report, informed by self assessment of performance against the Remuneration Committee Self Assessment Handbook, on the delivery of the Committee’s Remit and Workplan for endorsement by the Committee and submission to the Board.

4. Where issues with financial implications are to be discussed at the Remuneration Committee the implications will first have been discussed with the Finance Director and, where appropriate, the Finance Director may be invited to attend meetings of the Remuneration Committee.

5. The quorum for the Remuneration Committee will be attendance by 3 Non-Executive Directors, inclusive of the Chair.

FUNCTIONS

6. To oversee and agree the remuneration arrangements and terms and conditions of employment of Executive Directors and Senior Managers of The State Hospitals Board for Scotland, to include:

• Content and format of job descriptions.
• Terms of employment including tenure.
• Remuneration.
• Benefits including pension or superannuation arrangements.
• Annual salary review.

7. To ensure arrangements are in place for the assessment of the performance of The State Hospitals Board for Scotland and to monitor the performance of The State Hospitals Board for Scotland against pre-determined performance criteria to inform oversight of objective setting and support for decisions on individual performance appraisal.

8. To agree The State Hospitals Board for Scotland’s arrangements for performance management and to ensure that the performance of the Executive Directors is rigorously assessed against agreed objectives within the terms of the performance management arrangements referred to above.

9. To ensure that clear objectives are established for Executive Directors of The State Hospitals Board for Scotland before the start of the year in which performance is assessed by:

• Receiving a report from the Chair on the agreed Objectives for the Chief Executive.
• Receiving a report from the Chief Executive on the agreed Objectives for the other Executive Directors of the Board.

10. To monitor arrangements for the pay and conditions of service of other Senior Managers on Executive Pay arrangements and on Professional/Management Transitional pay arrangements in accordance with appropriate guidance and to implement annual pay uplifts and pay progression in accordance with national guidance.

11. To approve The State Hospitals Board for Scotland’s arrangements for the grading of Senior Manager and Executive Director posts and to oversee these arrangements by receiving regular reports from the Director of Human Resources.

12. To ensure that arrangements are in place to determine the remuneration, terms and conditions and performance assessment for staff employed under the Executive and Senior Management Pay arrangements. To receive formal reports (at least annually) providing evidence of the effective operation of these arrangements.
13. To consider any redundancy, early retiral or termination arrangement in respect of all State Hospital staff, excluding early retirals on grounds of ill health, and approve these or refer to the Board as the Committee sees fit. In addition the Committee will oversee the award of discretionary points to medical staff.

14. To fulfil its functions, the Remuneration Committee will take into account a range of factors which will include

- Regular reports from the Human Resources Director.
- The Remuneration Committee Self Assessment Handbook.
- Guidance issued by the Scottish Government Health Department.
- An annual report on the application of pay awards and pay movements.
- The need to recruit and retain appropriately qualified and skilled Directors, General and Senior managers.
- Equitable pay and benefits for the level of work performed.

CONDUCT OF BUSINESS

15. Meetings of the Committee will be called by the Chair of The State Hospitals Board for Scotland with items of business circulated to members one week before the date of the meeting.

16. The Committee will seek specialist guidance and advice as appropriate.

17. All business of the Committee will be conducted in strict confidence.

REGULARITY OF MEETINGS

18. Meetings of the Remuneration Committee will be held as necessary to conduct its business. At a minimum, the Committee should meet twice per annum, once to approve the performance assessments and annual Objectives of the Executive Directors and once to approve the annual application of pay awards and pay progression.

REPORTING ARRANGEMENTS

19. The Remuneration Committee will report to the Board. Regular reports on meetings and activity will be submitted to the Board through the Staff Governance Committee. Membership of the Remuneration Committee will be reported to and agreed by the Board. Appropriate details of Executive Members remuneration will be published in The State Hospitals Board for Scotland’s Annual Report.

Annual Report
In accordance with Best Value for Board and Committee Working, the Committee will submit to the Board in May each year an Annual Report, encompassing: the name of the Committee; the Committee Chair; members; the Executive Lead and officer supports / attendees; frequency and dates of meetings; the activities of the Committee during the year, including confirmation of delivery of the Annual Workplan and review of the Committee Terms of Reference; improvements overseen by the Committee; matters of concern to the Committee.

Where the review by the Committee of its Terms of Reference results in amendment the revised Terms of Reference must be submitted to the Board for approval. The Committee Annual Report will inform the submission of any appropriate assurance to the Chief Executive at the year-end, as part of the Statement of Internal Control.
20. Details of the business conducted by the Committee will be made available to the Scottish Government Health Department, the form and content being determined by the latter.

21. A Report, marked as ‘confidential’, on each meeting of the Remuneration Committee will be issued to the Non Executive Directors of the Board.
1 INTRODUCTION

It had been discussed at the March Staff Governance Committee that the Terms of Reference be reviewed. This matter was also considered for approval at the Audit Committee on 25 June 2015. This paper details the proposed change to the Terms of Reference. The full document is attached to this paper for information.

2 TERMS OF REFERENCE – PROPOSED CHANGES

The Board’s Code of Corporate Governance sets the membership of this Committee as follows:

“The Staff Governance Committee is appointed by the Board and shall be composed of the Employee Director and three other Non-executive Board Members, one of whom shall act as Chair. The Chairperson of the Board, and the Chief Executive, shall both be ex-officio members. There will be two lay representatives identified by the staff side organisations and nominated by the Partnership Forum.”

Practice has however been for there to be three members nominated by Staff Side of the Partnership Forum to the Committee. Staff Side has then nominated one each from POA, RCN and Unison, although that distribution is a matter for Staff Side.

The Employee Director has recently drawn attention to this discrepancy between the Code and current practice. Staff Governance benefits from the full participation of trades unions and professional bodies. It seems better therefore to align the Code with current practice rather than the other way round.

3 RECOMMENDATION

The Board is asked to provide final approval of the increase from two to three lay representatives as described in the attached amended terms of reference.
1 PURPOSE

The Staff Governance Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with the assurance that staff governance mechanisms are in place and effective within The State Hospital.

2 COMPOSITION

2.1 Membership

The Staff Governance Committee is appointed by the Board and shall be composed of the Employee Director and three other Non-executive Board Members one of whom shall act as Chair.

The Chairperson of the Board, and the Chief Executive, shall both be ex-officio members.

There will be three lay representatives identified by the staff side organisations and nominated by the Partnership Forum. The lay representatives will not act in an ex officio capacity.

An ex-officio member is a member of a body who is part of it by virtue of holding another office. Such members shall have the power to vote in the Committee’s decisions.

Membership will be reviewed annually.

The Staff Governance Committee will have the authority to co-opt other attendees from outwith the Board in order to carry out its remit.

2.2 Appointment of Chair

The Chair of the Committee shall be appointed at meeting of the Board in accordance with Standing Orders.

2.3 Attendance

Members shall normally attend meetings and receive all relevant papers. All Board Members will have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

Executive Directors of the Board are not eligible for membership of the Committee. The Accountable Officer (Chief Executive) and Human Resources Director shall be invited to attend meetings and receive all relevant papers. Other Directors and staff may also be invited by the Chair of the Committee to attend meetings as required.

3 MEETINGS

3.1 Frequency

The Staff Governance Committee will meet quarterly to fulfil its remit and shall report to the Board following each meeting.

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least five working days in advance of the meetings to allow time for members’ due consideration of issues. All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken. The format of agendas and papers will be in line with corporate document standards. The lead Executive for co-ordinating agendas and papers is the Human Resources Director.
3.3 Quorum
Two members of the Committee will constitute a quorum.

3.4 Minutes
Formal minutes will be kept of the proceedings and submitted for approval at the next Board meeting. The Chief Executive’s personal assistant is responsible for minute taking arrangements.

Following approval by the Board, minutes of the Staff Governance Committee will be presented to the next Staff Governance Committee meeting to ensure actions have been followed up.

The draft minutes will be cleared by the Chair of the Committee and the nominated lead Executive prior to submission to the Board.

3.5 Other
In order to fulfil its remit, the Staff Governance Committee may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of hospital staff to attend meetings.

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

4 REMIT

4.1 Objectives
The main objectives of the Staff Governance Committee are to provide the Board with the assurance that staff governance mechanisms are in place and effective within The State Hospital; and that the principles of the national Staff Governance Standards and The State Hospital’s Staff Charter are applied equitably and fairly to all staff.

Existence and effective operation of this committee will be demonstrated in continuous improvement and compliance with staff governance standards, in delivery of improved working arrangements for staff, and ultimately in achievement of outcome targets as evidenced through the staff related key performance indicators reported in the Local Delivery Plan.

4.2 Systems and accountability

4.2.1 To ensure that appropriate staff governance mechanisms are in place throughout the hospital in line with national standards.

4.2.2 To ensure that people management risks are managed in accordance with the corporate risk management strategy, policies and procedures.

4.2.3 To ensure that staff governance issues which impact on service delivery and quality of service are appropriately managed.

4.2.4 To review the Staff Governance Action Plan and ensure that the Partnership Forum is performance managing the action plan.

4.3 People management
To provide assurance to the Board in respect of people management arrangements, that:

4.3.1 Culture is maintained within the hospital where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the hospital and is built upon partnership and collaboration.
4.3.2 Structures are in place to monitor the outcome of strategies and implementation plans relating to people management.

4.3.3 Structures are in place to monitor the outcome of strategies and implementation plans relating to knowledge management.

4.3.4 Propose policy amendment, funding or resource submission to achieve the Staff Governance Standards.

4.3.5 Support is given for any policy amendment, funding or resource submission to achieve the Staff Governance Standards.

4.3.6 There is timely submission of all staff governance data required by the Scottish Executive Health Department and in respect of the Local Delivery Plan.

4.3.7 Pay modernisation processes are monitored and that the Boards Pay Benefits Realisation Plans are signed off.

4.3.8 Workforce planning and development is monitored and to sign off the Boards Workforce Plan and the Boards Development Plan and ensure they support the Local Delivery Plan.

4.3.9 Policies and procedures are developed, implemented and reviewed.

4.4 Controls assurance

To ensure that:

4.4.1 The information governance framework provides appropriate mechanisms for Codes of Practice on Data Protection and Freedom of Information to be applied to all staff.

4.4.2 The planning and delivery of services has fully involved partnership working.

4.4.3 Systems are in place to measure and monitor performance to foster a culture of quality and continuous improvement.

4.4.4 Staff governance information is provided to support the statement of internal control.

5 AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised to establish a Remuneration Committee to cover staff under executive and senior manager pay arrangements and to validate the work of that committee. The Remuneration Committee must include, as a minimum, three non executive Directors of the Board. The Remuneration Committee will be a closed committee and shall sign off its own minutes. The Staff Governance Committee will require to be provided with assurance that systems and procedures are in place to appropriately manage the pay of this group of staff. This will not include detailed confidential employment issues that are considered by the Remuneration Committee: these can only be considered by non executive Directors of the Board.

6 PERFORMANCE OF THE COMMITTEE

The Committee shall annually review and report on:

- Its own performance and effectiveness in meeting the terms of reference; including its running costs, and level of input of members relative to the added value achieved
- Proposed changes, if any, to the terms of reference.
7 REPORTING FORMAT AND FREQUENCY

The Chair of the Committee will report to the Board following each meeting of the Staff Governance Committee, by presenting the minutes of the Committee for approval.

The Chair of the Committee shall submit an Annual Report on the work of the Committee to the Board.

8 COMMUNICATION AND LINKS

The Chair of the Committee will be available to the Board as required to answer questions about its work.

The Chair of the Committee will ensure arrangements are in place to provide information to the Scottish Government as required to meet their reporting requirements.

This revision: March 2015
THE STATE HOSPITALS BOARD FOR SCOTLAND

Agenda Reference: Item 13
Date of Meeting: 25 June 2015
Presented by: Chair of Remuneration Committee
Title of Report: Review of Remuneration Committee Terms of Reference

1 INTRODUCTION

It had been discussed at a previous Committee that the Terms of Reference be reviewed. This matter will also be considered at the Remuneration Committee on 25 June 2015 to support the Board’s approval of these proposed changes. This paper details the proposed changes to the Terms of Reference. The full document is attached to this paper for information.

2 TERMS OF REFERENCE – PROPOSED CHANGES

2.1 Composition
To include the following wording which reflects the current practice in terms of membership of the Committee.

- The Committee Chair
- The Chair of The state Hospitals Board for Scotland
- All other Non-Executive Directors of the Board including the Employee Director

2.2 Conduct of Business
To clarify that the officer who has the delegated authority to call meetings of the Committee is the Chair of the Committee and not the Chair of the State Hospitals Board for Scotland.

3 RECOMMENDATION
The Board is invited to review and agree the revised terms of reference.
THE STATE HOSPITALS BOARD FOR SCOTLAND
REMUNERATION COMMITTEE

TERMS OF REFERENCE

TITLE

1. The Committee shall be known as the Remuneration Committee of The State Hospitals Board for Scotland. It will be a standing Committee of The State Hospitals Board for Scotland and will make decisions on behalf of The State Hospitals Board for Scotland.

COMPOSITION

2. The Remuneration Committee members will be appointed by The State Hospitals Board for Scotland and will consist of:

   • The Committee Chair
   • The Chair of The State Hospitals Board for Scotland
   • The Chairs of the three Governance Committees
   • Employee Director
   • All other Non-Executive Directors of the Board, including the Employee Director

In addition there will be in attendance:

   • Chief Executive
   • Human Resources Director
   • Board Secretary

No employee of the Board shall be present when any issue relating to their employment is being discussed.

3. The Human Resources Director will be the Executive Director Lead and will attend meetings of the Remuneration Committee as Advisor and to provide administrative support.

Executive Director Lead

Generally, the designated Executive Lead will support the Chair of the Committee in ensuring that the Committee operates according to / in fulfilment of its agreed Terms of Reference. Specifically, they will:

   • support the Chair in ensuring that the Committee Remit is based on the latest guidance and relevant legislation;

   • liaise with the Chair in agreeing a programme of meetings for the business year, as required by its remit;

   • oversee the development of an Annual Workplan for the Committee which is congruent with its remit and the need to provide appropriate assurance at the year-end, for endorsement by the Committee and approval by the Board;

   • agree with the Chair an agenda for each meeting, having regard to the

Approved May 2013 June 2015
Committee’s Remit and Workplan;

• oversee the production of an Annual Report, informed by self assessment of performance against the Remuneration Committee Self Assessment Handbook, on the delivery of the Committee’s Remit and Workplan for endorsement by the Committee and submission to the Board.

4. Where issues with financial implications are to be discussed at the Remuneration Committee the implications will first have been discussed with the Finance Director and, where appropriate, the Finance Director may be invited to attend meetings of the Remuneration Committee.

5. The quorum for the Remuneration Committee will be attendance by 3 Non-Executive Directors, inclusive of the Chair.

FUNCTIONS

6. To oversee and agree the remuneration arrangements and terms and conditions of employment of Executive Directors and Senior Managers of The State Hospitals Board for Scotland, to include:

• content and format of job descriptions
• terms of employment including tenure
• remuneration
• benefits including pension or superannuation arrangements
• annual salary review

7. To ensure arrangements are in place for the assessment of the performance of The State Hospitals Board for Scotland and to monitor the performance of The State Hospitals Board for Scotland against pre-determined performance criteria to inform oversight of objective setting and support for decisions on individual performance appraisal.

8. To agree The State Hospitals Board for Scotland’s arrangements for performance management and to ensure that the performance of the Executive Directors is rigorously assessed against agreed objectives within the terms of the performance management arrangements referred to above.

9. To ensure that clear objectives are established for Executive Directors of The State Hospitals Board for Scotland before the start of the year in which performance is assessed by

• receiving a report from the Chair on the agreed Objectives for the Chief Executive
• receiving a report from the Chief Executive on the agreed Objectives for the other Executive Directors of the Board.

10. To monitor arrangements for the pay and conditions of service of other Senior Managers on Executive Pay arrangements and on Professional/Management Transitional pay arrangements in accordance with appropriate guidance and to implement annual pay uplifts and pay progression in accordance with national guidance.
11. To approve The State Hospitals Board for Scotland’s arrangements for the grading of Senior Manager and Executive Director posts and to oversee these arrangements by receiving regular reports from the Director of Human Resources.

12. To ensure that arrangements are in place to determine the remuneration, terms and conditions and performance assessment for staff employed under the Executive and Senior Management Pay arrangements. To receive formal reports (at least annually) providing evidence of the effective operation of these arrangements.

13. To consider any redundancy, early retirement or termination arrangement in respect of all State Hospital staff, excluding early retirements on grounds of ill health, and approve these or refer to the Board as the Committee sees fit. In addition the Committee will oversee the award of discretionary points to medical staff.

14. To fulfil its functions, the Remuneration Committee will take into account a range of factors which will include

- regular reports from the Human Resources Director
- the Remuneration Committee Self Assessment Handbook
- guidance issued by the Scottish Government Health Department
- an annual report on the application of pay awards and pay movements
- the need to recruit and retain appropriately qualified and skilled Directors, General and Senior managers
- equitable pay and benefits for the level of work performed

**CONDUCT OF BUSINESS**

15. Meetings of the Committee will be called by the Chair of The State Hospitals Board for Scotland the Committee with items of business circulated to members one week before the date of the meeting.

16. The Committee will seek specialist guidance and advice as appropriate.

17. All business of the Committee will be conducted in strict confidence.

**REGULARITY OF MEETINGS**

18. Meetings of the Remuneration Committee will be held as necessary to conduct its business. At a minimum, the Committee should meet twice per annum, once to approve the performance assessments and annual Objectives of the Executive Directors and once to approve the annual application of pay awards and pay progression.

**REPORTING ARRANGEMENTS**

19. The Remuneration Committee will report to the Board. Regular reports on meetings and activity will be submitted to the Board through the Staff Governance Committee.

Approved May 2013, June 2015
Membership of the Remuneration Committee will be reported to and agreed by the Board. Appropriate details of Executive Members remuneration will be published in The State Hospitals Board for Scotland’s Annual Report.

**Annual Report**

In accordance with Board and Committee Working, the Committee will submit to the Board in May each year an Annual Report, encompassing: the name of the Committee; the Committee Chair; members; the Executive Lead and officer supports/attendees; frequency and dates of meetings; the activities of the Committee during the year, including confirmation of delivery of the Annual Workplan and review of the Committee Terms of Reference; improvements overseen by the Committee; matters of concern to the Committee.

Where the review by the Committee of its Terms of Reference results in amendment the revised Terms of Reference must be submitted to the Board for approval. The Committee Annual Report will inform the submission of any appropriate assurance to the Chief Executive at the year-end, as part of the Statement of Internal Control.

20. Details of the business conducted by the Committee will be made available to the Scottish Government Health Department, the form and content being determined by the latter.

21. A Report, marked as ‘confidential’, on each meeting of the Remuneration Committee will be issued to the Non Executive Directors of the Board.
Audit Committee

Agenda Reference:    Item 11
Date of Meeting:    25 June 2015
Presented by:    Audit Committee Chair
Title of Report:    Annual Report of the Audit Committee for the year ended
                    31 March 2015

1  INTRODUCTION

The Report outlined in Appendix 1 is presented to the committee to meet the requirements within the Committee’s Terms of Reference to submit an annual report of the work of the Committee to the board. The report also supports the Governance Statement in providing periodic reports to the Board from the Committee in respect of Internal Control.

2  SUMMARY

The establishment of an Annual Report by the Audit Committee is an important assurance process to the Board in considering the effectiveness of internal controls.

The report outlines the work of the Committee, including:

• Frequency of meetings
• The activities of the Committee
• Progress in Corporate Governance

3  FINANCIAL IMPLICATIONS

An effective system of internal control is fundamental to securing sound financial management of the Board’s affairs.

4  RISK

The consideration and review of internal and external audit reports, and management responses, together with reports submitted by other officers, assist the Committee in advising the Board with regard to material risks.

5  CONSULTATION

This report is presented draft for consultation at the meeting of the Audit Committee.

6  RECOMMENDATION

The Audit Committee is asked to consider the Annual Report on its work as part of its responsibility for reviewing the effectiveness of controls and recommend that the board approves the annual report.
1 Introduction

The Report is submitted to meet the requirements within the Audit Committee’s (the Committee’s) Terms of Reference to submit an annual report of the work of the Committee. The report also seeks to satisfy the Governance Statement requirement for the Committee to provide periodic reports to the Board in respect of Internal Control.

2 Membership and Role of the Committee

<table>
<thead>
<tr>
<th>Audit Committee Membership</th>
<th>Role</th>
</tr>
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<tbody>
<tr>
<td>M Whitehead (Chair)</td>
<td>To oversee arrangements for external and internal audit of the Board’s financial and management systems and to advise the Board on the strategic processes for risk, control &amp; governance. It met 4 times during 2014/15.</td>
</tr>
<tr>
<td>W Brackenridge</td>
<td></td>
</tr>
<tr>
<td>E Carmichael</td>
<td></td>
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<tr>
<td>A Gillan (from 1 April 2014)</td>
<td></td>
</tr>
</tbody>
</table>

3 Audit

External audit coverage of the Board was provided by Scott Moncrieff.

The Internal Audit service was provided by KPMG.

4 Review of the Work of the Committee

The Internal Audit Operational Plan from KPMG for 2014/15 was approved by the Committee at its meeting on 26 June 2014. The plan was kept under review for the remainder of the year.

The plan was designed to target priority issues and structures to allow the Chief Internal Auditor to provide an opinion on the adequacy and effectiveness of internal controls to the Committee, the Chief Executive (as Accountable Officer) and the External Auditors.

During financial year 2014/15, the Committee met on four occasions: 24 April 2014, 26 June 2014, 9 October 2014 and 22 January 2015.

During this period, the Committee has:

- Received progress reports from the Chief Internal Auditors against the Internal Audit Plans approved by the Committee.
- Reviewed audit reports and action plans.
- Reviewed progress on action taken by management on action plans.
- Reviewed the final Annual Report for 2013/14 from the Chief Internal Auditor.
• Received the Annual Report and audit certificate for the 2013/14 audit from Scott Moncrieff.
• Reviewed the Standing Financial Instructions, Standing Orders and Scheme of Delegation, and recommended these for approval to the Board.
• Reviewed its Terms of Reference and recommended no changes.
• Review the log of waivers of standing financial instructions.
• Received updates from the Risk and Governance Committee which maintains management oversight of the implementation of risk management strategy.
• Received a presentation from Counter Fraud Services.
• Considered the Fraud Incident Log.
• Reviewed Counter Fraud Service Alerts.
• Reviewed and noted progress against CEL11(2013) Strategy to Combat Fraud, review the Fraud Action Plan and approve the Counter Fraud Checklist.
• Reviewed updates regarding the 2014/15 National Fraud Initiative.
• Received updates on the progress with the national Shared Support Services Project, and its impact locally.
• Reviewed and noted the Policy Management update.
• Received national Audit Scotland reports and performance audit studies, relating to the Health Service and to the wider public sector.
• Reviewed and noted the Security Audit.
• Reviewed and noted update of Efficiency / Productivity / Best Value.
• Met in private with Internal and External Auditors.
• Reviewed the recommendations received from National Services Scotland from their service audit reports.
• Reviewed and approved the Accounting Policies.
• Reviewed the annual reports from the Governance Committees.
• Reviewed the annual report on Risk Management.
• Reviewed the summary of Losses and Special Payments.
• Reviewed and approved the Patients Funds Annual Accounts for submission to the Board.
• Reviewed and recommended approval of the statutory Annual Accounts to the Board.
• Reviewed and noted update on Business Continuity arrangements.
• Submitted minutes of meetings to the Board throughout the year.

5 **Corporate Governance**

During 2014/15 the Board’s Internal Auditors reported on the following significant areas of work:

• Patients’ Funds
• Governance Statement readiness
• Procurement
• Sickness Absence Trends
• Follow up of previous recommendations
6 Conclusion

Based on the work that it has undertaken, the Committee is satisfied that internal controls are adequate to ensure that the Board can achieve the policies, aims and objectives set by Scottish Ministers, to safeguard public funds and assets available to the Board, and to manage resources efficiently, effectively and economically.

M Whitehead
AUDIT COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Audit Committee
25 June 2015
1 **PURPOSE**

The Audit Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with assurance in respect of risk, governance and internal control including financial control.

2 **COMPOSITION**

2.1 **Membership**

The Audit Committee is appointed by the Board and shall be composed of at least three Non-executive Board members, one of whom shall act as Chair. Membership will be reviewed annually and disclosed in the Annual Report.

2.2 **Appointment of Chairperson**

The Chairperson of the Committee shall be appointed at meeting of the Board in accordance with Standing Orders.

2.3 **Attendance**

Executive Directors of the Board are not eligible for membership of the Committee. The Accountable Officer (Chief Executive), Finance and Performance Management Director, Chief Internal Auditor, a representative from External Audit and any other appropriate officials shall normally attend meetings and receive all relevant papers. Other Directors may also be invited by the Chair of the Committee to attend meetings as required.

All Board Members will have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

Audit Committee members must regularly attend the Committee and if not appropriate action taken.

3 **MEETINGS**

3.1 **Frequency**

The Audit Committee will meet at least four times a year to fulfil its remit and shall report to the Board at least twice in each financial year.

The Chair of the Committee may convene additional meetings as necessary.

The accountable officer should attend all meetings but if he/she does not, be provided with a record of the discussions.

The Accountable Officer of the Board may ask the Chair of the Committee to convene further meetings to discuss particular issues on which they want the Committee’s advice.

3.2 **Agenda and Papers**

The agenda and supporting papers will be sent out at least five working days in advance of the meetings to allow time for members’ due consideration of issues. All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken.
3.3 Quorum
Two members of the Committee will constitute a quorum.

3.4 Minutes
Formal minutes will be kept of the proceedings and submitted for approval at the next Audit
Committee meeting, prior to submission to the Board.

Recognising the issue of relative timing and scheduling of meetings, minutes of the Audit
Committee may be presented in draft form to the next available Board meeting.

The draft minutes will be cleared by the Chair of the Committee and the nominated lead
Executive prior to submission to the Board.

4 OTHER
In order to fulfil its remit, the Audit Committee may obtain whatever professional advice it
requires and invite, if necessary, external experts and relevant members of hospital staff to
attend meetings.

If necessary, meetings of the Committee shall be convened and attended exclusively by
members of the Committee and / or the External Auditor or Internal Auditor. It is expected
that this should occur at least once in each financial year.

The Chief Internal Auditor and the representative(s) of External Audit will have free and
confidential access to the Chair of the Committee.

The Chair of the Audit Committee should be available at the Board's Annual Accounts
Approval Meeting to answer questions about its work.

5 REMIT

5.1 Objectives
The main objectives of the Audit Committee are to provide the Board with the assurance
that the State Hospital acts within the law, regulations and code of conduct applicable to it,
and that an effective system of internal control is maintained.

The committee periodically assesses its own effectiveness to ensure that the Audit
Committee fulfils its remit, this may involve assessing the attendance and performance of
each member.

New members receive a suitable induction and declare his/ her business interests.

The duties of the Audit Committee are in accordance with the Audit Committee Handbook,

5.2 Internal Control and Corporate Governance

5.2.1 To evaluate the framework of internal control and corporate governance comprising
the following components:

- Control environment; Risk management strategy, procedures and risk register;
- The effectiveness of the internal control and risk managements systems
- Decision-making processes;
- Receive and consider stewardships reports in key business areas.
- Information;
- Monitoring and corrective action
5.2.2 To review the system of internal financial control which includes:

The safeguarding of assets against unauthorised use and disposition;

- Maintenance of proper accounting records and
- the reliability of financial information used within the organisation or for publication.

5.2.3 To have a mechanism to keep it aware of topical legal and regulatory issues and ensure the Board’s activities are within the law and regulations governing the NHS.

5.2.4 To monitor performance and best value by reviewing the economy, efficiency and effectiveness of operations.

5.2.5 To present an annual assurance statement on the above to the Board to support the Directors’ Governance Statement on Internal Control.

5.2.6 To take account of the implications of publications detailing best audit practice.

5.2.7 To take account of recommendations contained in the relevant reports of the Auditor General and the Scottish Parliament.

5.2.8 To review audit reports and management action plans in relation to physical security of the Hospital.

5.2.9 To provide assurance to the Board that plans are in place to ensure service continuity and to provide contingencies for emergency situations.

5.2.10 To provide assurance to the Board that plans and mechanisms are in place to ensure that Fraud is properly monitored and reported.

5.3 Internal Audit

5.3.1 To review and approve the Internal Audit Annual Plan.

5.3.2 To review the adequacy of internal audit staffing and other resources.

5.3.3 To monitor audit progress and review audit reports.

5.3.4 To monitor the management action taken in response to the audit recommendations through an agreed follow-up mechanism.

5.3.5 To consider the Chief Internal Auditor’s annual report and assurance statement.

5.3.6 To review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures.

5.3.7 To review the terms of reference and appointment of the Internal Auditors.

5.4 External Audit

5.4.1 To review the Audit Plan, including the Performance Audit Programme.

5.4.2 To consider all statutory audit material, in particular:
- Audit Reports (including Performance Audit Studies);
- Annual Reports;
- Management Letters.
5.4.3 To monitor management action taken in response to all External Audit recommendations including Performance Audit Studies (following consideration by the Staff Governance Committee or Clinical Governance Committee where appropriate).

5.4.4 To review the extent of co-operation between External and Internal Audit.

5.4.5 Annually appraise the performance of the External Auditors.

5.4.6 To note the appointment and remuneration of External Auditors and to examine any reason for the resignation or dismissal of the Auditors.

5.5 **Standing Orders and Standing Financial Instructions**

5.5.1 To review changes to the Standing Orders and Standing Financial Instructions.

5.5.2 To examine the circumstances associated with each occasion when Standing Orders are waived or suspended.

5.5.3 To review the Scheme of Delegation.

5.6 **Annual Accounts**

5.6.1 To review annually (and approve) the suitability of accounting policies and treatments.

5.6.2 To review schedule of losses and compensation payments.

5.6.3 Review the reasonableness of accounting estimates.

5.6.4 Review the external auditors management letter.

5.6.5 To review and recommend approval to the Board of the Annual Accounts.

5.6.6 To report in the Directors Report on the roles and responsibilities of the Audit Committee and actions taken to discharge those.

5.6.7 To review and recommend approval to the Board of the Patients Funds Annual Accounts.

6 **AUTHORITY**

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

7 **PERFORMANCE OF THE COMMITTEE**

The Committee shall review its own performance, effectiveness, including its running costs, and terms of reference on an annual basis.

The committee shall provide guidelines and/ or pro forma concerning the format and content of the papers to be presented.

The Chairman of the Committee shall submit an Annual Report on the work of the Committee to the Board.

Subject to annual review
This revision: approved April 2015
THE STATE HOSPITALS BOARD FOR SCOTLAND

Agenda Reference: Item 15
Date of Meeting: 25 June 2015
Presented by: Audit Committee Chair
Title of Report: Report on the Annual Accounts for the year ended 31 March 2015

1 INTRODUCTION

Each year, the Board prepares its Annual Accounts in a format prescribed by the Scottish Government Health and Social Care Directorate (SGHSCD). These accounts are subject to external audit by auditors appointed by Audit Scotland (the State Hospital’s external auditors are Scott Moncrieff) to ensure that they present a true and fair view of the year.

There is a requirement to have the Annual Accounts formally adopted by the Board, certified by external audit and submitted to the Scottish Government Health and Social Care Directorate by 30 June 2015.

The purpose of this paper is to advise the Board as to the Audit Committee’s consideration of the Annual Accounts and associated recommendations.

2 EXTERNAL AUDIT

Scott Moncrieff have concluded the audit of the Annual Accounts and issued the final accounts letter and certificate. This was considered at the Audit Committee on 25 June 2015, and confirms that the Annual Accounts for the year ended 31 March 2015 will be unqualified in respect of a true and fair opinion. Their opinion on regularity is unqualified, and their report on the Board’s Governance Statement is also unqualified.

The Audit Committee considered this final accounts letter and certificate, together with the Annual Accounts, at its meeting on 25 June 2015.

The decision of the Audit Committee was to recommend to the Board that it should adopt the Annual Accounts as attached to this paper and submit them to the SGHSCD.

Key points in relation to the accounts are included in the report by the Finance and Performance Director.

3 REVIEW OF SYSTEM OF INTERNAL CONTROL

The Statutory Annual Accounts for the year 2014/15 include a Governance Statement. The system of Internal Control is based on a framework of regular management information, administrative procedures including the segregation of duties and a system of delegation and accountability.
The Governance Statement covers:

- corporate governance
- clinical governance
- staff governance
- financial governance
- information governance

Annual reports from three governance committees of the Board have been submitted to give the Board assurance in these areas.


4 STATEMENT OF HEALTH BOARD MEMBERS RESPONSIBILITIES

In addition, there remains a statement in the Annual Accounts of Health Board Members responsibilities in respect of the Accounts, which includes:

- applying on a consistent basis the accounting policies and standards approved for the NHS in Scotland by Scottish Ministers
- making judgements and estimates that are reasonable and prudent
- stating where applicable accounting standards have not been followed where the effect of the departure is material
- preparing the accounts on the going concern basis unless it is inappropriate to presume that the Board will continue to operate

The Health Board Members require to confirm that they have discharged the above responsibilities during the financial year and in preparing the accounts.

5 AUDIT COMMITTEE REMIT

In accordance with the Scottish Government guidance and its approved Terms of Reference, the Audit Committee is required to provide the Board with “a Statement of Assurance to allow the approval of the Statutory Annual Accounts”.

In recognition of this remit, the Audit Committee has received the results of the work of Internal Audit during the year 2014/15 and has considered the Annual Internal Audit Report presented by the Chief Internal Auditor.

The Committee has received reports and assurances from the Finance and Performance Director and the Chief Executive.

6 ASSURANCE STATEMENT

On the basis of work undertaken by the Audit Committee in respect of the financial year 2014/15, the Committee considers the control environment and systems of internal control to be adequate. They can be relied on by the Board in approving the signing of the Governance Statement and the Statement of Health Board Members’ Responsibility in respect of the Accounts, and the adoption of the Annual Accounts for the year ended 31 March 2015 by the Board.

7 RECOMMENDATION

The Audit Committee recommend that the Board:
Adopt the Annual Accounts for the year ended 31 March 2015 and approve submission to the Scottish Government Health and Social Care Directorate.

Invite the Chief Executive to sign the Statement of the Chief Executive’s Responsibilities as the Accountable Officer of the Board

Authorise:

a) the Chief Executive to sign the Strategic Report
b) the Chief Executive to sign the Directors’ Report
c) the Chief Executive to sign the Remuneration Report
d) the Chairperson and the Finance and Performance Director to sign the Statement of Board Members’ responsibilities in respect of the Accounts;
e) the Chief Executive to sign the Governance Statement;
f) the Chief Executive and Finance and Performance Director to sign the Statement of Comprehensive Net Expenditure and the Balance Sheet.
1 Background

1.1 The Revenue and Capital plans, and financial monitoring, are considered by the Senior Team and the Board. This report provides information on the financial performance to 31 May 2015.

1.2 The three year financial plan for 2015/16 – 2017/18 is an integral part of the Board Local Delivery Plan (LDP). The LDP is the strategic plan which sets out the agreed vision for service delivery and development for the Board, and sets out a balanced budget for 2015/16 on the basis of achieving £1.332m efficiency savings.

Savings targets budgets are recognised within the directorates at the start of the year and phased as twelfths – there may be a timing issue when savings are made and realised against these targets. Savings will be taken following quarterly financial reviews.

2 Current situation

2.1 Revenue Resource Limit Outturn

The Board is reporting an over spend of £0.010m to 31 May 2015. The favourable movement in month was mainly to do with a reduction in Nursing overtime.

<table>
<thead>
<tr>
<th>Expenditure type</th>
<th>Annual Budget £'k</th>
<th>Year to Date Budget £'k</th>
<th>Year to date Actuals £'k</th>
<th>YTD Variance (budget less actuals) for period 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Operating Income</td>
<td>(659)</td>
<td>(110)</td>
<td>(132)</td>
<td>22</td>
</tr>
<tr>
<td>Pay</td>
<td>29,570</td>
<td>4,847</td>
<td>4,734</td>
<td>112</td>
</tr>
<tr>
<td>Savings</td>
<td>(1,332)</td>
<td>(222)</td>
<td>0</td>
<td>(222)</td>
</tr>
<tr>
<td>Purchase Of Healthcare</td>
<td>823</td>
<td>137</td>
<td>137</td>
<td>(0)</td>
</tr>
<tr>
<td>Non Pay</td>
<td>4,899</td>
<td>759</td>
<td>650</td>
<td>69</td>
</tr>
<tr>
<td>Hch Income</td>
<td>(921)</td>
<td>(177)</td>
<td>(176)</td>
<td>(1)</td>
</tr>
<tr>
<td>Capital Charges</td>
<td>2,549</td>
<td>425</td>
<td>415</td>
<td>10</td>
</tr>
<tr>
<td>Total £'k</td>
<td>34,928</td>
<td>5,558</td>
<td>5,569</td>
<td>(10)</td>
</tr>
</tbody>
</table>

It should be noted that, due to the nature of the service provided by The State Hospital and the challenges which arise from the safe management of our patients, and the continuing effect of high levels of clinical intensity, all nursing gaps are filled; this therefore translates automatically into higher levels of overtime staffing.
Management of vacancies is under continued scrutiny and will contribute to the planned corporate savings. There will also be a workforce plan review in this financial year which should influence recurring savings.

2.2 Revenue Resources
Revenue allocations received (including anticipated) up to 31 May 2015 amounted to £34.928m, this ties in with the Annual Budget.

The first return due to Scottish Government is mid July for the first quarter Apr – June, so this report is condensed for that purpose.

3 Efficiency Savings Target

3.1 To balance the financial plan in 2015/16 the Board was required to release £1.332m of cash from budgets through efficiency savings. Savings will be taken following the first quarter review (Apr – June position). As noted in 1.2, savings will be recognised quarterly.

The table below demonstrates this.

<table>
<thead>
<tr>
<th></th>
<th>R or NR</th>
<th>LDP £'k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Savings - Recurring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce - Pay Non Recurring</td>
<td>NR</td>
<td>544</td>
</tr>
<tr>
<td>Workforce - Pay Recurring</td>
<td>R</td>
<td>369</td>
</tr>
<tr>
<td>Non Pay Non Recurring (part handback)</td>
<td>NR</td>
<td>224</td>
</tr>
<tr>
<td>Non Pay Recurring</td>
<td>R</td>
<td>175</td>
</tr>
<tr>
<td><strong>Savings Total</strong></td>
<td></td>
<td><strong>1,332</strong></td>
</tr>
</tbody>
</table>

4 Capital Resource Limit

4.1 The Board has a Capital Resource Limit of £0.300m – the table below.

<table>
<thead>
<tr>
<th></th>
<th>Annual Plan £'k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Equipment</td>
<td>25</td>
</tr>
<tr>
<td>IM&amp;T</td>
<td>100</td>
</tr>
<tr>
<td>Vehicles</td>
<td>25</td>
</tr>
<tr>
<td>Other equipment</td>
<td>150</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>300</strong></td>
</tr>
</tbody>
</table>

5 CONCLUSION

5.1 Revenue
It should be noted that we have forecast a breakeven position for 2015/16, with the included benefit of the £0.090m under spend from the year to March 2015 carried forward. A sum greater than this, however, may well be required for the next stage of the legal process with regard to the non smoking appeal.
All departments undergo ongoing scrutiny for identification of savings to be achieved in order to reach required targets; monthly meetings between Head of Management Accounts and Directors/budget holders, with quarterly reviews involving the Finance and Performance Management Director will allow negotiations for savings to be taken.

A financial plan action list is also updated by the Head of Management Accounts following monthly budget meetings to eliminate any surprise element and to evaluate expected pressures and benefits to make the Finance and Performance Management Director and Chief Executive aware of the effects on the financial outturn; and to compare with the LDP trajectory.

5.2 **Capital**
It is expected that the allocation will be utilised in 2015/16 and a breakeven position is forecast.

6 **RECOMMENDATION**

The Board is asked to **note** the content of the report.
1 INTRODUCTION

This report presents a high level summary of organisational performance for the year from April 2014 until March 2015 and is based on the Local Delivery Plan (LDP) and its associated targets and measures. The data for Q1-Q4 are reported to present an overview of performance over the year (Appendix 1).

The figures from the previous two years have been included for comparison. The comparisons between the years have been made on the same periods – annual data against annual data, rolling figures against rolling figures etc (Appendix 2).

2 COMMENTARY ON PERFORMANCE OVER THE PERIOD (Appendix 1)

We have maintained good levels of performance in many areas but performance in the following areas merit comment:

- **No 4 Annual Physical Health Review and No 12 Access to Primary Care** – the Health Centre consistently meets its targets.

- **No 6 Healthier BMI**: as previously reported to the Board our performance against we are not meeting our target Healthier BMI of 25% with only 7% of patients being within a normal range.

- **No 7 Sickness absence**. This has remained higher than the local target of 5% throughout the year.

- **No 10 Staff have an approved PDP**. This has improved from 70.3% in Q1 to 86.8% in Q4. Performance against the target of 100% continues to be closely monitored by the SMT.

- **No 8 Reduction in CO2 and No 9 Reduction in Energy Consumption**. We have consistently achieved reductions well in excess of the targets set nationally.

- **No 16 Patients will have their clinical risk assessment review annually**. Following the introduction of new measures by Health Records and Clinical Effectiveness, performance has improved over the year from 79.5% in Q1 to 84% in Q4 although we are not yet meeting our 100% target.

- **No 17: Attendance by clinical staff at case reviews**. RMOs attended 98% of case reviews in Q4 and the attendance of key workers remained close to the target of 80% throughout the year. The attendance of Clinical Psychologists has dropped to 57.1% this quarter compared to 86.2% in Q3, although representatives of the wider Psychological Therapy Service attended >92% of case reviews throughout the year. Social Work attendance has also dropped to 63.3% in Q4 from 75.9% in Q3. Security attendance has
improved to 57.1%, approaching their target of 60%. The attendance of Occupational Therapists has fallen again to 67.3% and remains below their target of 80%. Staff from the Skye Centre have begun to attend case reviews registering an attendance figure of 18.4% in Q4 - no target has yet been set.

3 COMPARISON OF PERFORMANCE OVER 3 YEARS (14/15, 13/14, 12/13) (Appendix 2)

Due to the low number of patients, natural variations in the population can have an effect on the sample and small changes in our KPI figures can look more significant when presented as percentages. Bearing these limitations in mind the table at Appendix 2 provides a comparison with the previous year’s figures.

For many of the indicators there have been only small variations in performance over the years and consistently high levels have been maintained.

4 LOCAL DELIVERY PLAN (LDP) CONSULTATION EVENT

As part of the annual Local Delivery Plan review staff were invited to attend a consultation event to consider both the LDP and Key Performance Indicators.

This event was held in February. There were 3 presentations:

- Local Delivery Plan 2015 Consultation – Robin McNaught
- Key Performance Indicators: performance in the year to date – Angela Robertson
- Patients’ Day: findings from the review – Mark Richards

Participants took part in workshop sessions during which they could comment on any aspect of the LDP and KPIs. However, the groups were asked to focus on these specific issues:

- The lack of reliable patient activity data to populate KPIs (off-hub, meaningful activity and physical exercise).
- The need to replace the community meeting KPI which is obsolete following changes to these meetings. Are there better indicators of person centeredness?
- Our difficulty meeting our healthier BMI target -what indicators would reflect our efforts to prevent obesity and promote a healthy diet?

A paper outlining the feedback from this Consultation Event with proposals for the development of performance reporting in these areas has been prepared for the Senior Management Team and progress will be reported to the Board.

4 RECOMMENDATION

The Committee is asked to note the contents of this report.
## Key Performance Indicators

**2014/15: Comparison across Q1-4**

<table>
<thead>
<tr>
<th>Item</th>
<th>Code</th>
<th>Principles</th>
<th>Performance Indicator</th>
<th>Target</th>
<th>30 June</th>
<th>30 Sept.</th>
<th>31 Dec.</th>
<th>31 March</th>
<th>LEAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>H</td>
<td>8</td>
<td>Patients have their care and treatment plans reviewed at 6 monthly intervals</td>
<td>100%</td>
<td>95</td>
<td>93</td>
<td>97</td>
<td>92</td>
<td>LT</td>
</tr>
<tr>
<td>2</td>
<td>H</td>
<td>8</td>
<td>Patients will be engaged in psychological treatment</td>
<td>90%</td>
<td>82.5</td>
<td>80.3</td>
<td>92.6</td>
<td>90.8</td>
<td>MS</td>
</tr>
<tr>
<td>3</td>
<td>H</td>
<td>8</td>
<td>Patients will be engaged in off-hub activity centres</td>
<td>90%</td>
<td>77</td>
<td>82</td>
<td>87</td>
<td>82</td>
<td>MR</td>
</tr>
<tr>
<td>4</td>
<td>H</td>
<td>8</td>
<td>Patients will be offered an annual physical health review</td>
<td>90%</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>LT</td>
</tr>
<tr>
<td>5</td>
<td>H</td>
<td>8</td>
<td>Patients will undertake 90 minutes of exercise each week (Annual Audit)</td>
<td>60%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>MR</td>
</tr>
<tr>
<td>6</td>
<td>H</td>
<td>8</td>
<td>Patients will have a healthier BMI (bi-annual audit)</td>
<td>25%</td>
<td>12.1</td>
<td>-</td>
<td>7</td>
<td>-</td>
<td>LT</td>
</tr>
<tr>
<td>7</td>
<td>E</td>
<td>5</td>
<td>Sickness absence (National HEAT standard is 4%)</td>
<td>** 5%</td>
<td>5.74</td>
<td>5.72</td>
<td>5.89</td>
<td>6.0</td>
<td>BN</td>
</tr>
<tr>
<td>8</td>
<td>E</td>
<td>5</td>
<td>Reduction in CO2 emissions for fossil fuels</td>
<td>** -14.13%</td>
<td>-81.95</td>
<td>-83.41</td>
<td>-69.66</td>
<td>-56.93</td>
<td>DI</td>
</tr>
<tr>
<td>9</td>
<td>E</td>
<td>5</td>
<td>Reduction in energy consumption</td>
<td>** -4.9%</td>
<td>-37.32</td>
<td>-37.8</td>
<td>-25.98</td>
<td>-13.67</td>
<td>DI</td>
</tr>
<tr>
<td>10</td>
<td>E</td>
<td>5</td>
<td>Staff have an approved PDR</td>
<td>*100%</td>
<td>70.3</td>
<td>68.1</td>
<td>73</td>
<td>86.8</td>
<td>BN</td>
</tr>
<tr>
<td>11</td>
<td>A</td>
<td>1, 3</td>
<td>Patients transferred/discharged using CPA</td>
<td>100%</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>Social work</td>
</tr>
<tr>
<td>12</td>
<td>A</td>
<td>1, 3</td>
<td>Patients requiring primary care services will have access within 48 hours</td>
<td>*100%</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>LT</td>
</tr>
<tr>
<td>13</td>
<td>A</td>
<td>1, 3</td>
<td>Patients will commence psychological therapies &lt;18 weeks from referral date</td>
<td>**100%</td>
<td>99</td>
<td>99</td>
<td>100</td>
<td>99</td>
<td>MS</td>
</tr>
<tr>
<td>14</td>
<td>A</td>
<td>1, 3</td>
<td>Patients will engage in meaningful activity on a daily basis</td>
<td>100%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>MR</td>
</tr>
<tr>
<td>15</td>
<td>T</td>
<td>2, 6, 7, 9</td>
<td>Patients have their clinical risk assessment reviewed annually</td>
<td>100%</td>
<td>79.5</td>
<td>93</td>
<td>93</td>
<td>94</td>
<td>LT</td>
</tr>
<tr>
<td>16</td>
<td>T</td>
<td>2, 6, 7, 9</td>
<td>Hubs have a monthly community meeting</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>SM</td>
</tr>
<tr>
<td>17</td>
<td></td>
<td></td>
<td>Refer to next table.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>All Clinical Leads</td>
</tr>
</tbody>
</table>

---

*Key Performance Indicators (KPIs) are metrics used to measure the success of an organization, project, or business strategy.*
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>T</td>
<td>2, 6, 7, 9</td>
<td>Attendance by all clinical staff at case reviews</td>
<td>RMO (LT)</td>
<td>90%</td>
<td>87.5%</td>
<td>98.1%</td>
<td>94.8%</td>
<td>98%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medical (LT)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>98.3%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Key Worker/Assoc Worker (SM)</td>
<td>80%</td>
<td>76.6%</td>
<td>77.4%</td>
<td>79.3%</td>
<td>79.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Nursing (SM)</td>
<td>100%</td>
<td>94.7%</td>
<td>94.3%</td>
<td>94.8%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>OT (MR)</td>
<td>80%</td>
<td>85.7%</td>
<td>75.5%</td>
<td>70.7%</td>
<td>67.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pharmacy (LT)</td>
<td>60%</td>
<td>78.6%</td>
<td>66%</td>
<td>77.6%</td>
<td>69.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Clinical Psychologist (MS)</td>
<td>60%</td>
<td>71.4%</td>
<td>64.2%</td>
<td>86.2%</td>
<td>57.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Psychology (MS)</td>
<td>100%</td>
<td>96.4%</td>
<td>92.4%</td>
<td>96.5%</td>
<td>95.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Security (DI)</td>
<td>60%</td>
<td>62.5%</td>
<td>58.5%</td>
<td>48.3%</td>
<td>57.1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Social Work</td>
<td>80%</td>
<td>83.9%</td>
<td>66.0%</td>
<td>75.9%</td>
<td>63.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Skye Activity Centre (MR)</td>
<td>tbc</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>18.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dietetics (MR)</td>
<td>tbc</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

* denotes national target; ** denotes HEAT target

Note 1 – recently admitted patients are not included in this calculation.
Note 2 - We await further information on how the errors identified in the statistics reported nationally are to be addressed.
Note 3 – All patient activity indicators are being reviewed by the Patients’ Day Project with a view to providing a more complete record of meaningful activity for all patients.
<table>
<thead>
<tr>
<th>Item</th>
<th>Code</th>
<th>Principles</th>
<th>Performance Indicator</th>
<th>Target</th>
<th>RAG</th>
<th>14/15</th>
<th>13/14</th>
<th>12/13</th>
<th>LEAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>H</td>
<td>8</td>
<td>Patients have their care and treatment plans reviewed at 6 monthly intervals</td>
<td>100%</td>
<td>A</td>
<td>92%</td>
<td>97%</td>
<td>95%</td>
<td>LT</td>
</tr>
<tr>
<td>2</td>
<td>H</td>
<td>8</td>
<td>Patients will be engaged in psychological treatment</td>
<td>90%</td>
<td>G</td>
<td>90.8%</td>
<td>93%</td>
<td>96.9%</td>
<td>MS</td>
</tr>
<tr>
<td>3</td>
<td>H</td>
<td>8</td>
<td>Patients will be engaged in off-hub activity centres</td>
<td>90%</td>
<td>A</td>
<td>82%</td>
<td>74%</td>
<td>83%</td>
<td>MR</td>
</tr>
<tr>
<td>4</td>
<td>H</td>
<td>8</td>
<td>Patients will be offered an annual physical health review (AHR).</td>
<td>90%</td>
<td>G</td>
<td>100%</td>
<td>(78.8% uptake)</td>
<td>100%</td>
<td>(82% uptake)</td>
</tr>
<tr>
<td>5</td>
<td>H</td>
<td>8</td>
<td>Patients will undertake 90 minutes of exercise each week (Annual Audit)</td>
<td>60%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>66%</td>
<td>MR</td>
</tr>
<tr>
<td>6</td>
<td>H</td>
<td>8</td>
<td>Patients will have a healthier BMI</td>
<td>25%</td>
<td>RI</td>
<td>7%</td>
<td>12%</td>
<td>14%</td>
<td>RC</td>
</tr>
<tr>
<td>7</td>
<td>E</td>
<td>5</td>
<td>Sickness absence (National HEAT standard is 4%)</td>
<td>** 5%</td>
<td>R</td>
<td>5.96%</td>
<td>6.19%</td>
<td>5.16%</td>
<td>DI</td>
</tr>
<tr>
<td>8</td>
<td>E</td>
<td>5</td>
<td>Reduction in CO2 emissions for fossil fuels</td>
<td>** -14.13%</td>
<td>G</td>
<td>-63.02% (emissions up 0.21% on 13/14)</td>
<td>-</td>
<td>Figures for April 2014 - March 2015. Reduction measured against the baseline year of 2009/2010. Please note that these figures have not yet been verified nationally.</td>
<td>DI</td>
</tr>
<tr>
<td>9</td>
<td>E</td>
<td>5</td>
<td>Reduction in energy consumption</td>
<td>** -4.9%</td>
<td>G</td>
<td>-17.09% (consumption up 12.6% on 13/14)</td>
<td>-</td>
<td>Problems with the biomass boiler resulted in increased oil consumption. Protracted period of poor weather may also have led to increased use of heating and lighting in dull conditions. However, we continue to exceed the targets set.</td>
<td>DI</td>
</tr>
<tr>
<td>10</td>
<td>E</td>
<td>5</td>
<td>Staff have an approved PDP</td>
<td>*100%</td>
<td>A</td>
<td>86.8%</td>
<td>83.6%</td>
<td>65%</td>
<td>RC</td>
</tr>
<tr>
<td>11</td>
<td>A</td>
<td>1, 3</td>
<td>Patients transferred/discharged using CPA</td>
<td>100%</td>
<td>G</td>
<td>100%</td>
<td>98%</td>
<td>100%</td>
<td>Social Work</td>
</tr>
<tr>
<td>12</td>
<td>A</td>
<td>1, 3</td>
<td>Patients requiring primary care services will have access within 48 hours</td>
<td>*100%</td>
<td>G</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>LT</td>
</tr>
<tr>
<td>13</td>
<td>A</td>
<td>1, 3</td>
<td>Patients will commence psychological therapies &lt;18 weeks from referral date</td>
<td>**100%</td>
<td>G</td>
<td>&gt;99%</td>
<td>&gt;99%</td>
<td>100%</td>
<td>MS</td>
</tr>
<tr>
<td>14</td>
<td>A</td>
<td>1, 3</td>
<td>Patients will engage in meaningful activity on a daily basis</td>
<td>100%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>MR</td>
</tr>
<tr>
<td>15</td>
<td>T</td>
<td>2, 6, 7, 9</td>
<td>Patients have their clinical risk assessment reviewed annually.</td>
<td>100%</td>
<td>A</td>
<td>94%</td>
<td>92%</td>
<td>98%</td>
<td>LT</td>
</tr>
<tr>
<td>16</td>
<td>T</td>
<td>2, 6, 7, 9</td>
<td>Hubs have a monthly community meeting.</td>
<td>100%</td>
<td>-</td>
<td>-</td>
<td>98%</td>
<td>92%</td>
<td>SM</td>
</tr>
<tr>
<td>17</td>
<td>T</td>
<td>2, 6, 7, 9</td>
<td>Attendance by all clinical staff at case reviews Refer to Table above (appendix 1) for targets by profession</td>
<td>See above</td>
<td>-</td>
<td>60% overall</td>
<td>63% overall</td>
<td>71% overall</td>
<td>All Leads</td>
</tr>
</tbody>
</table>
1 BACKGROUND

The items noted below highlight issues in the Hospital, which do not feature on the Board’s formal agenda.

2 GENERAL ISSUES OF NOTE

The Chief Executive will provide the Board with a verbal update on the following issues:

- Feedback on NHS Scotland Event 23 and 24 June
- Planned visits by David Strang former Chief Inspector of Prisons 8 July and Lauren Murdoch Head of Mental Health Unit Scottish Government 16 July

2 PATIENT SAFETY UPDATE

We continue to progress our local programme of activity across the five agreed national workstream areas under the stewardship of the Patient Safety Steering Group. Current activity includes, but is not exclusive to:

- Phase 3 of ‘Leadership Walkrounds’ well underway: Non Executives now participating. Full evaluation of impact later in the year. Regular review of progress with resultant actions now in place.
- Pre-weekend safety briefings introduced in May 2015 for all on-site and on-call Managers and Directors. Progressing well and for full review in August.
- Plans being developed for the second run of the Staff Safety Climate Tool for August 2015.
- Post incident debrief protocol being developed to improve practice. Mull Hub carried out early pilot work; this has now been evaluated. Further alterations being made before roll out.

Review standard of risk assessments on admission – project underway, excellent results regarding timescales and quality through first quarter of the year.

Work has also begun on how as a Board we develop a wider and sustainable approach to Quality Improvement that includes the Patient Safety Programme. Further reports on this will come to the Board in due course.
3 HEALTHCARE ASSOCIATED INFECTION (HAI)

The main points of note regarding HAI activity since the last Board meeting are:

The Annual Programme of Work, approved by the Board, is rolling out on target. This includes the annual audit programme and educational programmes.

New National Infection Control Standards were introduced across the NHSiS in February of this year. All NHS Boards were required to complete a self-assessment against these new standards by 12 June 2015. The State Hospital HAI and Clinical Effectiveness staff completed this and it was signed off by myself and Stephen Milloy and submitted on time. This will be used by HEI Inspectorate in advance of any future inspection.

Board members will recall Stephen Milloy presented a paper on the Vale of Leven Inquiry Report at a previous Board meeting and the need for us to respond, but proportionately.

In the months since, we have identified 15 recommendations (from the 75 in the report) where we could improve on practice.

From the 15 identified, 13 are now complete; the final two are well progressed but not yet complete.

A progress report was again requested of all NHS Boards by the Scottish Government by 24 June 2015. This was submitted earlier this week.

4 RECOMMENDATION

The Board is invited to note the content of the Chief Executive’s report.