THE STATE HOSPITALS BOARD FOR SCOTLAND

Meeting of The State Hospitals Board for Scotland to be held on Thursday 29 June 2017 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 meetings held on 4 May 2017
   - Chair

4. Action Points and Matters Arising from Minutes of previous meetings
   - Chair

CLINICAL GOVERNANCE:

5. Skye Centre Annual Report
   - Report by Director of Nursing and AHP
   - For Consideration

6. Annual Report of Clinical Governance Committee for year ended 31 March 2017
   - Report by Chair of Committee
   - For Approval

7. Clinical Governance Committee Meeting held on 11 May 2017
   - Draft Minutes – Chair of Committee
   - For Noting

8. Safety and Protection of Patients, Staff and Volunteers in NHSScotland DL (2017) 07
   - Report by Director of Nursing and AHP
   - For Noting

STAFF GOVERNANCE:

9. Workforce Plan 2016-2021
   - Report by Chief Executive
   - For Approval

10. Annual Report of Staff Governance Committee for year ended 31 March 2017
    - Report by Chair of Committee
    - For Approval

11. Annual Report of Remuneration Committee for year ended 31 March 2017
    - Report by Chair of Committee
    - For Approval

12. Staff Governance Committee Meeting held on 1 June 2017
    - Draft Minutes – Chair of Committee
    - For Noting

/...
**CORPORATE GOVERNANCE:**

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<tr>
<th></th>
<th>Item Description</th>
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<th>Type</th>
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<td>13</td>
<td>Annual Report of the Audit Committee for year ended 31 March 2017</td>
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<td>Report on the Annual Accounts for year ended 31 March 2017</td>
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<td>Property and Asset Management Strategy (PAMS) 2017-2022</td>
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<td>Chief Executive's Report</td>
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<tr>
<td>20</td>
<td>Any Other Business</td>
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<tr>
<td>21</td>
<td><strong>Date and Time of next meeting</strong></td>
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<td></td>
<td>Thursday 24 August 2017 at 9.45am in the Boardroom, The State Hospital</td>
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<td>22</td>
<td>Exclusion of Public and Press</td>
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*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 4 May 2017 at 9.45am in the Boardroom, The State Hospital, Carstairs.

Present:
Chair                Terry Currie
Employee Director    Anne Gillan
Non Executive Director Nicholas Johnston
Non- Executive Director Maire Whitehead
Chief Executive      James Crichton
Finance and Performance Management Director Robin McNaught
Director of Nursing and Allied Health Professions Mark Richards
Medical Director     Lindsay Thomson

In attendance:
Mental Health Manager for Social Work Service Kathy Blessing
Security Director    Doug Irwin
Board Secretary      Jean Wade
Interim HR Director  John White

Observing:
Board Member, Patient Advocacy Services Anne Swann

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Apologies were received from Bill Brackenridge, Elizabeth Carmichael and Caroline McCarron. Terry Currie welcomed everyone to the meeting and introduced John White to his first meeting of the Board in his capacity as Interim HR Director and Anne Swann, who was attending as an observer.

Members noted an update from Terry Currie on the main issues discussed at the last Senior Leaders Forum on 22 February 2017.

This related to the request from Paul Gray for Chief Executive’s to declare an interest, if appropriate, in assuming a leadership position with regard to East, West and North Regions and for National Boards. Those taking up those roles would become Members of the National Programme Board for the delivery of the Health and Social Care Plan.

Discussion at the main session centred around Population Health Improvement and presentations were received on the constituent parts of Primary Care, Mental Health, Health Improvement and Public Health. In terms of Primary Care, and on the eve of agreeing a new contract, there was a view that there were a number of lessons to be learned from the 2004 GP contract.

The Quality Outcomes Framework did not improve outcomes; Out of Hours costs were greater than anticipated; and there was mixed evidence on whether the large increase in practice income helped the recruitment challenge. Members noted that there is now a distinctive Scottish approach in this area of collaboration and co-production and that there would be a national core role and maximum local flexibility for additional services.

Penny Curtis highlighted three ambitions which will feature in the new Mental Health Strategy - Prevention and Early Intervention; Joined Up Accessible Services which will respond early; and Tackling the Early Deaths situation.
Within Public Health, the focus is on developing a high level framework of Public Health Priorities for Scotland. The framework referred to three specific fields of activity:

- People, eg tackling obesity
- Places and Culture, eg poverty and life expectancy
- Systems, eg housing and education

Terry Currie stated that the Health and Social Care Delivery Plan, published in December 2016, referenced the significant challenges for NHS Scotland and the presentations received at the Senior Leaders Forum were the first indications of how it would play its part in meeting these challenges.

Terry Currie also provided a summary of the main points of the NHS Chairs meeting with the Cabinet Secretary held on 20 March 2017.

This related to the Health and Social Care Delivery Plan and the establishment of the National Programme Board, following expressions of interest from Chief Executives to undertake the roles of national and regional implementation leads. (The appointments have now been made and were referred to in item 9 of today’s agenda). The Cabinet Secretary had confirmed that she was pleased with the progress on Health and Social Care Integration.

Other issues discussed related to the forthcoming publication of the 10 year Mental Health Strategy (now published and on today’s agenda at item 6), and the exercise on reviewing Targets which was being led by Sir Harry Burns, the final report on which was due in May 2017.

2 CONFLICTS OF INTEREST

Other than those declared at earlier meetings, no other 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 9 February 2017 were approved as an accurate record.

4 ACTION POINTS FROM PREVIOUS MEETING AND MATTERS ARISING

All actions were completed or progressing satisfactorily.

5 TEMPORARY WARD CLOSURE – PROGRESS UPDATE

Members received a report from Mark Richards which provided an update on the temporary closure of Mull 3 on Wednesday 12 April 2017.

Mark Richards summarised the report and Members noted the actions taken to achieve the closure; the numbers of patients and staff affected; the monitoring of bed occupancy; the contingency arrangements identified to manage bed pressures; the engagement with internal and external partners and opportunities for further learning from this process.

Discussion took place on a number of issues in relation to the effective completion of the closure and the lessons that had been learned from the closure of Arran 3; the importance of monitoring of savings and benefits and the work underway to capture this information; the recent incidents which have had an impact on the savings and benefits expected by this time; the contingency plans in place to re-open Mull 3 should this be required; and the subsequent impact on activity in the Skye Centre which it would be interesting to hear about at the next meeting.

**Action:** Mark Richards

Members noted the successful temporary closure of Mull 3, the planning to mitigate against the risk of bed pressure, and the intention to evaluate and report the experience of patients and staff affected by this change.
Members received a report from Lindsay Thomson in respect of the Mental Health Strategy 2017-2027 which had been published by Scottish Government in March 2017 and replaced the previous Mental Health Strategy for 2012-2015.

Lindsay Thomson advised that the Strategy included 40 actions covering Prevention and Early Intervention; Access to Treatment and Joined Up, Accessible Services; the Physical Wellbeing of People with Mental Health Problems; Rights, Information Use and Planning, Data and Measurement; and that the Hospital had ambitions linked with all of these areas.

The implications and actions that may have implications for The State Hospital and the Forensic Network were summarised and noted.

A number of issues were discussed in relation to supporting mental health in the workplace and the importance of including this in any Hospital projects going forward; and the system in place for young offenders in Scotland. It was noted that the Forensic Network Review was not referred to within the Mental Health Strategy.

In relation to the proposed refreshed Justice Strategy, noted at Action 10 of the new Mental Health Strategy, the importance of Mental Health playing a part in the Justice Strategy was emphasised. Lindsay Thomson would ensure the Board’s views on this would be communicated through the various existing links and channels.

Action: Lindsay Thomson

Members noted the Mental Health Strategy 2017-2027.

7 PREVENT UPDATE

Members received a report from Doug Irwin which provided an update on PREVENT, one of the four strands of the UK Government’s counter-terrorism strategy CONTEST, and in which NHSScotland and NHS Boards continued to participate and take forward.

It was noted that during the year, lead responsibility for PREVENT was delegated to the Security Director who had organisational resilience within his remit. The PREVENT Policy was approved in May 2016 with minor changes required to ensure The State Hospital/Social Work alignment of systems.

There had been no reported incidents or events over the past 12 months; communication continued with Scottish Government NHSScotland Resilience Unit by means of quarterly reporting on PREVENT activity; and that 25% of clinical staff and 54% of non-clinical staff had undergone WRAP training at the Hospital.

Members noted the content of the PREVENT Update.

8 CLINICAL GOVERNANCE COMMITTEE MEETING HELD ON 9 MARCH 2017

Members received the draft Minutes of the Clinical Governance Committee meeting held on 9 March 2017 from Nicholas Johnston who summarised key points of the discussion that had taken place.

This related to a number of annual reports received, including Clinical Forum and Psychological Therapies; and the Forensic Medium and High Secure Care Standards. He also referred to the discussion item on the Forensic Network Review which had not yet been published.

Members noted the Minutes of the Clinical Governance Committee meeting held on 9 March 2017.
9 NATIONAL BOARDS JOINT DELIVERY WORK STREAMS AND HR SHARED SERVICES UPDATE

Members received a report from Jim Crichton which provided an update on discussions he has had with Chief Executives of the other National Boards on how they would work collaboratively to support the National Integration Delivery Plan.

It was noted that the requirement to plan on a cross Board basis had been underpinned by the additional efficiency target of £15m recurring and the appointments made by Paul Gray of Lead Chief Executives to both the Regional Planning structures and the National Boards. Details of the appointments were included in the report.

Members noted that there was an expectation that a single shared LDP would be developed across the National Boards by September 2017 to set out a plan to deliver on the £15m efficiency saving, based on a programme of redesign. Finance Directors had been working closely to identify common areas across the National Boards that would yield efficiencies through collaborative approaches and initial scoping had been undertaken in relation to various service areas.

It was recognised that each of the Boards would require to make a non-recurring contribution to the £15m efficiency saving in 17-18 as it would take time for any initiatives to impact on a recurring basis. The Hospital was working on an initial assumption of £440k non recurring contribution.

In terms of the work undertaken to review HR services across the Boards, Members noted that a number of potential options, developed with local staff, had been produced and considered.

A summary of the discussion with NHS Chairs on 27 March was noted and confirmed that the Chairs were content with the progress made so far. Jim Crichton confirmed that wider representation from Boards would be invited to a full day session on 5 June to further develop the opportunities and priorities.

The challenges going forward were acknowledged. Members also acknowledged the importance of ensuring work was being done jointly and that Staff Side were engaged in the process.

Members noted the progress made to date on the development of the National Boards Joint Delivery Work Stream.

10 STAFF GOVERNANCE COMMITTEE MEETING HELD ON 2 MARCH 2017

Members received the draft Minutes of the Staff Governance Committee meeting held on 2 March 2017 from Terry Currie who summarised some of the discussion that had taken place.

This related to reports the Committee had received that included an i-Matter Update and Implementation Plan confirming that this exercise would now be delivered once a year for all staff in the Hospital as of 1 May 2017; EASY Implementation and the first phase which commenced on 1 April 2017 with no issues of concern reported; and Attendance Management which continued to be the main focus of the Committee. In view of the significant length of time the Committee had been trying to resolve attendance management issues, consideration had been given to sourcing external expertise. It had been agreed to review the position at the end of August 2017 should no material improvement be evident.

Members noted the Minutes of the Staff Governance Committee meeting held on 2 March 2017.

11 ANNUAL REVIEW OF STANDING DOCUMENTATION

Members received a report from Robin McNaught which provided an update on proposed changes to Standing Documentation.

The report proposed one amendment to the Standing Financial Instructions; two amendments to
the Scheme of Delegation and no amendments to the Standing Orders. Details of proposed amendments were outlined, all of which were considered as minor.

Members approved the review of the Standing Documentation and the proposed changes.

12 STATE HOSPITAL DRAFT SERVICE STRATEGY – PROGRESS UPDATE

Members received a report from Jim Crichton which provided an update on progress and feedback on a leadership engagement event in March 2017 which focussed on the strategic priorities for the service. The issues raised would provide an opportunity to further develop the Draft Service Strategy before all staff engagement in May 2017.

Jim Crichton summarised the content of the leadership engagement event at which participants were asked to share their views on the Strengths, Weaknesses, Opportunities and Threats facing the organisation and the key themes from their views were set out as well as the Actions to be taken forward from the event.

A number of issues of the report were discussed in relation to the weaknesses identified; and the development programme underway as part of the Nursing Leadership changes.

Jim Crichton would follow up the various suggestions put forward for inclusion in the final document in terms of storytelling, staff attitudes, patients' views and to have a more engaging narrative for staff.

Action: Jim Crichton

It was noted that the event had been very positive and that there was more work to be done on the Strategy before it was returned to the Board for approval.

Members noted the excellent consideration and feedback from the event, the progress to date and that the next step would be to engage the wider staff, patient and carer groups on the draft Strategy.

13 DRAFT LOCAL DELIVERY PLAN (LDP) 2017-2020 – UPDATE

Members received a report from Robin McNaught which confirmed that the LDP includes a summary of the financial plan for the three years to 2019-20, the full detail of which was the subject of a separate submission to Scottish Government. For each year, The State Hospital was required to set a balanced budget as set out in the LDP.

Robin McNaught referred to the changes in the structure of the LDP. As well as reflecting the much greater collaboration of National Boards, it gives greater focus to strategy and provides clearer linkages between the Board’s priorities and the 2020 Vision.

It was noted that the LDP was submitted to Scottish Government in draft by the required deadline of 31 March 2017, with final submission for sign-off due by 30 September 2017. It would be clear at that point whether the submission was to be Board specific, or combined for the eight National Boards or for both.

Feedback on the draft narrative was awaited from the Board’s Finance Lead at Scottish Government Health and Social Care Directorate.

While today's approval of the draft plan was to be noted, the Board would be asked at a future meeting either to approve the final LDP for sign-off or to delegate authority to the Chair, the Chief Executive and the Finance and Performance Management Director to sign off the LDP when due for final submission in September.

Following discussion the Board agreed the following amendments to the draft plan:
- The new Mental Health Strategy should be referred to within the LDP
- The Board’s endorsement of the Healthy Choices Strategy should be highlighted
- The implications of the return of two senior managers who have been on secondment should be noted.

Members noted the draft LDP and that a further update would be provided by the meeting of 24 August 2017 with regard to the submission of the final document.

14 FINANCE REPORT AS AT 31 MARCH 2017

Members received the Finance Report as at 31 March 2017 from Robin McNaught who summarised the information provided.

He was pleased to report that the draft unaudited financial position at the year end, as presented in the paper, achieved the aim of a break-even position on the revenue budget ending with a small underspend of £50k. The savings target for the year was also achieved which Robin McNaught confirmed was of great credit to the effort of many of the budget holders.

Members noted that despite the continuing over-riding adverse variance of nursing overtime, the reviews in the final quarter identified sufficient levels of savings to overcome this. The overtime and nursing staff costs remained the key issue into 2017-18 and this must be the focus to ensure operational steps were taken to have this addressed.

The savings requirement in 2017-18 was higher than in 2016-17 and the pressure on budget holders continues accordingly. Should overtime not reduce from current levels, there was the likelihood that savings identified by other Directorates categorised as ‘higher risk’ would require implementation.

The Capital resource limit had a small overspend in 2016-17, principally due to IT project work on the network replacement for which a transfer was agreed from the revenue budget. A review was underway of 2017-18 capital priorities in line with the anticipated budget allocation to meet the Board’s needs.

Finally, Members noted that the year end external audit would begin next week for approval of the annual report and accounts.

Members noted the Finance Report to 31 March 2017 and that a breakeven position was achieved, as expected. The Board also endorsed Robin McNaught’s comments on the efforts of budget holders in achieving the savings required.

15 AUDIT COMMITTEE MEETING HELD ON 23 MARCH 2017

Members received draft Minutes of the Audit Committee meeting held on 23 March 2017 from Robin McNaught who summarised the key points of the discussions that had taken place.

This related to the Follow-up of audit recommendations, an area of which the Committee has a strong focus, and while progress made was acknowledged, this would continue to be monitored closely; the update of Fraud matters which had no areas of specific concern; the update received on the Corporate Risk Register; various internal audit reports on Sickness Absence, Staff Scheduling, and Interim External Audit; and the Standing Documentation, Accounting Policies and Committee Terms of Reference which had all been reviewed.

Robin McNaught also advised that with effect from 1 April, the Board’s new Internal Auditors were RSM UK.

Members noted the Minutes of the Audit Committee meeting held on 23 March 2017.
Members received a report from Jim Crichton on the Hospital’s website traffic using Google Analytics, covering the period 1 April 2016 to 31 March 2017.

Members noted the interesting data set out and that there had been over 21,000 visits to the website during the 12 month period under review

Members noted The State Hospital Web Traffic Report 2016-17.

Members received a report from Jim Crichton, which reported progress on Patient Safety; Healthcare Associated Infection (HAI); Patient Admission/Discharges and CIR Reviews extended beyond the three month target completion date.

Jim Crichton also provided a verbal update on a range of general issues in relation to Supporting the Implementation of the Health & Social Care Delivery Plan; Security Update Initial Agreement Approval Letter from Paul Gray; an Update on the Significant Incidents Involving Staff Injuries; Phase 1 Implementation of the EASY Staff Support System; the Temporary Closure of Ward 3 in Mull, and the Supreme Court Judgment on McCann v The State Hospital.

Members noted the Chief Executive’s report.

Members noted that a demo model of the Patient Movement and Tracking System (PMTS) had been set up in Harris. Doug Irwin explained the benefits this would bring to the process of patient movement across the site.

The next meeting would take place on Thursday 29 June 2017 at 1.00pm in the Boardroom, The State Hospital, Carstairs.

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

29 June 2017
MINUTE ACTION POINTS  
FROM THE MEETING OF THE STATE HOSPITALS BOARD FOR SCOTLAND HELD ON 4 MAY 2017

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<th>ITEM</th>
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<tr>
<td>1</td>
<td>5</td>
<td>Temporary Ward Closure – Update</td>
<td>An update on the subsequent impact on activity in the Skye Centre would be provided at the next meeting.</td>
<td>Mark Richards</td>
<td>Next Meeting</td>
<td>Next Meeting</td>
</tr>
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<td>2</td>
<td>6</td>
<td>Mental Health Strategy 2017-2027</td>
<td>The Board’s views on the importance of Mental Health playing a part in the Justice Strategy would be communicated through the various existing links and channels.</td>
<td>Lindsay Thomson</td>
<td>Ongoing</td>
<td>Ongoing</td>
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<tr>
<td>3</td>
<td>12</td>
<td>State Hospital Draft Service Strategy – Progress Update</td>
<td>The various suggestions put forward would be included in the final document.</td>
<td>Jim Crichton</td>
<td>In due course</td>
<td>Ongoing</td>
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THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 29 June 2017
Agenda Reference: Item No: 5
Sponsoring Director: Director of Nursing & AHP
Author(s): Jacqueline Garrity – Skye Centre Manager
Title of Report: Skye Centre Annual Report
Purpose of Report: update on progress

1 SITUATION

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 2016 to May 2017. Key pieces of work undertaken and future developments are also highlighted within the report.

The Skye Centre service has experienced challenges at times over the past year with the fluctuation in the staffing resource directly impacting on the delivery of activities. However despite this staff have remained dedicated and professional in their approach during this period of change and have made concerted efforts towards reviewing existing activities and delivering a quality service to our patients. The service is also committed to being involved in the ongoing work related to the ‘Patient Active Day’ project.

2 BACKGROUND

The Skye Centre service to date has been defined by five Activity Centres, including the Atrium where the patients can access the Activity group room, café, library, shop and bank. There are also a variety of other groups facilitated within this environment by the Involvement & Equality Team (Patient Partnership Group, Christian Fellowship, Multi Faith Services), and the Psychological Therapies Service and AHP staff. Advocacy events and service and strategic meetings which include patient representation are also held in the Skye Centre. It is also important to note that the Health Centre is an integral part of our service and operates closely with the wider activity centres.

Plans are in place to progress the work of the Patient Active Day Group to improve on the multi-disciplinary working and delivery of services in a more integrated way. The ‘ward closure’ model is being piloted in Lewis Hub commencing June 2017.

3 ASSESSMENT

Information is provided in the following categories within the report

Governance & Management Arrangements
  • Governance Arrangements
  • Management Arrangements

Key Performance Indicators
  • Safe
  • Effective
  • Person Centred
Key Pieces of Work Undertaken During the Year
• Vocational Qualifications/Courses
• Health Care Retail Standards
• Social Events
• Volunteers
• Carer Involvement
• Yoga

Identified Issues and Potential Solutions
• Sustainable workforce/succession planning
• Sickness

Future Areas of Work and Potential Service Developments
• Review of supervision model
• Induction for New Admissions/Hard to Reach Patients
• Redesign of Woodwork Centre
• Patient Active Day Project – Lewis Hub
• Activity Scheduling
• Supporting Health Choices
• Workforce review/Efficiency Savings Targets

4 RECOMMENDATION

The Board are invited to agree to the following areas of work and potential service developments as outlined fully in the report.

• Review of supervision model
• Induction for New Admissions/Hard to Reach Patients
• Redesign of Woodwork Centre
• Patient Active Day Project – Lewis Hub
• Activity Scheduling
• Supporting Health Choices
• Workforce review/Efficiency Savings Targets
## Monitoring Form

| How does the proposal support current Policy / Strategy / LDP / Corporate Objectives | Information contained in the report supports the LDP targets for activity, corporate objectives related to Patient Learning and clinical outcomes. |
| Workforce Implications | eg Considered in Section 3 of the report |
| Financial Implications | No financial implications if approved |
| Route To SMT | SMT |
| Which groups were involved in contributing to the paper and recommendations. | |
| Risk Assessment | No significant risks identified |
| (Outline any significant risks and associated mitigation) | |
| Assessment of Impact on Stakeholder Experience | Impact on Stakeholder experience has been considered and options have been considered for capturing the patient voice and improve the quality of information/feedback the service receives from outpatients |
| Equality Impact Assessment | EQIA Screened – no identified implications |
THE STATE HOSPITAL BOARD FOR SCOTLAND

SKYE ACTIVITY CENTRE

BOARD ANNUAL REPORT

June 2016 – May 2017

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<tr>
<td></td>
<td>Jacqueline Garrity, Skye Centre Manager</td>
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<td>Tracy Tait, Skye Centre Secretary</td>
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<td>The State Hospital Board</td>
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<td>May 2018</td>
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<td></td>
<td>Mark Richards, Nursing &amp; AHP Director</td>
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  • 2015/16 Recommendations Update
  • Overview
  • Service Delivery

Section 2 – Governance & Management Arrangements
  • Governance Arrangements
  • Management Arrangements

Section 3 – Key Performance Indicators
  • Safe
  • Effective
  • Person Centred

Section 4 – Key Pieces of Work Undertaken During the Year
  • Vocational Qualifications/Courses
  • Health Care Retail Standards
  • Social Events
  • Volunteers
  • Carer Involvement
  • Yoga

Section 5 – Identified Issues and Potential Solutions
  • Sustainable workforce/succession planning
  • Sickness

Section 6 - Future Areas of Work and Potential Service Developments
  • Review of supervision model
  • Induction for New Admissions/Hard to Reach Patients
  • Redesign of Woodwork Centre
  • Patient Active Day Project – Lewis Hub
  • Activity Scheduling
  • Supporting Health Choices
  • Workforce review/Efficiency Savings Targets

Section 7 – Financial Implications

Section 8 – Next Review Date

Appendices
**Section 1 – Introduction**

This report provides an update on patient activity services within the Skye Centre. It details service activity levels, key achievements and future development for the period June 2016 to May 2017. Key pieces of work undertaken and future developments are also highlighted within the report.

The Skye Centre service has experienced challenges at times over the past year with the fluctuation in the staffing resource directly impacting on the delivery of activities. However despite this staff have remained dedicated and professional in their approach during this period of change and have made concerted efforts towards reviewing existing activities and delivering a quality service to patients. The service is also committed to being involved in the ongoing work related to the ‘Patient Active Day’ project.

**2015/16 Recommendations Update**

**Comparison with last annual report**

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<th>Achieve/Partly Achieved/Not Achieved</th>
<th>Comments</th>
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<tbody>
<tr>
<td><strong>Workforce Review/Efficiency Savings Targets</strong></td>
<td>Achieved</td>
<td>The Skye Centre Service exceeded the savings target identified for 2016/17 and also achieved the £58,000 recurring saving target.</td>
</tr>
<tr>
<td>For the financial period 2016/17 the agreed savings target is £134,000. The necessary steps have been identified to meet the agreed savings target with £58,000 being identified as recurring savings.</td>
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<tr>
<td><strong>Curriculum Planning</strong></td>
<td>Achieved</td>
<td>Patient Guide to Therapies now a developed process which is supported by the Skye Centre Service.</td>
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<tr>
<td>The Skye Centre supported the creation and implementation of the Patient Guide to Therapies and Activities and will support the update and delivery of the handbook which is due in October 2016.</td>
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<td><strong>Patient Voice</strong></td>
<td>Achieved</td>
<td>Following discussions with the Involvement and Equality Lead it was agreed that the best way forward and adopted a more focused approach by organising a Skye Centre wide event on “what matters to you day; 6th June 2017.</td>
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<tr>
<td>Patient feedback questionnaire to be devised in relation to patient views on attendance whilst at the Skye Centre in order to illicit patients views and opinions in relations to their attendance at the activity centre.</td>
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<td><strong>Using Data and Gathering Outcomes</strong></td>
<td>Partly Achieved</td>
<td>It has proved challenging to identify one specific assessment tool that ‘fits’ all activity areas. Work has progressed with the Induction programme and the OT assessment tools will be used to inform the patient needs.</td>
</tr>
<tr>
<td>The importance of gathering evidence of impact and clinical outcomes remains an area that requires further development. The Induction Programme and Gardens &amp; Animal Assisted Therapy have been identified as the pilot areas.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendation Description</td>
<td>Achieve/Partly Achieved/Not Achieved</td>
<td>Comments</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Equity of Access to Interventions</td>
<td>Partly Achieved</td>
<td>The Skye Centre Induction and referral process has been reviewed and changes have been implemented as of June 2017. Progress will be monitored and reported to SCMT and SMT.</td>
</tr>
<tr>
<td>Supporting Health Choices Consultation</td>
<td>Partially Achieved</td>
<td>SLA for Physiotherapy will be reviewed by Lead AHP when they take up post. Active day model agreed and will be implemented on 20th June 2017, with focus on increasing capacity in sports.</td>
</tr>
<tr>
<td>Review of Supervision Model</td>
<td>Not Achieved</td>
<td>Unfortunately the development of a suitable supervision model for our support staff has not been progressed as had been anticipated. Discussions are ongoing regarding appropriate models of formal clinical supervision for this staff group.</td>
</tr>
</tbody>
</table>

**Overview**

The Skye Centre service to date has been defined by five Activity Centres, including the Atrium where the patients can access the activity group room, café, library, shop and bank. There are also a variety of other groups facilitated within this environment by the Involvement & Equality Team (Patient Partnership Group (PPG), Christian Fellowship and Multi Faith Services), the Psychological Therapies Service and Allied Health Professions (AHP) staff. Advocacy events, service and strategic meetings which include patient representation are also held in the Skye Centre. It is also important to note that the Health Centre is an integral part of the service and operates closely with the wider activity centres.

Plans are in place to progress the work of the Patient Active Day Group to improve on the multi-disciplinary working and delivery of services in a more integrated way. The ‘ward closure’ model is being piloted in Lewis Hub commencing 20th June 2017.

**Service Delivery**

*Staff configuration*

The Skye Activity Centre service consists of a group of registered Nursing staff and skilled technical staff, who are all dedicated to meeting the clinical, educational, health & wellbeing, vocational and recreational needs of our patient population.
The Skye Centre staffing establishment is presently 38.33 wte, the actual staff in post is 32.33 wte due to vacancies. The service is currently operating with 6 vacancies with an additional long standing member of staff due to retire in September 2017. These posts are at various stages of the recruitment process. Adjustments have been made to internal staff deployment across the service to mitigate against the temporary loss of these posts.

The Skye Centre service operates Monday to Friday with session times commencing at 9am and finishing at 4pm and activity is also available on a Saturday and Sunday with evening activities provided on 2 of the 6 Saturday evenings within the 6 week shift rota.

Skye Centre staff are supported by Hub based nursing staff to provide weekend and evening activities. The number of Skye Centre shift workers will reduce from 4wte to 3wte in September 2017 due to a planned retirement. The Skye Centre Manager has commenced discussions with the Clinical Operations Manager and Lead Nurses to consider the implications of this and the impact on skye centre activities and ward staffing resources.

The Health Centre is appropriately resourced within the current staffing establishment and this also includes 1wte staff time for the Tribunal Service. During periods of planned or unplanned leave there is no budget arrangement in place to provide backfill for service delivery. In addition the service supports and accommodates one member of staff to participate in regular Staff Side duties and Public duties for which there is no budget arrangement in place to provide backfill for service delivery. Whilst it is often successfully achieved, it can prove a challenging task to balance the staffing requirements and reallocate the existing staffing resource to minimise the disruption of the activities on offer to patients.

The ‘ward closure’ model will be tested as part of work related to the Patient Active Day Project. The Skye Centre service will benefit from the additional staff released at ward level and this will inform proposed changes to the service delivery model within the hospital as it relates to patient activity.

**Delivery of Interventions**

There are a wide range of group interventions available to the patient group attending the Skye Centre. The range of groups on offer are defined under the following categories. These are:-

- Crafts & Creative Expression
- Education & Learning
- Life Skills
- Physical Health & Fitness
- Recreation
- Mental Health & Recovery
- Vocation & Working Activities

Appendix 1 provides an overview of each group intervention including capacity, and duration of each group. This table demonstrates that there are a wide range of interventions available at varying degrees of complexity to meet our patient needs.

The groups are delivered in a variety of formats. There are regular ongoing group activities such as the animal care, crafts or sports sessions for which there is no restricted time limit. The scope of these activities will be modified depending on the needs of the patients participating. In contrast to this there are a number of planned, time limited groups such as SVQ qualifications i.e. Sports Leadership,
Introduction to Crafts. Patients are referred to these group activities after discussion with their respective Clinical Teams. The Crafts staff also work collaboratively with the Art Therapist delivering group interventions in the Craft & Design Centre.

It has been acknowledged that further progression of the timetabling work stream, part of the Patient Active Day project would be greatly assisted by the implementation of an appropriate software system; CELCAT. This would further enable Clinicians to plan and coordinate their treatment interventions in a more efficient and effective manner. A business plan has been progressed in relation to the purchase of this system and it has been approved and may be included in the eHealth project plan for this coming financial year.

Section 2 - Governance & Management Arrangements

Governance Arrangements

Formal reports on Skye Centre activity are reported on an annual basis to The State Hospital (TSH) Board and the service is represented at this group by the Nursing & AHP Director. Skye Centre activity and service performance data is also included in the annual Rehabilitation Therapies report to the Clinical Governance Committee.

Strategic aims and priorities for Skye Centre activity levels are monitored on an ongoing basis by the Skye Centre Manager who reports to the Operations Manager. Approval for new developments and initiatives are approved by the Senior Management Team at which the Skye Centre service is represented.

Management Arrangements

The Skye Centre Manager is operationally responsible for the Skye Centre service and staff group. The Senior Charge Nurse is managerially responsible for the group of nursing staff located in each centre. This post has been vacant for the past 9 months due to maternity leave and aspects of this role have been devolved to the Nursing Team Leaders within the service, with support from the Skye Centre Manager.

Over the past year the Skye Centre Manager’s workload has continued to be split between operationally managing the Skye Centre service and AHP service. The Lead AHP/Lead OT post was recently advertised and a successful candidate has been offered the post. It is anticipated that they will take up post within the next 3 months.

Section 3 - Key Performance Indicators

Figures 2: The Local Delivery Plan targets for activity are and set out as key performance indicators (KPI’s) 2016-17 and comparison with previous 3 years

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Target</th>
<th>16/17</th>
<th>15/16</th>
<th>14/15</th>
<th>13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient will be engaged in off-hub activity centres</td>
<td>90%</td>
<td>83%</td>
<td>81%</td>
<td>73%</td>
<td>79%</td>
</tr>
<tr>
<td>Patients will undertake 90 minutes of exercise each week</td>
<td>60%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>66%</td>
</tr>
<tr>
<td>(Annual Audit)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients will engage in meaningful activity on a daily basis</td>
<td>100%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Attendance by all clinical staff case reviews</td>
<td>-</td>
<td>59%</td>
<td>59%</td>
<td>60%</td>
<td>63%</td>
</tr>
</tbody>
</table>
The LDP targets are underpinned by a number of supporting measures, including:

- Provision of reports for annual review meetings
- Patient Learning Outcomes
- Attendance at clinical supervision

**Safe**

The nursing staff within the Skye Centre service receive clinical supervision in line with the nursing supervision model that has been agreed and approved within the organisation. Over the past 12 months all Skye Centre registered nursing staff received formal supervision - 4 staff members participated in individual supervision and 5 staff members participated in group supervision facilitated by a Clinical Nurse Specialist allocated from the Psychological Therapies Service. (2 staff participated in both)

A suitable model of supervision has yet to be identified for the support staff and this is currently being explored.

There were 75 Health and Safety incidents reported involving the Skye Centre over the last 12 months (18 behavioural incidents, 9 verbal aggression, 3 assault, 3 attempted assault, 4 sexual, 24 staff/patient injury, 13 slip/trip/fall, 1 moving & handling). The delivery of activities across the service continue to be risk assessed and modified to ensure that patients have access to the necessary resources, tools and equipment at a level appropriate to their needs i.e. induction sessions, low tool and tooled sessions.

**Effective**

The progress of individual patients is monitored in a number of ways. This can be achieved subjectively using non standardised methods such as observation of behaviours, interactions with peers/staff and the recording of staff clinical reasoning and judgement, documented using the electronic patient record (RIO).

There are presently a range of Patient Learning Outcomes and KPI’s in place across the service and these are reported annually in a separate report to the Board. This report was received in February 2017 and detailed the progress made and the recommendations related to patient learning for the coming year. It is important to note that these outcomes related to patient learning are an integral part of the Activity Centres and support the selection and development of the patient timetable.

Skye Centre staff currently attend weekly Clinical Team meetings as and when the clinical need is indicated.

- During the period of the report there were 91 annual reviews and the Skye Centre VAT form completion was 100%.
- Skye Centre reports were provided to 75.8% (n=69) of annual case review meetings, compared with 83% (n=72) the previous year. 2 reports were not done due to staffing issues, 3 reports were not done with no reason given and 17 were not done as the patients did not have a Skye Centre placement during the review period.
- Skye Centre nursing staff attendance at annual case reviews was recorded at 0%. This has been a decrease from the 7% recorded in last year’s report. Whilst the benefit of nursing staff attending the CPA review is widely acknowledged, the staffing is prioritised to ensure that activity centres remain open. The reasons for non attendance include staffing levels (81.3%) and no Skye Centre placements (18.7%). Discussions have taken place re
a model that will support both nursing staff and Senior Rehabilitation Instructors to attend these meetings. This will commence in the coming year, as a pilot initially, facilitating staff attending at Monday CTM meetings on a rotational basis, looking at using a test of change model.

- To ensure patient participation, each profession should discuss their annual report prior to submission for the annual report. On discussion with staff and patients this practice is carried out however at present is not recorded within the VAT forms. A request has been noted to amend the VAT form to assist with monitoring this.

As noted earlier in the report Appendix 1 provides an overview of the range of group activities that are currently on offer. Groups vary from being regular/ongoing activities to planned groups, with time limits established at the outset. Appendix 1 provides a description of the activity, the capacity for each group and the number of patients engaged.

**Person – Centred**

There has been an increase in the number of formal complaints from patients regarding the Skye Centre within the last 12 months as detailed in Figure 3 below.

<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>
<tr>
<td>2015</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2016</td>
<td>10</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>2017 (end May)</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

In previous years a number of complaints have been received from patients regarding access to services and centre closures. The increased number of complaints that were recorded over the year in 2013 is directly related to the temporary closure of Woodcraft and the staffing resource issues being experienced at that time.

The increased number of complaints that were recorded in 2016 is related to centre closures and staffing resource issues. The 10 upheld complaints were submitted over an 8 week period between the end of September 2016 and mid November 2016. Every effort has been made to redistribute the staffing resource to minimise the impact on patients’ placements and this is reflected in the number of complaints received over the past 6 months.

The Skye Centre service will strive to ensure that the principles outlined in the recently revised NHS Complaints & Feedback Procedure are adhered to in order to enable staff to build positive relationships with patients and rebuild trust when things go wrong. The revised procedure puts the person providing the feedback and their carers at the heart of the process, encouraging staff to act on all feedback effectively, resolving issues as early as we can, and learning from them where we can so that we can improve our services for everyone.
'What Matters to You’ Campaign: 6th June 2017

One of the recommendations in 2015/16 Annual Report was to develop a Patient feedback questionnaire in relation to patient views on attendance whilst at the Skye Centre in order to illicit patients views and opinions in relations to their attendance at the activity centre.

Following discussions with the Involvement and Equality Lead it was agreed that the best way forward and adopted a more focused approach by organising a Skye Centre wide event on “what matters to you day; 6th June 2017

This campaign is supported by the Scottish Government and Healthcare Improvement Scotland with the aim of encouraging and supporting more meaningful conversations between people who provide health and social care and the people, families and carers who use health and social care. The Involvement and Equality Lead met with Skye Centre staff to reflect on last year’s initiative and inform a different approach this year.

This discussion included a review of the existing Skye Centre Community Meetings which have been the source of some challenges in respect of levels of patient engagement.

There was a consensus that the broad ‘what matters to you’ question presented a challenge for many patients who experience significant barriers to communication. This year, we therefore adopted a more focused approach, asking only two questions:

• “When you have a good session at your placement, what are the things that make it good?”
• “If your session has not gone so well, what do you think would have made it better?”

The Skye Centre Team, supported by the Involvement and Equality Lead, facilitated the ‘What Matters to You?’ session on the afternoon of 6 June, attended by 32 patients, 18 staff, 1 volunteer and 3 students. The group reflected on both questions in relation to each activity area, from which a focused discussion took place to identify common themes, following which priority actions were developed.

Patients with significant barriers to communication were supported to share their views, eliciting some really insightful comments. The Involvement & Equality Lead has stated that the feedback from patients, staff and the volunteer who attended has been very positive. She feedback that:

“There was a real buzz in the room, with some great conversations taking place – patient involvement in its truest sense, and even more significant given the nature of our care setting. The experience was a really collaborative process and, as a result, empowered everyone present to have a say”.

Having reviewed the feedback, it is very encouraging to note the balanced way in which some of the challenges have been described and the extremely creative ideas shared in terms of ways of overcoming some of these issues. These priority action plans will help to inform the work of the Skye Centre Management Team, in terms of prioritising service development and will also support objective setting within individual activity areas.

Having tested the model, quarterly workshop sessions have been agreed as the preferred method of involving patients in the development of Skye Centre services moving forward. The next event is planned for September 2017. A Hospital wide report, identifying common themes and the learning opportunities emerging from the event across the site will be shared later this month. However, what is
apparent already is the clear message shared around the importance of the relational aspects of accessing activity within the Skye Centre. One patient shared their feedback relating to placements within the Patient Learning Centre:

“Good refuge when having a personal bad day”

Figure 4 below provides detail of the number of planned sessions over the past 4 years in comparison to the actual number of sessions attended. The number for both planned sessions and actual attendances has decreased over the past 12 months. However there is a continued trend in improvement over the past 4 years of the % between interventions scheduled and the number of actual interventions attended.

<table>
<thead>
<tr>
<th></th>
<th>Scheduled Interventions</th>
<th>Number of interventions attended</th>
<th>% between planned and attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/17</td>
<td>21212</td>
<td>18938</td>
<td>11%</td>
</tr>
<tr>
<td>2015/16</td>
<td>24032</td>
<td>19076</td>
<td>21%</td>
</tr>
<tr>
<td>2014/15</td>
<td>22712</td>
<td>16798</td>
<td>27%</td>
</tr>
<tr>
<td>2013/13</td>
<td>23068</td>
<td>15255</td>
<td>34%</td>
</tr>
</tbody>
</table>

This demonstrates a significant improvement in the planned versus actual delivery of activities. A summary of the reasons for non attendance over the past 12 months are detailed in Figure 5 below.

Overall the figures related to non attendance have increased. The centre closures have had the most impact on non attendance over the past year (this can be attributed to decreased staffing levels across the service due to vacancies, sickness and other leave). The number of non attendances related to patient mental & physical health and patient refusal have also all slightly increased over the past year. Appointments with other Health Care Professionals have risen again in the last year. The purchase of CELCAT would enable the scheduling of patient activities across all disciplines and support a more consistent approach to coordinating activity.

<table>
<thead>
<tr>
<th>Reasons for patients not attending at planned interventions</th>
<th>2016/17</th>
<th>2015/16</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deterioration in Mental Health</td>
<td>615</td>
<td>578</td>
<td>679</td>
<td>674</td>
</tr>
<tr>
<td>Physical Health Problem</td>
<td>521</td>
<td>518</td>
<td>765</td>
<td>612</td>
</tr>
<tr>
<td>Appointments with other Health Care Professional</td>
<td>534</td>
<td>429</td>
<td>517</td>
<td>681</td>
</tr>
<tr>
<td>External appointments</td>
<td>148</td>
<td>500</td>
<td>805</td>
<td>116</td>
</tr>
<tr>
<td>Tribunal/CMT/CPA Appointments</td>
<td>51</td>
<td>58</td>
<td>65</td>
<td>66</td>
</tr>
<tr>
<td>Patient refuses to attend</td>
<td>512</td>
<td>481</td>
<td>501</td>
<td>561</td>
</tr>
<tr>
<td>Service Closed/Reduced Service</td>
<td>2112</td>
<td>1511</td>
<td>1253</td>
<td>3767</td>
</tr>
<tr>
<td>Patient seeing external visitor</td>
<td>14</td>
<td>79</td>
<td>94</td>
<td>18</td>
</tr>
<tr>
<td>Visit on ward</td>
<td>300</td>
<td>109</td>
<td>315</td>
<td>273</td>
</tr>
<tr>
<td>Discharge/Transfer/rescheduled/withdrawn sessions</td>
<td>277</td>
<td>219</td>
<td>101</td>
<td>204</td>
</tr>
<tr>
<td>Bad Weather</td>
<td>104</td>
<td>45</td>
<td>69</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>417</td>
<td>354</td>
<td>463</td>
<td>728</td>
</tr>
<tr>
<td>Attending other Skye Centre activities using Drop in total</td>
<td>293</td>
<td>75</td>
<td>287</td>
<td>113</td>
</tr>
<tr>
<td>Total</td>
<td>5898</td>
<td>4956</td>
<td>5914</td>
<td>7813</td>
</tr>
</tbody>
</table>
Referrals - There were 170 referrals received for 117 patients to attend a range of activities provided by the Skye Activity Centres. This is an increase from last year’s figures of 136 referrals received for 58 patients.

Figure 6 below provides the number of referrals received from each hub following discussion and approval from the respective Clinical Teams.

Figure 6

![Graph showing number of patient referrals received from each hub]

Skye Centre Induction Programme: The Induction programme takes place twice a week over a 4 week duration. This group consists of new admission patients and ‘hard to reach’ patients with no current placements.

During the reporting period there have been 36 new admission patients, of which 7 patients within this group have since been discharged. A total of 21 new admission patients completed the Induction programme during this timeframe. From this group of newly admitted patients 8 have not completed the programme to date however; 3 are due to start in June 2017; the remaining 5 will commence in at the start of July 2017 dependent on their presentation at the time the Induction programme starts.

The referrals made for the Induction have been monitored over the past 12 months. On average it takes 54 days from admission to receiving the initial referral from the CTM and it take an average of 67 days from admission for the patients to commence the 4 week Induction programme. The Skye Centre Induction has recently been revised as described in section 5.

Figure 7 below details the number of patients engaged in Skye Centre interventions for the period June 2016 to May 2017. At the time of collating the data for this report the number of patients that have planned interventions at the Skye Centre over the course of a week has remained fairly constant at 91 patients (83%) compared to 90 patients in May 2016. Their sessions can range between 1 session and 10 sessions.
Figure 8 provides an overview of the planned/scheduled activity for each activity centre and the actual attendance by patients during the period June 2016 to May 2017.

Figure 9 below details information related to the number of patients on the waiting list for each activity centre. The 3 patients who are on the waiting list for Gardens have placements elsewhere across the service and are awaiting access to a low tool session.

Skye Centre Board Annual Report 2017
Many patients attend more than one activity centre and they may be involved in individual tasks or participate in group projects. The table in Appendix 1 provides an overview of the activities that are timetabled across the week in each of the activity centres.

The following charts have been developed to demonstrate the range of Skye Centre activities that individual patients are scheduled to attend across each Hub. It is evident upon reading the information detailed that each hub varies greatly in relation to individual patient engagement at the various activity centres. The data presented is reflective of the patients’ weekly Skye Centre timetable and does not include the time spent attending the Health Centre which varies or Patient Shop which the majority of patients attend one morning per week. It also does not include groups facilitated by the Involvement and Equality team some of which are supported by Skye Centre staff.

The numbers of sessions patients attend are recorded over the period 9am – 4pm Monday to Thursday and 9am – 3pm on a Friday. The patients normally attend for a full morning session and the afternoons are currently split into two sessions with patients having the option to stay at the Skye Centre all afternoon.

Arran

- 2 of the 3 of the patients with no activity placements access the Skye Atrium on a regular basis over the course of a week on a “drop in” basis for tea/coffee with Occupational Therapy and Psychology staff and the remaining patient refuses to attend placements due their presenting poor mental health/Physical Health.
- From the 3 patients who do not attend, 1 has completed the Skye Centre Induction but as yet has not accessed regular placements due to presenting mental health.
Iona

- From the 5 Iona patients with no placements; 1 has been discharged, 2 scheduled for Skye Centre Induction at the start of July, 2 mental health remains poor

Lewis

- From the 7 Lewis patients with no placements; 1 commenced the Skye Centre Induction in June 2017, 2 are scheduled to commence in July 2017, 2 mental health remains poor and 1 refuses to engage (previously provided with placement at Sports in September 16 and refused to attend over a 5 week period, refused to consider alternative activity centres. Following discussion at Clinical team it was agreed to discharge from Sports centre.

Mull
From the 3 Mull patients with no placements; 2 have recently been provided placements in June 17 and 1 patient refused to attend the service due to poor mental health.

Section 4 – Key Pieces of Work Undertaken During the Year

Vocational Qualifications/Courses
The Patient Learning Centre, 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 February 2017. 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. Five members of staff across the activity centres successfully achieved the SQA Assessor qualification.

The Craft & Design department gained approval to deliver 2 new qualifications. These are:
- Creative Arts at National 2
- Practical Craft Skills Qualification at National 2

The development of these qualifications has allowed increased opportunities in 2017 for embedding of core skills qualifications across vocational areas (Crafts).

A range of themed learning courses have taken place during the period of reporting – FIFA European Championship Group (in which learners who took part achieved qualifications in ICT) and The Glasgow Story Group (in which learners achieved Communications level 3 & 4) The programmes comprised of learning that was open to all patients and each consisted of a 10 week course. This initiative continues to be part of our aim to increase themed and group learning programmes. The most recent themed learning courses are “The Space and Galaxies Group” which concluded in May 2017 with an exhibit of the patients work opened to the wider patient group and staff to view and the “Tour De France Group” which commenced at the start of June 2017.

Health Care Retail Standards
The Healthcare Retail Standards is a Scottish Government initiative and is a mandatory requirement that applies to all retail outlets within NHS Scotland healthcare buildings and on NHS Scotland property. It came into effect from 31st March 2017 and is based on the ethos that an institution which provides healthcare should also provide healthier choices for people to consume, whether the customer is an NHS employee, patient or visitor.

Provision Criteria as set out in the HCR Standard:

- **FOOD**: At least 50% of food must meet the Provision Criteria as set out in the HCRS document
- **SOFT DRINKS**: In soft drinks, 70% of range provided must be sugar free. Fruit juices would be included in the remaining 30%.
- The HCRS is a minimum requirement – Boards can apply stricter criteria in line with local policies.

It was the view of the TSH Board that the needs of the patient group require to be weighed up carefully against the risks posed to patient health and wellbeing through excessive consumption of foodstuffs. Therefore a key objective of the Supporting Healthy Choices Implementation Group was to review the Hospital Shop, taking into consideration the stock availability, access and pricing as part of any change to the routes of purchase of foodstuffs. The Healthcare Retail Standards supported this change.

The ‘Shop Review’ Sub Group was established with a patient representative nominated from the PPG involved. The following parameters were agreed:

- 80%/20% split for food items
- 100% for sugar free drink items
- Reviewed stock lines – additional suppliers were sourced to increase available food items that meet agreed criteria.
- Extended range of non-food items for sale i.e. clothing
- Optimise the shelving and storage space available

The Pre-assessment visit took place in December 2016 and the State Hospital was the first Board in Scotland to pass the assessment. The first formal assessment took place in February 2017 and our hospital shop passed the assessment with 86% of food stock items and 97% of drink items meeting the Provision Criteria. The 3% of remaining drink items includes fruit drinks and diluting juice.

**Social Events**

The Skye Centre service continues to provide a series of planned social events throughout the year and hosted a number of events over the last 12 months. These included the Celebration of Success and Achievements Ceremony and the Sportsman’s Dinner; both events acknowledge the successes and achievements of our patients. The Patient & Carer Christmas lunches and Christmas social and spiritual events were again delivered successfully and many positive responses were received from patients and carers regarding the enjoyment and quality of service they experienced. All of these events are accessed by patients and their carers. The success of these events can be attributed to the dedication and commitment of the Skye Centre and Involvement and Equality staff group.

The Skye Centre also organised a Patient Olympic Games in August 2016 which provided a week long programme of activities to celebrate the Rio 2016 Olympic Games Appendix 2. This was facilitated by the Sports & Fitness staff supported by the wider Skye Centre staff group and staff.
across each of the Hubs. Patients and staff from across the hospital came together to participate in what can be described as a very successful and uplifting event for all who took part. A total of 63 patients participated from all 4 hubs across the week.

Volunteers
The Skye Centre service continues to work alongside the Involvement & Equality Team to support the role of volunteers across the service. The number of volunteers has increased over the last 12 months with around 8 Volunteers working in the Skye Centre, supporting activity in the Patient Learning Centre, Gardens, Crafts and Sports. There are also five volunteers who help facilitate the Spiritual and Pastoral Care Team by attending the weekly Christian Fellowship group held in Skye Centre.

Investing in Volunteers Re-accreditation
The re-accreditation process was due at the end of 2016 and Volunteer Scotland were on site for 2 days in December 2016 to undertake the assessment. The assessment criteria required the assessor to meet with staff who work directly with volunteers, in addition to those who do not (in order to determine if those who don’t, recognise the value of volunteering). The process involved informal semi-structured interviews which lasted around 20/30 minutes and questions were based on determining appropriate levels to the Investing in Volunteers standard.

The organisation has since been successfully re-accreditated and the Involvement & Equality Lead provided very positive feedback – particularly in respect of the way in which Skye Centre staff make our volunteers feel part of our ‘family’ and the caring way in which they ensure volunteers are supported to do their role.

Carer Involvement
The Skye Centre staff in conjunction with our Involvement and Equality colleagues supported National Carers’ Week in June 2017 by hosting a range of planned activities within our Patient Learning Centre, Gardens and Craft & Design centres following by lunch in the Skye Atrium. The national theme was ‘Building Carer Friendly Communities’ and both teams ensured that a customary warm welcome was given to our patients and their carers throughout their involvement providing the carers with the opportunity to experience firsthand the environment and range of activities on offer to their family members.

Yoga
The PPG provided feedback regarding the provision of new activities with yoga being a popular suggestion. It was agreed that the Skye Centre staff would support the Phoenix Trust to deliver a yoga taster session for a group of 8 patients in August 2016. The patient feedback was very positive with all patients reporting the benefits gained in terms of relaxation and even after one session the positive impact on mental health and physical health symptoms.

A further two 12 weeks yoga groups have been delivered, facilitated by an experienced yoga instructor and Skye Centre staff. These groups are being evaluated and an SBAR update will be presented to the July SMT. It is the intention to deliver this activity for planned blocks of time throughout the year. Appendix 3 provides detail of the patient feedback. In addition to the patient groups, funding was made available through the Health Working Lives to provide a staff yoga session over lunch time which proved very successful and was consistently attended by around 20 staff.

Section 5 – Identified Issues and Potential Solutions
**Sustainable Work Force/Succession Planning**

Hub based Nursing leadership has been reviewed and a new structure implemented as part of The State Hospital’s workforce planning activity. This has been fully implemented since February 2017 and is intended to clarify and strengthen Nursing leadership at ward level. As part of this change, it was agreed that band 6 Senior Staff Nurse roles will cease and that these roles will close on 1st April 2020.

The Skye Centre was not included in the initial tranche of workforce planning activity. It has been agreed in partnership that this will now be brought forward, applying the same principles as ward based Nursing leadership roles.

Similar to the wards there are Senior Staff Nurses and Nursing Team Leader roles in the Skye Centre, all at band 6 level. In the workforce planning recommendations set out and implemented within the Hubs, it was stated that clarity regarding the ward level Nursing leadership structure could be realised through the phasing out of our current Senior Staff Nurse role at band 6, and the implementation of a revised Team Lead structure. The principles which underpin this apply equally to the Skye Centre.

Initial face to face engagement has taken place with the staff group who would be affected by any changes which are agreed. A paper outlining the options will be presented to the Transitions Group in June regarding the future shape of the workforce.

**Sickness**

The staff sickness levels across the service have increased, averaging 7.13% over the past 12 months compared to 5.05% reported the previous year. Long term sickness has increased from 2.80% to 5.65% however short term sickness has decreased slightly from 2.25% to 1.48%. The monitoring of staff sickness levels remains a focus for the Skye Centre Manager to drive improvement in this area and as of June 2017 will be supported with the implementation of the new Early Access to Support for You (EASY) model.

**Section 6 - Future Areas of Work and Potential Service Development**

**Review of Supervision Model for Support Staff**

Unfortunately the development of a suitable supervision model for our support staff has not been progressed as had been anticipated. This remains an area for development and it is acknowledged that the provision of good quality supervision is important for the personal and professional development of our staff and assists in equipping staff with the skills, knowledge and experience to adequately deal with the ever changing clinical and environmental changes that they may encounter in their everyday practice. Whilst all support staff are supported on a daily basis by the nursing team across the service discussions are taking place regarding appropriate models of formal clinical supervision for this staff group.

**Induction for new admissions/Hard to Reach Patients**

In line with the Local Delivery Plan access to therapeutic services is based on needs, using a single integrated system. There is regular review of which patients do not have access to services, to ascertain the reasons, and to ensure that as many patients as possible have time off their ward. Patients access the Skye Centre as an expected part of the daily menu of activity.

*Skye Activity Centre Induction*
The current Skye Centre Induction Pathway to date has been; Skye Centre staff contact the patient’s key worker within 4 weeks following admission then every four week thereafter until the referral is received; all corresponding actions are recorded within Rio.

The format of the Induction group takes 4 weeks to complete and provides an opportunity to access each activity centre for a ‘taster session’. On the last week Skye Centre staff discuss with each patient which activity centres they would be interested in attending. The outcome of this discussion is communicated back to the patient’s Key worker for further discussion at the CTM and agreed referrals to be submitted for the identified activity centre.

Taking this information into consideration it was agreed at SMT in April 17 that the Skye Centre Induction pathway is reviewed and the named Skye Centre Nurse and Occupational Therapist for each Hub will work collaboratively throughout the induction process (Appendix 4). The following amendments will be introduced as of June 2017:

- All new patients will be referred within 2 weeks of admission.
- Exception reporting will be initiated for non attendance
- MOHOST assessment and Interest Checklist completed by named Occupational Therapist
- The Patients Guide to Therapy will be distributed, as indicated within the current Admission ICP.
- Assessment report completed and submitted to Admission CPA
- Skye Centre Secretary to monitor, record and report performance data monthly to Skye Centre Management Team.

**Sports Induction**
The Physical Fitness assessment has been an integral part of the Admission ICP for a number of years now and the current standard require the assessment is completed within 42 days following admission. The assessment includes Hub Induction, Sports Induction, PAR-Q Assessment, Fitness Test (Peek Flow, Flexibility, BP, Heart Rate and Walk Assessment).

In order to ensure that the opportunity to participate in Sports & Fitness activities is readily available to all new patients in line with the Supporting Healthy Choices objectives, the Physical Activity & Fitness Pathway has been revised with new recording systems being developed. Appendix 5 provides details of the patient journey. This new pathway has been implemented as of June 2017. Activity data will be reported monthly to Skye Centre Management Team.

**Redesign of Woodwork Centre**
The Woodwork Activity Centre was closed on 02 December 2016 as a direct result of both experienced technical staff resigning at the same time to take up further career opportunities out with the NHS. This activity centre has gone through a significant transition of change over the past 4 ½ years.

The 4wte longstanding Rehab staff all left the service through planned retirement and ill health retirement. This took place over an 18month period with a significant increase in unplanned closures resulting in the centre being closed for a period of 10months whilst appropriately skilled staff were recruited. Due to a review of the range of woodwork activities on offer it took a further 8 months for the centre to resume operating at maximum planned sessions. The Skye Centre Manager was requested to carry out a scoping exercise and needs assessment for our current patient group and review to options for whether or not it was viable to reopen the Woodwork centre.
During the period January 2016 to November 2016 the Woodcraft centre was closed on 53 occasions. This was related to a number of factors mainly staff related i.e. sickness, annual leave, training.

The room capacity for this centre is 6 patients due to the nature of the activities provided and the risks associated with the environment (tools and equipment). The centre was open for 8 sessions with the potential of a maximum 44 planned placements offered (inclusive of 1 induction session with a maximum capacity of 4 patients). At the time the centre temporarily closed it was operating under capacity with 24 planned placements.

In April the SMT approved the option to close the Woodwork and redesign this area into a generic therapeutic space in which a range of planned individual or group activities can be facilitated by a range of professionals i.e. Skye Centre, Occupational Therapy, Arts Therapy, Involvement & Equality. There are a number of existing groups, time limited in nature that could also utilise this space. For example Painting & Decorating Course, Slim & Trim, Participate, Individual or Group Art Psychotherapy interventions. The maximum room capacity would be 12 patients across a potential 10 sessions.

It was also approved to reallocate the staff costs to other activity centres i.e. Sports & Vocational Corridor, in order to consolidate the overall service delivery in all activity centres. It is anticipated that there will be a positive impact on the number of unplanned centre closures and the service can contribute more efficiently and effectively to wider corporate initiatives such as the Supporting Healthy Choices agenda. In particular the creation of a band 3 Clinical Support worker attached to the Vocational Corridor, from the existing budget would support collaborative working across the wider professional staff resource. This shared working approach will enable staff from other professions to work safely and effectively alongside the activity centre staff to facilitate activity in this redesigned space.

The further development of this integrated multi-disciplinary model will support the wider involvement and access of our patients to the Skye Centre. In particular the hard to reach patient group who do not currently attend the Skye Centre would have increased opportunities to use this resource supported by other disciplines such as the Occupational Therapy staff and Arts Therapy Staff.

The above recommendations were discussed at the PPG during which the patients were very open to the proposed changes and all present engaged in the discussion making a number of suggestions as to what alternative activities could take place in this redesigned space.

Patient Active Day Project – Lewis Hub
In late 2016, there was a review of our clinical service delivery model, recognising that the model was now almost 5 years into its operation. This work was progressed through the Clinical Forum, and following a site wide engagement exercise, recommendations were made about how an ‘Active Day’ model could be introduced in the Hospital. These recommendations were considered and accepted by the Senior Management Team.

The thinking behind this new model is to create a different focus to service delivery that maximises opportunities for therapeutic activity across the site, makes best use of our activity and staffing resources, and which also has the potential to deliver a clearer sense of progression for our patient group.

The Active Day model, will involve, in the first instance one ward (Lewis 2) closing Monday to Friday, morning and afternoon, with the patient group spending their day in the Skye Centre. This will support greater access to activity for this specific group of patients, and will also provide an opportunity to deploy staffing in a way that best meets delivery of activity in the Skye Centre and in the Hubs.
This model draws upon learning from a test of change that was undertaken in Mull Hub in 2015, in which nursing staff were linked to the Skye Centre for a period of time. This model allowed us to create more capacity within the Skye Centre, minimise departmental closures, and our staff also reported positively on their work experience during this time.

The Skye Centre staff and Lewis Hub staff have been working in collaboration to design and test out new ways of working, ultimately reaching the point where we can deliver a safe and sustainable Active Day model. An improvement cycle approach will be implemented to develop the model.

Staff will be deployed differently in the Active Day model, with Hub based staff working more regularly within the Skye Centre as a consequence of the model. In its simplest sense, if we start the day with 4 Nursing staff on duty, when the patients move to the Skye Centre for their morning and afternoon sessions, then 2 staff will go with them and work within the Skye Centre throughout the session. Staff will be inducted and trained to support them in this role. The balance of staff released from the closure of the ward will be available to support care delivery at Hub level.

**Activity Scheduling**
A robust business case for the purchase of the electronic scheduling system CELCAT was completed and approved by the IT Sub Group and SMT in April 2017 and added to the eHealth project list. Unfortunately at this point in the financial year no funding has been allocated for this.

In order to progress the Activity Scheduling work across the hospital a solution is still required to ensure a more consistent and effective method for scheduling activity across all disciplines. This would enable the Skye Centre along with the other services to plan patient activity in a more efficient manner.

**Supporting Health Choices**
The Supporting Health Choices consultation has been contributed to by the Sports & Fitness staff Health Centre and Shop staff. Each of these services will continue to demonstrate their support and deliver the agreed priorities for this plan of work.

**Workforce Review/Efficiency Savings Targets**
Discussions are ongoing with the Clinical Operations 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 has achieved and in fact exceeded the agreed savings target over the past 3 years on a non recurring basis, with £58,000 identified as recurring savings for the financial period 2016/17. For the financial period 2017/18 the agreed savings target is £50,000. The necessary steps have been identified to meet the agreed savings target.

**Section 7 – Financial Implications**
There are no major financial implications with regards to delivering the service developments described above, however it will require new, innovative and integrated models of practice and staffing to be agreed and implemented. The desired change ensuring that the most appropriate range of activities are delivered safely and effectively.

**Section 8 – Next Review Date**
The next annual report will be provided to the Board in June 2018.
### Description of Activity

**Intensity:**

<table>
<thead>
<tr>
<th>High</th>
<th>Access Tools required / Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medium</td>
<td>Low Tools required / Patients</td>
</tr>
<tr>
<td>Low</td>
<td>No Tools required</td>
</tr>
</tbody>
</table>

**Patients Learning Centre**

<table>
<thead>
<tr>
<th>Name of Intervention</th>
<th>Description</th>
<th>Intensity</th>
<th>Capacity Numbers</th>
<th>Current number of patients involved on intervention (May 2017)</th>
<th>Length of Group</th>
<th>Time of Course</th>
<th>Number of times this activity is available over the course of week</th>
<th>Number of course ran (June 2016 – May 2017)</th>
<th>Number of patients completed (June 2016 – May 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer Learning Sessions</td>
<td>Patients will learning basic IT skills</td>
<td>Low</td>
<td>12</td>
<td>20</td>
<td>n/a</td>
<td>2-3 hours</td>
<td>2</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Numeracy Learning Session</td>
<td>Patients have the opportunity to improve their numeracy skills</td>
<td>Low</td>
<td>12</td>
<td>20</td>
<td>n/a</td>
<td>2-3 hours</td>
<td>1</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Communication Group</td>
<td>Patients have the opportunity to improve their literacy skills</td>
<td>Low</td>
<td>12</td>
<td>20</td>
<td>n/a</td>
<td>2-3 hours</td>
<td>1</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Open Learning / Out Reach</td>
<td>A range of patients learning activities are available within these session</td>
<td>Low</td>
<td>12 each session</td>
<td>7</td>
<td>n/a</td>
<td>2-3 hours</td>
<td>2</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Themed Learning Group</td>
<td>Patient have the opportunity to learn about a specific topic i.e. Scottish heritage</td>
<td>Low</td>
<td>12</td>
<td>20</td>
<td>n/a</td>
<td>2-3 hours</td>
<td>2</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>Open &amp; Distance Learning</td>
<td>Provide patients with the opportunity to take part in further and higher education</td>
<td>Low</td>
<td>8</td>
<td>5</td>
<td>n/a</td>
<td>2-3 hours</td>
<td>1</td>
<td>n/a</td>
<td>n/a</td>
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</tr>
<tr>
<td>Sports Leadership Course</td>
<td>Patients have the opportunity to develop basic skills in leadership within a Sporting environment</td>
<td>Low</td>
<td>6</td>
<td>0</td>
<td>12-16 weeks</td>
<td>2-3hours</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Hard to Reach Patient session</td>
<td>Staff will interact with patients with low stimuli to encourage them to participate in physical activity</td>
<td>Low</td>
<td>8</td>
<td>9</td>
<td>n/a</td>
<td>2 -3hours</td>
<td>1</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Gym and Main Hall activities</td>
<td>Give patients full access to the sports and fitness department. Patients have access to all gym equipment as well as a variety of sporting activities within the main hall, including badminton, table tennis etc</td>
<td>Low</td>
<td>25 each session</td>
<td>30</td>
<td>n/a</td>
<td>2-3hours</td>
<td>2</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Football Session</td>
<td>Patients have the opportunity to play football</td>
<td>Low</td>
<td>15</td>
<td>11</td>
<td>n/a</td>
<td>2 hours</td>
<td>1</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Gym</td>
<td>Patients have the opportunity to use the equipment within the Gym</td>
<td>Low</td>
<td>14 each session</td>
<td>22</td>
<td>n/a</td>
<td>1 hours</td>
<td>2</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Indoor Carpet Bowls</td>
<td>Patients participate in indoor carpet bowls</td>
<td>Low</td>
<td>12</td>
<td>12</td>
<td>n/a</td>
<td>2 hours</td>
<td>1</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Block fitness session</td>
<td>This sessions covers a large range of Activities including metafit, touch rugby etc</td>
<td>Low</td>
<td>15</td>
<td>6</td>
<td>n/a</td>
<td>2 hours</td>
<td>1</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Bike Ability Course</td>
<td>Patients have the opportunity to complete a adapted bike ability course</td>
<td>Low</td>
<td>6</td>
<td>0</td>
<td>12 weeks</td>
<td>2-3 hours</td>
<td>1</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Volleyball</td>
<td>Patients have the opportunity to participate in volleyball</td>
<td>Low</td>
<td>15</td>
<td>7</td>
<td>n/a</td>
<td>2 -3hours</td>
<td>1</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
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</tr>
<tr>
<td>Crafts “Low Tools” Session</td>
<td>Patient will have access to a variety of tools classed as “low tools” and will take part in projects</td>
<td>Medium</td>
<td>10 each session</td>
<td>10</td>
<td>n/a</td>
<td>2-3</td>
<td>3</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Craft “Full Tools Access”</td>
<td>Patients will have access to a variety of tools and take part in projects</td>
<td>High</td>
<td>12 each session</td>
<td>20</td>
<td>n/a</td>
<td>2-3</td>
<td>7</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Pottery Session</td>
<td>Patients will participate in pottery making</td>
<td>High</td>
<td>12</td>
<td>0</td>
<td>12 weeks</td>
<td>2-3</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Art Therapy Session</td>
<td>To provide structure art therapy sessions to patients</td>
<td>Low</td>
<td>4</td>
<td>4</td>
<td>12 weeks</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td>SVQ Course</td>
<td>Patient will participate in SVQ Accredited courses</td>
<td>High</td>
<td>6</td>
<td>6</td>
<td>12 weeks</td>
<td>1-2hours</td>
<td>1</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>Garden Low Tools Session</td>
<td>Patient will have access to a variety of tools classed as “low tools” and will take part in projects</td>
<td>Medium</td>
<td>12 each session</td>
<td>28</td>
<td>n./a</td>
<td>1-2hours</td>
<td>6</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Tooled sessions/ Animal Care</td>
<td>Patient will have access to a variety of tools classed as “low tools” and will take part in projects. Patients will also work with the animals</td>
<td>High</td>
<td>12 each session</td>
<td>22</td>
<td>n/a</td>
<td>2-3hours</td>
<td>4</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Hard to Reach Patients</td>
<td>This allows sports and fitness staff to attend the hub to provide interventions with patients who are unable to attend the Sports and Fitness Centre</td>
<td>Low</td>
<td>1-2</td>
<td>2</td>
<td>n/a</td>
<td>1hour</td>
<td>1</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
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</tr>
<tr>
<td>Chess Club</td>
<td>A group of patients will take part in the weekly Chess challenge</td>
<td>Low</td>
<td>12</td>
<td>10</td>
<td>n/a</td>
<td>2-3 hours</td>
<td>1</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Book Club</td>
<td>Patients pick a book, which the read and then discuss</td>
<td>Low</td>
<td>12</td>
<td>8</td>
<td>n/a</td>
<td>1-2 hours</td>
<td>1</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>
The Sports & Fitness Department will celebrate the Rio 2016 Olympics with our own Olympic week. This will commence on Monday, 29 August 2016 with an opening ceremony involving patients and staff, walking around the campus. The procession will be led by Robin McNaught, Finance & Performance Management Director who will once again be playing the bagpipes. The procession will finish in the Skye Centre for the reading of the declaration and the opening of the games.

**Opening Ceremony**

There will be a week of events including badminton, table tennis, football, and field events.

**Week of Events**

The closing ceremony takes place on Friday, 2 September 2016 with patients and staff coming together to celebrate the week of events and to present awards for individual, team and hub winners.

**Closing Ceremony**

We have previously held two events like this; the Olympics 2012 and the Commonwealth Games 2014. These events were a huge success in getting patients, including the hard to reach patients, motivated to be more physically active and involved in sporting activities, which in turn has had a positive effect on their physical and mental health.

We hope:

• To get all patients involved throughout the week.

• Staff will come and support their hub and patients to achieve the best they can.

• There will be a great (and shared) sense of achievement for everyone involved.

• The event will be as successful as in previous years with patients (and staff) being motivated to become more physically active.

• To keep the legacy going and change lives for the better through health improvement.

Check the staff bulletin for further information as it becomes available, and look out for the posters on display across the site.

"Thanks in advance for your support!"

For further information contact Gemma Melrose or Allan Burnett on x4377
Yoga Focus Group with 5 patients in attendance – 2nd June 2017

What words would you describe your mood before the yoga sessions?

- Tired
- Anxious
- Agitated
- Tense
- Stable
- Fine
- Stiff joints
- Short of breath
- Balance not great

What words would you describe your mood after the yoga session?

- Calm
- Brilliant
- Relaxed
- Good
- Eager to learn
- Looking forward to next session
- Settled
- Happy
- Helpful
- In zone from day 1

Overall, in what way did the yoga sessions help your wellbeing (mental and physical)?

- Less back pain
- More mellow
- Increased concentration
- Increased positive thinking
- More relaxed in stressful situations
- Stringer mentally and physically
- Increased flexibility
- Better overall wellbeing
- Calmer and more focussed
- Increased confidence
- Better coping mechanisms in ward and at meetings
- Kept mind busy
- Helps sleep
- Helped shy patient with assertiveness
What ways could you improve the sessions to encourage other patients to attend?

- More sessions in the block
- Could be longer
- Longer relaxation at the end
- Positive promotion from patients
- Better publicity of it – to encourage more patients and make sure they understand that they don’t have to be flexible at all to come along

Additional areas were highlighted by the patient group:

Size: Group size was ideal for size of room and to gel as a group

Venue: Room was perfect – nice and subdued lighting

Equipment: All equipment was provided

The overall general consensus from all the patients was that they were:

- Disappointed that it had finished and would like to attend a group in the future
Within two weeks of admission the Induction Team to email to be sent to patients Clinical Team to discuss patients possible attendance at Skye Centre Induction

**Yes**

- Referral to be submitted to Skye Centre Secretary within 7 days for discussion at weekly Formalise Meeting.
- Date will be set for patient attending 4 week induction programme
- Patient’s Key worker will be emailed informing them of patients start date for induction
- On week four of induction, patients and induction team will meet to discuss possible centre to attend
- Report will be sent to Patients Clinical Team for discussion at Admission CPA Meeting
- Skye Centre Referral to be submitted to Formalisation Meeting within two weeks of Admission CPA for further patients for patients to attend

**No**

- RIO entry will be made noting that patients is unfit to attend at present time
- Clinical Teams will be contacted every four weeks until patient is able to attend.

Induction Team to note in RIO that this request has been made

Skye Centre Secretary to be cc into email to record in referral database that this has been requested

Skye Centre Secretary to be informed to ensure that this is recorded within database

Not Received

- Skye Centre Secretary will note at weekly formalise meeting
- Induction Team will contact Clinical Team and note on RIO
- Skye Centre Secretary will note at weekly formalise meeting

Not Received
Skye Centre – Sports and Fitness Induction Programme

New Admission

Within 48hrs of admission the Sports and Fitness Team will arrange to attend ward to complete Hub gym induction

Yes

Patient will attend Sports and Fitness within 14 days of admission to complete Sports and Fitness induction and Assessment

Yes

Drop in will be facilitated

Within 21 days of admission patient will receive 2 ring-fenced induction sessions per week to attend sports and fitness session

By day 42 (ICP) discussions will take place with patient around moving into planned session

Email to CTM requesting referral to planned sessions

Report to submitted for admission CPA (Nurse or Rehab 1)

Not completed within 48 hours

Sport and Fitness Team to note in RIO reasons for not completing

Reschedule for suitable time within 7 days

Not completed within 14 days

Sport and Fitness Team to note in RIO reasons for not completing

Reschedule for suitable time within 7 days

Not placed within 21 days

Sport and Fitness Team to note in RIO reasons for not being place

Referral not received with 7 days of request.

Formalisation meeting to be information

PAR-Q to be completed when attending ward

Sport and Fitness Team to note in RIO

BP, Heart Rate, Peak flow, Flexibility, Walk beep test to be completed

ICP to be signed

Sport and Fitness Team to note in RIO
THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 29 June 2017
Agenda Reference: Item No: 6
Sponsoring Director: Medical Director
Author(s): Medical Director/Clinical Effectiveness Team Leader
Title of Report: Clinical Governance Annual Report
Purpose of Report: To note and approve

1 SITUATION

The attached Clinical Governance Committee Annual report outlines the wide range of activity overseen by the Committee during 2016/17. The stock take also includes the Committee’s Terms of Reference, Reporting Structures and Work Programme.

2 BACKGROUND

Each year the committee undertakes a review of clinical governance arrangements, consisting of:
- A review of reporting structures within the hospital.
- A review of the committee’s work programme for forthcoming years.
- A review of the committee’s terms of reference.
- An annual report summarising the work of the groups and departments that report to the Clinical Governance Committee.

3 ASSESSMENT

Governance Reporting Arrangements
A diagram to show how each group within the hospital reports and escalates any issues.

Terms of Reference
The Committee’s Terms of Reference are subject to annual review.

Programme of Work
The programme of work sets out the topics that will be presented to the committee over the coming months.

Clinical Governance Committee Annual report
The report summarises the work of the Clinical Governance Committee and highlights particular areas of good practice along with matters of concern that have been discussed throughout the year.

4 RECOMMENDATION

The Board is asked to note and approve the Clinical Governance Committee Annual Report
## MONITORING FORM

<table>
<thead>
<tr>
<th>How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?</th>
<th>n/a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce Implications</td>
<td>n/a</td>
</tr>
<tr>
<td>Financial Implications</td>
<td>n/a</td>
</tr>
</tbody>
</table>
| Route To Clinical Governance Committee  
Which groups were involved in contributing to the paper and recommendations? | n/a |
| Risk Assessment  
(Outline any significant risks and associated mitigation) | n/a |
| Assessment of Impact on Stakeholder Experience | n/a |
| Equality Impact Assessment | n/a |
THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE ANNUAL REPORT

1 April 2016 – 31 March 2017
1. Introduction

The State Hospital, like all NHS organisations, has a statutory responsibility to establish clinical governance arrangements to ensure continuous improvement in the quality of care and treatment provided to patients. The national requirements for clinical governance have been the subject of substantial guidance, from the *Clinical Governance and Risk Management Standards* published by NHS Quality Improvement Scotland (NHS QIS) in 2005, to *Better Health, Better Care*, published by NHS Scotland in 2007, and subsequently through the Scottish Government’s publication of the *Healthcare Improvement Strategy for NHS Scotland* in 2010 which outlines three main quality ambitions:

- Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.
- There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.
- The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

The underlying principle of effective clinical governance is that systems and processes provide the framework for patients to receive the best possible care. This report provides an overview of the work of the Clinical Governance Committee during 2016/17 and examples of good practice and matters of concern.

2. Committee Chair Members and Attendees

**Committee Chair:**
Nicholas Johnston, Non-Executive Director

**Committee Members:**
Maire Whitehead, Non-Executive Director
Elizabeth Carmichael, Non-Executive Director

**Attendees:**
Terry Curry, NHS Board Chair
James Crichton, Chief Executive
Prof. Lindsay Thomson, Medical Director
Morag Slessor, Head of Psychological Services
Mark Richards, Director of Nursing and AHPs
Robin McNaught, Finance & Performance Director
Dr Robert Gibb, Chair, Medical Advisory Committee (until November 2016)
Dr Khuram Khan, Chair of Medical Advisory Committee (from February 2017)
Sheila Smith, Clinical Effectiveness Team Leader
3. Meetings during 2016/17

During 2016/17 the Clinical Governance Committee met on 4 occasions, in line with its terms of reference. Meetings were held on:
12th May 2016
11th August 2016
10th November 2016
9th March 2017

4. Reports Considered by the Committee During the Year

All 12 monthly rolling internal governance reports are submitted using the following headings:

- Introduction
- Governance arrangements
- Committee membership
- Role of the committee
- Aims and objectives
- Patient Voice
- Meeting frequency and dates met
- Strategy and workplan
- Management arrangements
- Key pieces of work undertaken during the year [include outcomes]
- Key performance indicators [with data]
- Comparison with last annual report
- Areas of good practice
- Identified issues and potential solutions
- Future areas of work and potential service developments
- Implications
  - Staffing
  - Finance
- Next review date

4.1 12 Monthly Internal Governance Reports

Research Committee/Research Governance and Funding – In May the committee received and approved the 2015/16 Research Committee Annual Report. The reporting period covered was 1st April 2015 to 31st March 2016. The report included information on the key pieces of work including: an overview of the 15th Research and Clinical Effectiveness Conference; an overview of the Forensic Network Research Special Interest Group Conference; data on completed studies; information on journal articles and presentations accepted from State Hospital staff and information on the third point prevalence data collection for the Forensic Network Inpatient Census.

Rehabilitation Services Report - The committee received a report from the Skye Centre Manager at their May meeting. The report provided details of rehabilitation therapies including an update on the work of the Allied Health Professions (AHP) and Skye Centre staff covering the period 1st April 2015 – 31st March 2016. An updated document containing the number of patients currently engaging in rehabilitation services was also tabled. The report provided a Service Overview; Service Delivery; Governance
and Management Arrangements; LDP Targets; Data Gathering; Clinical Supervision; an overview of the work of patient day project; and the future areas of work for the service.

**Fitness to Practice** - The committee received a report in relation to Fitness to Practise at its May meeting. The reporting period covered was 1st April 2015 to 31st March 2016. The Committee were informed that HR undertake monthly checks of all staff who require professional registration to ensure registrations are up to date. Follow up letters are sent to staff 8 days later to ensure staff have registered. In the past year there were no issues regarding medical or AHP staff. 35 initial reminder letters were sent to nursing staff, with a further follow up required for 8 of these staff. All staff were registered within the appropriate timescales, with no lapses in registration.

**Child and Adult Protection** – The committee received the report in May 2016 and it covered the period 1st April 2015 – 31st March 2016. The report included key areas of work around keeping children safe; child visits; there were 3 notifications of concern with appropriate investigations and liaison with Social Work colleagues; adult protection referrals down from 57 to 36 attributed to 23 patients; the main source of harm noted was patient to patient interactions, with 5 referrals relating to allegations regarding the conduct of staff; there is steady progress in all areas of training. It was agreed that for incidents that result in serious harm, the committee should be informed at an early stage rather than at the completion of the investigation.

**Involvement and Equality Service Report** - The report was presented at the August meeting and covered the period 1st July 2015 – 30th June 2016. The report provided an update in respect of how the workstreams contributed to the delivery of high quality care and treatment which is based on individual need; and also in respect of progress to service objectives, highlighted some of the challenges moving forward; alerted the committee to national development of the complaints handling procedures; demonstrated a more robust approach to compliance with the Equality and Diversity agenda; shared developments relating to volunteering input and provided assurance in relation to processes being developed to embed quality improvement practice across all areas.

**Patient Safety** - In August the committee received and approved the Patient Safety Report covering the period 1st July 2015 – 30th June 2016. The report included updates on the following workstreams from the programme: risk assessment and safety planning, restraint, seclusion and emergency sedation, leadership and culture, medicines management, communication at point of transition. The report also included information on how the State Hospital is influencing the national agenda and details on the patient safety national events that have been attended by State Hospital staff.

**Risk Register** – the committee received and noted a report on progress with the Corporate Risk Register at its August meeting. It was noted that the Corporate Risk Register had been subject to full review by internal audit (KPMG) in May 2015 with the report finalising the recommendations being published at the end of January 2016. A number of issues were discussed it was confirmed that the register would be fully compliant when it was submitted to Audit Committee in September.

**Infection Control** – At the August meeting, the committee noted the progress in the Infection Control Annual Report 2015-16 (covering 1st April 2015 to 31st March 2016) and
endorsed the Programme of Work for 2016-17. The main headlines of the report included a summary of Infection Control Activity in respect of Education; Audit; and Healthcare Inspection; Key Performance headlines in respect of Outbreaks/DATIX incidents; Blood Borne Virus; and Future Areas of Work. The committee were pleased to note that over the last year a sustained improvement in the Infection Control Service was noted and that this was evidenced by the most recent Healthcare Environment Inspection (HEI) in February 2016.

**CPA/MAPPA** – At its August meeting, the committee noted the report covering the period 1st July 2015 to 30th June 2016. The report summarised the main headlines which covered the fourth full reporting year following transition into the new Hospital and demonstrated that during this challenging period, all transfers, were managed through the CPA process as required by the Local Delivery Plan (LDP); the report evidenced successful implementation of the principles of the Clinical Model. The report identified a number of key issues and suggested potential solutions in relation to Multi Disciplinary CPA attendance; Patient and Carer Involvement; CPA and MAPPA Management Arrangements; MAPPA Expansion; and Strategic Engagement and Representation. A number of areas of the report were discussed in more detail in relation to carer participation/involvement in meetings and the difficulties carers experienced in respect of meeting times; some admin resourcing issues within Social Work Department; the appointment of the new Social Work Manager whose start date awaited confirmation.


**Physical Health Steering Group** – In November the committee received and approved the 12 month rolling report from the Physical Health Steering covering the period 1st October 2015 to 30th September 2016. The report noted the developments and progress made in the five key strands for which the Physical Health Steering Group had responsibility. These related to Primary Care (including long term conditions); Physical Activity; Nutrition and Weight Management; Food, Fluid and Nutrition and National Guidelines and Standards. For each of these areas, details were provided of the work undertaken and the performance against Local Delivery Plan (LDP) targets.

**Medicines Committee** – In November the committee received and approved information on the key pieces of work undertaken throughout the year (1st October 2015 -30th September 2016) by the Medicines Committee. This included the introduction of more medicines for patients, new guidance on the use of intramuscular medication, agreed frameworks to support medicine management at the GP Clinic and also for Pharmacist Independent prescribing at ward level. Clinical Audit projects continued, both local and national, as well as working with the Patient Safety Group on local medicine topics. The committee discussed a number of areas of the report in respect of the pharmacy independent prescribing on wards, the importance of ensuring practice standards were met in terms of medicine trolleys; and the average monthly spend on patents which was trending downwards in the last ten years.

**Clinical Forum**
In March 2017 the committee received the third Clinical Forum Report from the Medical Director covering the period 1st January 2016 – 31st December 2016. The key pieces of work included overseeing the standards and guidelines process, review of Clinical Governance Committee issues, annual monitoring reports for the professional nursing forum, security, social work, psychology and pharmacy, outcome measures, development of a discharge ICP, review of clinical model, clinical audits and overseeing
the Mental Health Practice Steering Group. The committee also noted that a review of the Clinical Forum had been undertaken during 2016 and the role and remit of this group will change to be a more professional advisory group.

Psychological Therapies
In March 2017 the committee noted the Department of Psychological Therapies Report covering the period 1st January 2016 to 31st December 2016. Key pieces of work included: the revision of the PTS referrals and guidance booklet; work to support the integration of the psychological formulations into the nursing care plans; a summary of the work of the national forensic matrix implementation group that includes the commission and review of a number of further psychological interventions this year; findings from a preliminary audit of the level of trauma experienced by patients by the therapy leads of trauma and the feasibility of introducing Behavioural Family Therapy to the service.

Forensic Medium and High Secure Care Standards – Action Plan Update
In March the committee received a report that provided an annual update on the actions agreed following a peer review visit by NHS Quality Improvement Scotland which took place on 8 October 2013. The visit was to assess the hospital against a set of Secure Care Standards for high secure services that were developed by the Forensic Network. The standards include assessment, care planning and treatment, physical health, risk management, physical environment and teams, skills and staffing. The committee noted that all outstanding actions apart from one relating to a suicide prevention policy had now been achieved.

Clinical Effectiveness Report – The committee received a new report at its November meeting from Clinical Effectiveness which detailed the work of the Clinical Effectiveness Department. The committee welcomed the report which closed the gap in information received following the review of the Clinical Governance Annual Report and its new format. The report gave information on all clinical audits, quality improvement projects, data from the integrated care pathways and assurances around implementation of the evidence base from national standards and guidelines.

SPSO Annual Letter – The committee received a report from the Chief Executive in respect of the Annual Letter, with statistics, in respect of complaints to SPSO about the Board and across NHS Scotland in 2015-16. SPSO had received one complaint about the Board in the period under review which related to Admission/Discharge/Transfer Procedures and represented 0.7% of the sector total across NHS Scotland. The committee noted that as the investigation has not concluded, any organisational learning from the complaint received by the Ombudsman will be contained in the 2016-17 letter.

4.2 Standing Items Considered by the Committee During the Year

Critical Incident Reviews – Four CIR reports were considered during the reporting year. All 4 had their recommendations and actions agreed. The committee asked for information to be added to the Incident Reporting and Patient Restrictions Report to advise them how long CIRs were taking to complete. The committee also asked to be made aware immediately of any CIRs relating to injuries to patients during restraint.
The committee noted the report published in September 2016 in terms of the implications for The State Hospital. It was noted that the publication of learning summaries had been discussed regularly within the Hospital and also at HIS Adverse event review visits. The committee noted the basis of the Hospital’s decision not to publish learning summaries on its website or the Community of Practice website hosted by HIS, and agreed that the protection of patient confidentiality was extremely important. The committee were assured to hear that CIR reports continued to be shared with interested parties, both internally and externally; and that the Forensic Network received an annual summary document on learning from adverse events.

**Learning from Complaints and Feedback Report**

The quarterly Learning from Complaints and Feedback report was considered at the Clinical Governance Committee at every meeting. This was the first year that complaints and feedback were integrated into one report. It now includes information on the statistics presented in respect of the feedback the Hospital received which encompassed complaints, concerns, comments and suggestions as well as any positive feedback received. The committee highlighted the important information provided in the appendix which detailed the action taken as a result of any complaints being received.

**Patient Movement Statistical Information** – The committee received 2 reports during the year at its May and November meetings. The May report covered the reporting period 1st January 2016 to 31st March 2016 and the November report covered 1st April 2016 to 30 September 2016. These reports provided an overview of bed occupancy, area and source of admission, delay between referral and admission, admissions of young people (under 18), ‘exceptional circumstances’ admissions, appeals against excessive security, discharges and transfers and number of patients on the transfer list.

**Incident Reporting and Patient Restrictions Report** – The quarterly Incident Reporting and Patient Restrictions report was considered at the Clinical Governance Committee at every meeting. The report showed the type and the amount of incidents received through the incident reporting system DATIX, as well as all the restrictions applied to patients during the periods under review. The report provided more information of the various incidents that had occurred in relation to PAA activations; the use of handcuffs; patient seclusions; withheld mail; urinalysis results; security incidents; communication/information incidents; those relating to equipment, facilities and property; and prohibited items brought in by staff which were now recorded in DATIX.

5. **Discussion Items During the Year**

**Mental Health (Scotland) Act 2015** – At its May meeting the committee received a presentation from the Medical Director on the new Mental Health (Scotland) Act 2015 which amends the Mental Health (Care and Treatment) (Scotland) Act 2013 or where relevant to the Criminal Procedure Act 1995. The presentation gave an overview of the 12 areas of change.

**Draft Research Strategy** - At its August meeting the committee received the draft Research Strategy 2016-2019 for discussion. The draft Strategy and the Outline Action
Plan of the Aims and Objectives proposed were discussed and in an attempt to enhance
the Strategy further, a number of suggestions were offered. These included clarity as to
what was achieved in comparison to the aim at the outset; detailing the current position
and the way forward with more of a contextual focus; providing timescales for delivery;
how finances were being disseminated; the implementation of findings; the effect on staff
in terms of evidence based practice; and training opportunities eg within the Forensic
School. It was agreed that all studies should yield a benefit to the Hospital's patients and
achieving the right balance was important.

**Clinical Model** – The committee received a presentation from the Director of Nursing
and AHPs entitled 'Active Day Model – Planning for Improvement' at its November
meeting. The aims of the Model fell into two categories, *Primary*: demonstrable,
sustainable increased access to activity places available and increased uptake of
placements within the Skye Centre; and *Secondary*: the reduction in additional hours
use and positive feedback from patients and staff. Discussion centred around the
importance of defining measurable aims and benefit and links to the LDP, area of focus
(sports), external partners, the need to test operational feasibility then scale, how to
ensure a needs led focus, project capacity – improvement skills and culture and practice
change.

**Forensic Network Review** – At its March meeting the Medical Director gave a
presentation containing information on the current forensic estate in Scotland across
High, Medium and Low secure. The presentation also highlighted the issues that are
currently being discussed across the network i.e. shortage of medium secure Major
Mental Illness (MMI) and Learning Disability (LD) beds and the lack of a Scottish high
secure female service. Various options that are being considered to address the issues
and possible solutions were discussed by the committee.

**Clinical Governance Annual Stock Take** – At its May meeting, the committee received
and approved: the Clinical Governance Reporting Structures for 2016-17; the
Programme of Work for 2016-2017 subsequent to any changes that may arise at future
meetings; the Clinical Governance Committee Terms of Reference; and the Clinical
Governance Annual Report 2015-2016. The annual report summarised the work of the
Committee during the financial year 1<sup>st</sup> April 2015 – 31<sup>st</sup> March 2016.

6. **Areas of Good Practice to the Committee**

**Medicines Committee Report** – The introduction of the pharmacy independent
prescribing on wards, the importance of ensuring practice standards were met in terms
of medicine trolleys; and the average monthly spend on patents which was trending
downwards in the last ten years

**Research Committee and Research Funding Committee Report** - At the May meeting
the committee were encouraged to hear about the valuable work that had been
undertaken over the period.

**Involvement and Equality Service Report** - A more robust approach to compliance
with the Equality and Diversity agenda; shared developments relating to volunteering
input and assurance in relation to processes being developed to embed quality
improvement practice across all areas.
Learning from Complaints and Feedback – The inclusion of patient feedback both positive and negative and the documented learning from complaints added a new level of assurance to this report.

Clinical Forum Report - At the March 2017 meeting the committee were encouraged to see the further developments being made in relation to outcome measures and the review of this group to being more a professional advisory group.

Physical Health Steering Group – The introduction of pedometers on Lewis hub for patients to encourage their motivation and physical activity was commended

Clinical Governance Group - The introduction of the Clinical Governance Group will give greater assurance to the Board with a real focus on not only quality assurance but quality improvement with action plans being monitored and delivered through this group.

CPA/MAPPA - At the August meeting the committee was very happy with the continued positive feedback that is being received from patients about the current transfer processes within the hospital.

7. Matters of Concern to the Committee

These matters are followed at each committee meeting until improvements have been evidenced.

Infection Control Committee Report - A number of areas of the report were discussed in relation to various disappointing issues that were noted. This related to the Cleanliness Champion Programme; the robustness of the infection control audit process; hand hygiene audits; Blood Borne Virus; and the three main areas of concern noted in the report under Identified Issues and Potential Solutions.

Update: At the November meeting the committee received a report which provided an update on the areas of concern raised at the August meeting in relation to the Cleanliness Champion Programme, the robustness of the infection control audit process, submission of hand hygiene audits and the assessment of patients for blood borne viruses. The committee agreed that good progress had been made to address the concerns raised.

Critical Incident Review (CIR) Reports - A number of areas of the CIRs were discussed in relation to the delay in concluding the reports and the improvements required.

Update: Further data has been added to the Incident Reporting and Patient Restrictions Report to give the Committee a better idea of how long investigations are taking and reasons for going over the agreed timescales.

Child and Adult Protection - It was agreed that for incidents that result in serious harm, the committee should be informed at an early stage rather than at the completion of the investigation.

Update: There is now a process in place whereby the Director of Nursing and AHPs advises the Chairman of any incidents that have resulted in serious harm.

Physical Health Steering Group – The levels of obesity in the hospitals patient population and the need to improve patient motivation with regards to physical activity.

Update: This has been included in the Healthy Choices Project Plan being led by Dr Khan and will be monitored quarterly through the Clinical Governance Group.
8. Conclusion

From the review of the performance of the Clinical Governance Committee, it can be confirmed that the Committee has met in line with the Terms of Reference, and has fulfilled its remit. Based on assurances received and information presented to the Committee, adequate and effective Clinical Governance arrangements were in place throughout the year.
The State Hospital

CLINICAL GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

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

2 COMPOSITION

2.1 Membership

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

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

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

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

Members:
- M Whitehead
- N Johnston (Chair)
- E Carmichael

Ex-officio Members
- Terry Currie, Chairperson

In Attendance
- Jim Crichton, Chief Executive
- Prof. Lindsay Thomson, Medical Director
- Morag Slesser, Head of Psychological Services
- Mark Richards, Director of Nursing & AHPs
- Robin McNaught, Finance & Performance Director
- Dr Khuram Khan, Chair, Medical Advisory Committee
- Sheila Smith, Clinical Effectiveness Team Leader
2.2 Appointment of Chair

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

2.3 Attendance

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

If attendance at the meeting is only required on a periodic basis, this should be agreed with the Committee Chair in advance. Apologies should be tendered to the Chair of the Committee via the minute secretary at least 2 working days prior to the meeting, unless an exceptional event prevents this level of notice.

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

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

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

3 MEETINGS

3.1 Frequency

The Clinical Governance Committee will meet quarterly to fulfil its remit and shall report to the Board following each meeting.
The Chair of the Committee may convene additional meetings as necessary.
The Accountable Officer of the Board may ask the Chair of the Committee to convene further meetings to discuss particular issues on which they want the Committee’s advice.

3.2 Agenda and Papers

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

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

All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken. Cover papers should be prepared in the format set out in Corporate Document Standards, to draw out the main issues for the Committee. Annual Reports of reporting committees should follow the format set out in Corporate Document Standards.
Documents will be watermarked as Confidential or Draft as required. Documents which are watermarked as Confidential should not be shared outwith the Committee membership. Guidance on confidentiality and openness can be sought from the Records Services Manager.

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

3.3 Quorum

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

3.4 Minutes

Formal minutes will be kept of the proceedings and submitted for approval at the next Board meeting. The Board Secretary is responsible for minute taking arrangements. The draft minutes will be cleared by the Chair of the Committee and the nominated lead Executive (Medical Director) prior to 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
o Lessons are being learned from adverse events and near misses
o 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)
o Arrangements are in place to support child and adult protection obligations.

4.4 Health, Wellbeing and Care Experience

o 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.

o To ensure that arrangements are in place to embed Patient Focus and Public Involvement activities, including equality and diversity issues pertinent to clinical governance.

o To ensure that care is provided by appropriately trained and skilled professionals with the competencies required to deliver the required care.

o To ensure that clinical policies and procedures are developed, implemented and reviewed.

o To ensure that poor performance of clinical care will be identified and remedial action taken.

4.5 Control Assurance

o To ensure that quality of clinical care drives decision making and that clinicians are involved in planning, organising and managing services.

o To ensure that the planning and delivery of services has taken full account of the perspective of patients and the general public.

o To ensure that systems are in place to measure and monitor performance to foster a culture of quality and continuous improvement.

o To ensure that research and development programmes are initiated, monitored and reviewed.

o 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:

o Its own performance, effectiveness, and the level of input of members to the Committee relative to added value achieved.

o 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.

Subject to annual review.
Next revision: May 2018.
Minutes of the Clinical Governance Committee Meeting held on Thursday 11 May 2017 at 9.45am in the boardroom, The State Hospital, Carstairs.

PRESENT:
Non Executive Director        Elizabeth Carmichael
Non Executive Director        Nicholas Johnston (Chair)

IN ATTENDANCE:
Advanced Practitioner for Infection Control    Karen Burnett (part)
Chief Executive         Jim Crichton
Chair of Medical Advisory Committee     Khuram Khan
PA to Medical & Security Directors      Jacqueline McDade (Minutes)
Research & Development Manager      Jamie Pitcairn (part)
Director of Nursing and AHP       Mark Richards
Head of Psychological Services      Morag Slesser
Clinical Effectiveness Team Leader     Sheila Smith
Medical Director         Lindsay Thomson
Interim HR Director        John White (part)

1 APOLOGIES AND INTRODUCTORY REMARKS

Apologies were noted from Terry Currie, Maire Whitehead, Robin McNaught and Jean Wade. Nicholas Johnston welcomed everyone to the meeting.

2 CONFLICTS OF INTEREST

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

3 MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 9 March 2017 were approved as an accurate record.

4 PROGRESS ON ACTION NOTES

All actions were complete or progressing satisfactorily.

Statistics on New to Forensics
Mark Richards advised that there is a refocus on New to Forensics within the organisation over the past couple of months with a focus on building on the mentor capacity for the programme; an additional 10 to 15 mentors are required. Nine of the recent 36 new starts had completed the programme. The focus is to get as many clinical staff through the programme, particularly new starts within the organisation. Mark Richards will provide an update on numbers in 6 months time.

Action: Mark Richards

Suicide Awareness & Prevention Policy
Sheila Smith advised that the Policy is now in draft format. It is anticipated that this will go out for consultation before the end of May with implementation by July 2017.

Burns Night
Mark Richards advised that the Hospital has not held a Burns Supper within Hospital for 4 years primarily due to resourcing issues. It would be possible to hold this during the day but this would result in departmental closures within the Skye Centre. The Committee are happy to leave the arrangements for this to the Management Team.

Action: Mark Richards
CIR – Size of Sling
Lindsay Thomson advised that this is now complete. The issue was to do with the patient wearing a tight sports top and the nature of the injury therefore they improvised using the patient’s sports top as a makeshift sling. This has been reviewed by Carol Anne Topping and she is happy that this is adequate.

5 MATTERS ARISING

There were no matters arising.

6 INFECTION CONTROL COMMITTEE ANNUAL REPORT

Karen Burnett joined the meeting.

Members received the Infection Control Committee Annual Report from Karen Burnett for the period 1 April 2016 to 31 March 2017.

The report outlined the wide range of Infection Control activity undertaken within the Hospital and summarises the work conducted within the Infection Control Services.

Key achievements over the year include a full review of the uniform policy which is now with HR for discussion at the Partnership Forum; clinical waste and environmental audits now linked to Control book audits and inspections undertaken by Senior Charge Nurses or Nursing Team Leaders with the Advanced Practitioner for Infection Control undertaking a quality assurance audit at least once per year. There is a reduction in the number of patients not seen by the Advanced Practitioner for Infection Control for BBV; 2 patients have been diagnosed with Hepatitis C and they have now commenced treatment. BBV screening will be incorporated into the admission bloods with a follow up at 6 months and then annually thereafter. Chlamydia and Gonorrhoea will also be part of the admission screening. There was an increase in the uptake of seasonal flu vaccination by staff with new people attending clinics; this year the approach was changed slightly and clinics were publicised in a different way.

Members were advised that hand hygiene compliance continues to be a focus for this year.

Members discussed the cleanliness champion programme and were advised that from November 2016 the NES programme was replaced by the Scottish Infection Prevention and Control Education Pathway (SIPCEP) which is based on three layers of training: foundation, intermediate and advanced; The Infection Control Committee will agree on the most appropriate way to take this forward.

Members noted the content of the Infection Control Annual Report.

Karen Burnett left the meeting at this point.

7 FITNESS TO PRACTICE REPORT

Members received the Fitness to Practice Report from John White which outlines the process for monitoring professional registration status at the State Hospital and provides assurance that all members of staff hold current professional registration.

Members were advised that revalidation for nurses was brought in from 1 April 2016. There has been one failure to revalidate which is being managed in accordance with due process.

Members noted the Fitness to Practice Report and agreed that it be shared with the Staff Governance Committee. **Action: Lindsay Thomson**

John White left the meeting at this point.
Members received the Adult and Child Protection Report from Mark Richards for the period 1 April 2016 to 31 March 2017.

Members were advised that all patients have a child protection summary from the point of their admission case conference. 13 patients are parents and of their 21 children, 6 have some form of contact with their father; there were 125 child visits to the hospital which is a decrease of 48 in the previous reporting period; 23 child contact applications were received during the reporting period, of these 16 were approved, 1 was not processed at the patient's request and 6 applications were still being processed at the end of the reporting period. At the end of the reporting period 30 children were approved to have some form of contact with a State Hospital patient. No patients under the age of 18 years were admitted to the hospital in the reporting period.

There were 7 notifications of child protection concerns during the period of the report: unapproved child at home visit, unapproved child presented at the hospital as part of a pre-agreed visit, unauthorised photographs, unauthorised accompanying adult, domestic abuse concern with 3 children identified. The concern related to a family in Ireland which was referred to Irish Social Work Services.

Adult support and protection referrals increased from 36 in the previous reporting period to 55, spread across 23 patients with 47 received from State Hospital staff, 7 from Advocacy and 1 from an RMO. The main source of harm noted was patient to patient interactions (41) with 11 referrals relating to allegations regarding the conduct of staff and 3 self referrals. The main category of harm noted was physical (24), with psychological/emotional harm (20) sexual harm (2) and self harm (2), discrimination (6) and radicalisation (1). 51 of the referrals required no further action following initial enquiries under the ASP legislation with the remaining 4 being subject to additional enquiries/investigations. Whilst there was no cause to proceed to case conference under ASP legislation, on one occasion it was recognised by the Child and Adult Protection Forum that there was outstanding management action to be followed up and possible future practice development. Adjustments have been made to the referral process through updated DATIX and asking staff to consider the three point test at point of submission rather than using DATIX as proxy for adult protection.

The PREVENT policy was finalised within year and passed to the Resilience Committee as it mirrors Adult Support and Protection referral procedures. Members discussed the issue of radicalisation and the difference between the Board Report and today's and were advised that one referral was made during the reporting period whereby an RMO had a concern about the risk of radicalisation by a patient who had come into our care from the prison system but this did not progress beyond the initial referral. The report requires to be amended to reflect this.

**Action: Mark Richards**

Two members of social work staff were trained as ASP officers during reporting period; all field work staff are fully trained as ASP council officers and 6 are trained appropriate adults with a further 2 awaiting training from South Lanarkshire Council.

An area of good practice noted was the success with online training, with only a small number of staff still required to complete online training for ASP.

An area of concern is the challenge in releasing staff to attend training.

The Committee noted the progress described in the Annual Report and supported the future areas of work identified.

**9 LEARNING FROM COMPLAINTS AND PATIENT FEEDBACK**

Members received a report from Lindsay Thomson on Learning from Complaints and Feedback
which provided an overview of activity of complaints and feedback of the fourth quarter of the financial year 2016/17 and the period 1 January to 31 March 2017. The report showed the type and sources of feedback received with an update on formal complaints and types of feedback.

Lindsay Thomson summarised the report and provided more information on the statistics presented. Members noted that for the period under review, 12 formal complaints were received; 13 formal complaints were closed; 3 complaints were upheld; 3 were partially upheld; 6 complaints were not upheld; one complaint was withdrawn; one complaint response exceeded the 20 day national target; and the average response time was 15 days, compared to 11 days in the previous quarter. One new complaint was taken to the Scottish Public Services Ombudsman (SPSO) in this quarter; a patient complained about the hospital’s decision not to uphold a complaint made about the conduct and attitude of a staff member, following investigation the file on this complaint was closed. One historical case is still being considered.

152 pieces of feedback were received, including feedback arising from the Sportsman's Dinner, the Celebration of Patient Achievement event and the 2016 Visit Experience Questionnaire. 49 pieces of feedback were received relating to Meal Feedback. Of the meal feedback forms received, there were 67 negative and 16 positive pieces of information. The negative feedback relates to replacement items or insufficient amounts being sent to the ward and is a continuing theme. As a result of this feedback a short life working group has been commissioned to identify areas for improvement within the meal ordering system. The 16 pieces of positive information received were as a result of changes being made to menus following suggestions by patients.

The Committee noted the report on Learning from Complaints and Feedback.

10 INCIDENT REPORTING AND PATIENT RESTRICTIONS

Members received a report from Lindsay Thomson which provided an overview of activity of Incidents and Patient Restrictions within the fourth quarter of the financial year 2016/17 - 1 January to 31 March 2017. Members noted the type and amount of incidents received through the incident reporting system (Datix); and an update on all the restrictions applied to patients during the period under review.

In summarising the report, Lindsay Thomson advised that for the fourth quarter, the following issues were noted; there had been one ‘high’ graded incident recorded relating to malicious e-mails; 47 PAA activations were recorded compared to 37 in the last quarter; 8 patients were handcuffed, compared to 13 in the previous quarter and all involved clinical outings; 4 patient seclusions occurred compared to 7 in the previous quarter; there were 2 room search finds with a white substance and a part dissolved white tablet found in patient’s rooms; a mobile phone was found in a bag of foodstuffs handed in by a visitor; there were 2 positive tests for urinalysis and 67 patients tested orally for drugs with no positive samples.

During the quarter there were a total of 507 incidents reported in Datix, compared with 467 in the last quarter. 250 incidents related to health and safety; 16 were assault incidents which was an increase from 13 in the previous quarter; the number of behavioural incidents has increased from 80 to 109; attempted assaults have decreased from 39 to 30; slips trips and falls have decreased from 25 to 11 this quarter, 9 of these were patient falls involving 8 patients. There were 257 non Health and Safety incidents, 97 of which were security incidents, 19 communication incidents, 34 related to property and equipment, 80 direct patient care incidents, 62 self harm with one patient making up 48% of cases.

Members discussed staff resource issues reported and agreed that this be shared with the Staff Governance Committee. Lindsay Thomson agreed to circulate a copy of the report on staffing issues to members present following the meeting.

Action: Lindsay Thomson / Jacqueline McDade

The Committee noted the Incidents and Patient Restrictions report
Members received a report from Lindsay Thomson which provided an overview of the activity across admissions, discharges and transfers at 31 March 2017.

Lindsay Thomson summarised the report which provided information on Bed Occupancy; Area and Source of Admission; Delay Between Referral and Admission; Admission List; Admissions of Young People (under 18 years of age); ‘Exceptional Circumstances’ Admissions; Appeals Against Excessive Security; Discharges and Transfers from 1 April 2016 to 31 March 2017; the Transfer List and Future Developments.

Members noted that as at 31 March 2017, there were 111 occupied beds in the Hospital; there had been 14 admissions and 17 discharges since end of September 2016.

From 1 April 2016 to 31 March 2017, of the 35 patients admitted, the majority were admitted from court and prison and were geographically fairly evenly spread and largely in keeping with what would be expected socio-demographically.

All but two of the patients had been admitted within the six week time limit between referral and admission. The delay with the other two patients related to court dates and further assessments being made prior to admission. Since the beginning of October 2016 there have been no patients waiting more than 6 weeks from referral to admission.

As of 31 March 2017, there were no patients awaiting admission to the Hospital.

In the period under review, there were no patients admitted to the Hospital who were under the age of 18; and there were three admissions under the ‘Exceptional Circumstances’ Admissions category due to a lack of beds in medium security. There had been 9 patients who had their appeal against excessive security upheld; 16 patients were on the transfer list, which was a decrease of 3 from the position recorded at the end of September 2016; the majority of patients on the list continued to be from Greater Glasgow and Clyde. Overall, 7 patients were awaiting transfer and had been fully assessed and agreed with the local service.

The Committee noted the report on Admissions, Discharges and Transfers as at 30 September 2016.

12 NHS HIS – EVIDENCE DIRECTORATE STRATEGIC PLAN 2017/2020

Members received the NHS HIS Evidence Directorate Strategic Plan 2017/2020 from Sheila Smith.

The strategic plan outlines how the work, working arrangements and outputs of the Evidence Directorate will be developed across the social care partnership. The State Hospital has a robust process in place when new evidence based advice is received. The Quality Improvement Strategy that is currently being developed will include this as well as the Mental Health Strategy.

The Committee noted the Strategy.

13 RESEARCH COMMITTEE / RESEARCH GOVERNANCE AND FUNDING

Members received the Research Committee / Research Governance and Funding Report from Jamie Pitcairn. The report outlines the wide range of Research activity undertaken during the period 2016 / 2017 by State Hospital Staff.

Members discussed a number of issues in the report in respect of the review of service evaluation, which is of particular importance as they are exempt from research ethics review and given the vulnerability of our patients, and dissemination of completed studies. They wish to see further information on research into practice.
The Committee noted and approved the Research Committee/Research Governance and Funding Annual Report.

14 CLINICAL GOVERNANCE ANNUAL REPORT AND STOCK-TAKE

Members received the Clinical Governance Annual Report and Stock-take which outlines the wide range of activity overseen by the Committee during 2016 / 2017. The stock-take also includes the Committee’s Terms of Reference, Reporting Structures and Programme of Work.

The Committee would like to have reassurance that areas of concern are being addressed and would like to see what has been done in future reports. They would also like future reports to have a section on quality improvement.

Action: Sheila Smith

The Committee approved the Governance Reporting Arrangements, Terms of Reference, Programme of Work and Clinical Governance Committee Annual Report.

15 CLINICAL GOVERNANCE COMMITTEE MINUTES TO CLINICAL GOVERNANCE GROUP

Members received an SBAR report requesting the sharing of minutes in draft form with the Clinical Governance Group together with the Terms of Reference for this Group. Lindsay Thomson advised that the Clinical Governance Group met for the first time in April and part of their role is to look at issues that arise as well as help to prepare for the Committee. In order to be able to do this, it would be helpful to have draft minutes in advance of the committee.

The Committee supported the request to share minutes with the Clinical Governance Group.

16 DISCUSSION ITEM : CLINICAL OUTCOMES MONITORING

Jamie Pitcairn provided a presentation on Clinical Outcomes Monitoring.

The presentation summarised the background, development, outcome areas and indicators, process and ongoing development of Clinical Outcomes Monitoring.

Members were advised that reports have been presented to the Clinical Forum for 4 years and have developed and changed to help support clinical teams in their roles and how having data aggregated to a number of levels will support this work.

The Committee noted this positive piece of work and would like to be kept informed of how the dissemination of reports on a hospital, hub, ward and individual patient level progresses.

17 WORKPLAN

Members received and noted the proposed Clinical Governance Committee Plan of Work 2016-2017.

Updates from today’s meeting would be included as required.

Action: Sheila Smith

18 ANY OTHER BUSINESS

a) Agreement of discussion item for next meeting:

Future discussion topics would be as follows:

August 2017 – Duty of Candour : November 2017 – Healthy Choices

Action: Lindsay Thomson
b) Consideration of information to be shared with Staff Governance Committee

It was agreed that the Fitness to Practice Report and issues around staff resources should be shared with Staff Governance Committee.  

Action: Lindsay Thomson/Jacqueline McDade

19 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 10 August 2017 at 9.45am in the Boardroom, The State Hospital, Carstairs.
<table>
<thead>
<tr>
<th>NO</th>
<th>DATE OF MEETING</th>
<th>AGENDA ITEM NO</th>
<th>TITLE OF REPORT</th>
<th>AREA OF GOOD PRACTICE</th>
<th>AREA OF CONCERN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9.3.17</td>
<td>7</td>
<td>Clinical Forum Annual Report</td>
<td>Outcome Work and the sophisticated process in place to address various challenges.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>11.5.17</td>
<td>8</td>
<td>Adult and Child Protection Report</td>
<td>The success with online training, with only a small number of staff still required to complete online training for ASP.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>11.5.17</td>
<td>8</td>
<td>Adult and Child Protection Report</td>
<td></td>
<td>The challenge in releasing staff to attend training.</td>
</tr>
</tbody>
</table>
1 SITUATION

The Lampard Report was published in 2015, following investigation into matters relating to Jimmy Savile. The report considered emerging themes to identify risks and lesson learned, and offered recommendations for the NHS in England and Wales. 14 recommendations were made focusing broadly on celebrities, VIPs and other official visitors, volunteering, safeguarding, vetting arrangements, risk assessment and the use of social media by patients and visitors.

The Scottish Government has now chosen to give careful consideration as to how the Lampard Report recommendations may be applied in NHS Scotland, which is set out in DL (2017) 7.

2 BACKGROUND

Boards have been asked to consider each of the Lampard Report recommendations, identifying any local actions, and to ensure that arrangements for the monitoring, measurement and reporting of the impact of these actions are considered through their Board level governance processes.

Boards have also been asked to consider the themes identified in the Lampard Report, and ensure any actions are fed into local improvement plans. These themes are implied in relation to some of the culture and process issues raised in view of their impact on individual behaviour in the workplace, and include how encouraging openness and accountability relate to organisational effectiveness/safety and public protection.

Finally, Boards are asked to engage with national groups or organisations to consider local issues in the application of the recommendations and the actions set out in the appended plan.

3 ASSESSMENT

The Board has previously received assurance regarding our processes for safely managing volunteers and official visitors at the point of the publication of the Lampard Report.

A new assessment of the compliance of the State Hospitals Board against the 14 recommendations set out in the Lampard Report has been undertaken. This was completed by the Involvement and Equality Lead, Head of Human Resources, and Head of Financial Accounts.
The Board has well developed systems and policies to support the safe involvement of volunteers within our service. There is a high level of visibility of this to the Board through, for example, the Involvement and Equality Service annual report.

Visits to the Hospital are approved through well established official visitors policy, with safety and governance of this enhanced by security processes as a consequence of us being a high secure service.

Larger groups of visitors are discussed and agreed via the Chief Executive’s office.

The assessment of the Board’s status against the 14 recommendations set out in the Lampard Report is included as an appendix to this paper. No specific developmental actions were identified with regard to potential deficits against specific actions or themes. NHS Scotland also benefits from a very clear employment policy framework through which safeguarding is achieved.

4 RECOMMENDATION

The Board is invited to note the assessment against the Lampard Report recommendations.
## MONITORING FORM

<table>
<thead>
<tr>
<th>How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce Implications</td>
<td>eg Considered in Section 3 of the report</td>
</tr>
<tr>
<td>Financial Implications</td>
<td>eg No financial implications if approved</td>
</tr>
<tr>
<td><strong>Route to the Board (Committee)</strong></td>
<td><strong>Route to the Board (Committee)</strong></td>
</tr>
<tr>
<td>Which groups were involved in contributing to the paper and recommendations?</td>
<td>eg SMT / Clinical Forum / Patient Forum / Medical Advisory Committee / other</td>
</tr>
<tr>
<td><strong>Risk Assessment</strong></td>
<td><strong>Risk Assessment</strong></td>
</tr>
<tr>
<td>(Outline any significant risks and associated mitigation)</td>
<td>No significant risks identified</td>
</tr>
<tr>
<td><strong>Assessment of Impact on Stakeholder Experience</strong></td>
<td><strong>Assessment of Impact on Stakeholder Experience</strong></td>
</tr>
<tr>
<td>Captures feedback on stakeholder experience and provides opportunity to improve this</td>
<td></td>
</tr>
<tr>
<td><strong>Equality Impact Assessment</strong></td>
<td><strong>Equality Impact Assessment</strong></td>
</tr>
<tr>
<td>EQIA Screened – no identified implications</td>
<td></td>
</tr>
</tbody>
</table>
## Recommendations Arising from the Lampard Report (2015): Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Policy/Guidance/Arrangements</th>
<th>NHSScotland Boards are required to fully consider local arrangements and take the necessary action in the following areas:</th>
<th>TSH Compliance – May 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits.</td>
<td>Local compliance of these PIN requirements regarding celebrities, VIPs and other official visitors.</td>
<td>Safer pre and post employment checks included in the Recruitment and Selection Policy. Fully compliant</td>
</tr>
<tr>
<td></td>
<td><strong>Safer Pre and Post Employment Checks PIN</strong>: employment checks for individuals engaged in unpaid placement.</td>
<td></td>
<td>Preventing and Dealing with Bullying and Harassment in NHSScotland PIN - bullying and harassment of staff by patients, service users, carers, relatives, visitors or advocates.</td>
</tr>
<tr>
<td></td>
<td><strong>Preventing and Dealing with Bullying and Harassment in NHSScotland PIN</strong>: bullying and harassment of staff by patients, service users, carers, relatives, visitors or advocates.</td>
<td></td>
<td>Preventing and Dealing with Bullying and Harassment in NHSScotland included in Dignity at Work Policy. Policy has been updated. EQIA and local consultation process completed. To be tabled for approval at Partnership meeting in June 2017.</td>
</tr>
<tr>
<td></td>
<td><strong>Implementing and Reviewing Whistleblowing Arrangements in NHSScotland PIN</strong>: raising concerns including concerns about child protection.</td>
<td></td>
<td>Whistleblowing Policy currently being reviewed and updated to be completed by August 2017</td>
</tr>
<tr>
<td></td>
<td><strong>Local Boards’ policy for visitors to premises.</strong></td>
<td></td>
<td>All official visiting parties are discussed and approved via the Chief Executive’s Office.</td>
</tr>
<tr>
<td></td>
<td><strong>Local arrangements for managing visitors in view of the good practice and protocols which are being developed and shared through NHSScotland Communication Leads.</strong></td>
<td></td>
<td>Official Visitors Policy in place and applied to all visitors.</td>
</tr>
<tr>
<td>2</td>
<td>All NHS trusts should review their voluntary services arrangements and ensure that: They are fit for purpose, Volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision. All voluntary services managers have</td>
<td>Local compliance of these PIN requirements regarding volunteers.</td>
<td>Fully compliant.</td>
</tr>
<tr>
<td></td>
<td><strong>Safer Pre and Post Employment Checks PIN</strong>: employment checks for individuals engaged in unpaid placement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong><a href="http://www.sehd.scot.nhs.uk/mels/CEL2013_05add.pdf">http://www.sehd.scot.nhs.uk/mels/CEL2013_05add.pdf</a></strong>: NHSScotland volunteer roles which involve regulated work require the volunteer postholder to</td>
<td>Local compliance of these CEL requirements in particular, volunteering</td>
<td>Fully compliant.</td>
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<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Development opportunities and are properly supported.</td>
<td>Become a PVG scheme member.</td>
<td>Support and supervision. Local compliance with the Protection of Vulnerable Groups Scheme regarding volunteers. Ensure local Board engagement in the work of Voluntary Health Scotland.</td>
<td>Fully compliant. N/A. All volunteers engaged direct.</td>
</tr>
<tr>
<td>Voluntary Health Scotland is working with NHS Boards and third sector organisations in 2016/17 to consider the implications of the situation involving indirect engagement of volunteers through third party/third sector organisations.</td>
<td>Volunteering in NHSScotland: a handbook for volunteering Feb 2014</td>
<td>Local arrangements for recruitment and checking of indirectly engaged volunteers in view of the work being undertaken by Voluntary Health Scotland to produce guidance and share good practice. Local arrangements for volunteer support and supervision.</td>
<td>See above.</td>
</tr>
<tr>
<td><strong>Volunteering in NHSScotland Programme</strong></td>
<td>Local volunteer managers’ ability to access development and support including opportunities provided through the Volunteering in NHSScotland Programme.</td>
<td>Fully compliant. Explicit within Involvement and Equality Lead job description.</td>
<td></td>
</tr>
<tr>
<td>The Department of Health and NHS England should facilitate the establishment of a properly resourced forum for voluntary services managers in the NHS, through which they can receive peer support and learning opportunities and disseminate best practice.</td>
<td><a href="http://www.sehd.scot.nhs.uk/mels/CEL2008_10.pdf">http://www.sehd.scot.nhs.uk/mels/CEL2008_10.pdf</a></td>
<td>Local compliance of this CEL requirement to have a local strategic lead for volunteering</td>
<td>Director of Nursing and AHPs undertakes this role.</td>
</tr>
<tr>
<td><strong>NHSScotland Volunteer Managers Network</strong></td>
<td>Local volunteer managers’ ability to access and engage with the national Volunteer Managers Network.</td>
<td>Fully engaged. Involvement and Equality Lead is a core member of the National Volunteer Leads Group.</td>
<td></td>
</tr>
<tr>
<td>4 All NHS hospital staff and volunteers should be required to undergo formal refresher training in safeguarding at the appropriate level at least every three years.</td>
<td>National Guidance for Child Protection in Scotland (2014) and Child Protection Guidance for Health Professionals 2013</td>
<td>Local implementation of child protection guidance including training.</td>
<td>Forms part of mandatory training programme for all staff and volunteers.</td>
</tr>
<tr>
<td>5</td>
<td>All NHS Hospital trusts should undertake regular reviews of: - Their safeguarding resources, structures and processes (including their training programmes) and the behaviours and responsiveness of management and staff in relation to safeguarding issues to ensure that their arrangements are robust and operate as effectively as possible.</td>
<td>Contain instructions for the provision of child protection within Health Boards. This is then determined locally.</td>
<td>Monitored by the local Child and Adult Protection Forum, chaired by the designated Exec Lead, Director of Nursing and AHP. Datix system, CiR and SUI process ensures a robust approach to reporting and investigating any areas of concern. Training and Professional Development manager responsible for monitoring compliance with this area of mandatory training.</td>
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<tr>
<td>6</td>
<td>The Home Office should amend relevant legislation and regulations so as to ensure that all hospital staff and volunteers undertaking work or volunteering that brings them into contact with patients or their visitors are subject to enhanced DBS and barring list checks.</td>
<td>Addendum to CEL 5(2013)- In NHSScotland, volunteer roles which involve regulated work require the volunteer postholder to become a PVG scheme member. Disclosure Scotland Protecting Vulnerable Groups Scheme</td>
<td>Local compliance of this CEL requirement through assessment of volunteer roles against the definition of regulated work in the PVG Scheme. Consideration of approach to those volunteers engaged in activities outwith scope of PVG to mitigate potential risk.</td>
</tr>
<tr>
<td>7</td>
<td>All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.</td>
<td>Note that the continuous and automatic updating nature of PVG compared to the NHS England DBS System, means that 3 year checks are not required. Safer Pre and Post Employment Checks PIN- <a href="http://www.sehd.scot.nhs.uk/mels/CEL2013_05.pdf">http://www.sehd.scot.nhs.uk/mels/CEL2013_05.pdf</a> -All staff who meet the definition of working with children and vulnerable groups, as laid down by the scheme, must obtain membership by 1 April 2015.</td>
<td>Local arrangements for employee and volunteer PVG checks. All staff and volunteers undergo enhanced disclosure checks prior to commencing roles.</td>
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| 8    | The Department of Health and NHS England should devise and put in place an action plan for raising and maintaining NHS employers’ awareness of their obligations to make referrals to the local authority designated officer (LADO*) and to the Disclosure and Barring Service.  
*The Designated Officer or team of officers (previously LADO) is a local authority role responsible for managing and overseeing concerns, allegations or offences relating to staff and volunteers in any organisation across a local authority area.  
Safer Pre and Post Employment Checks PIN  
Note that the PVG Scheme means that Disclosure Scotland would be alerted to any criminal offence and advise the employer accordingly.  
https://www.disclosurescotland.co.uk/disclosureinformation/guidancedocuments/PVGGuidanceChapter6ReferralsbyOrganisations.pdf  
Where an employer takes disciplinary action to remove an individual from regulated work as a result of harmful behaviour towards a vulnerable person, then they have a duty to refer the individual to the PVG Scheme so that consideration can be given to whether that individual should be barred from any kind of regulated work with protected groups.  
Local arrangements for referrals to Disclosure Scotland.  
Fully compliant. See above. |
| 9    | All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.  
Local arrangements for access by patients and visitors to the internet, to social networks and other social media activities.  
No patient access to the internet / any social media. Volunteering Policy (updated every 3 years) and individual Volunteer Agreements make explicit safeguarding responsibilities in relation to reference to any area of TSH business via social media. |
| 10   | All NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.  
Safer Pre and Post Employment Checks PIN - Board and service provider responsibilities regarding Suppliers of Temporary Agency Staff, locum doctors and medical bank staff.  
Assurance of service provider compliance with responsibilities and local arrangements regarding Suppliers of Temporary Agency Staff, locum doctors and medical bank staff  
All staff in regulated post as defined by Disclosure Scotland undergo PVG checks.  
Agency, locum and bank staff are also required to either undergo PVG checks or provide evidence of scheme membership as appropriate.  
See above for Recruitment and Selection Policy |
|   | NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director. | Safer Pre and Post Employment Checks PIN – recruitment processes.  
Personal Development Planning and Review PIN Policy  
Implementing and Reviewing Whistleblowing Arrangements in NHSScotland Policy – Designated Whistleblowing Officer  
Responsibility in each Board for PIN Policy implementation lies with the Director of Human Resources | Local PIN compliance.  
Arrangements for volunteers. | Responsibility of HRD.  
Process mirrors that of staff with operational responsibility explicit within the Involvement and Equality Lead job description. Responsibility at Exec level falls within the remit of the Director of Nursing and AHP. |
|---|---|---|---|---|
|   | NHS hospital trusts and their associated charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect this. | Boards’ Code of Conduct/Standing Financial Instructions  
Security Services Standards for NHSScotland 2014  
Financial Risk Register | Local Code of Conduct and risk assessment. | Not applicable to The State Hospital. |
|   | Monitor, the TDA, the CQC and NHS England should exercise their powers to ensure that NHS hospital trusts, (and where applicable, independent organisations, providing hospital services to NHS patients), comply with recommendations 1, 2, 4, 5, 7, 9, 10 and 11. | [http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_reviews.aspx](http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_reviews.aspx) - Healthcare Improvement Scotland (HIS) will progress these recommendations through the next phase of testing and implementation of the Thematic Reviews of Major Priorities. | Support HIS as required. | External recommendation. |
| 14 | Monitor and the TDA should exercise their powers to ensure that NHS hospital trusts comply with recommendation 12. Monitor-

*Monitor is an executive non-departmental public body of the Department of Health. It is the sector regulator for health services in England.

TDA- NHS Trust Development Authority: provides support, oversight and governance for all NHS Trusts

SITUATION

To provide members with the final workforce review report to cover the period 2016/2021

BACKGROUND

Members have previously received reports outlining the process and work undertaken to date in relation to the work that underpins the workforce review. This involved engagement with all key stakeholders both clinical and non-clinical and also with partnership representatives.

This proved to be very productive and produced a number of Workforce Workstreams which in addition to being considered as local priorities also link to the key priorities described within the 2020 strategic vision identified by Scottish Government.

The Staff Governance Committee reviewed the Workforce Plan at their meeting on 1 June 2017. The plan has been updated to incorporate comments received from the committee.

ASSESSMENT

Attached is the Workforce Plan 2016/2021 based upon this work which aims to fulfil the following objectives:

- To outline the priority actions which require to be taken forward in 2017/18 in order to support implementation of the outputs and recommendations from the various workstreams which were established

- To provide a further strategic context in terms of the workforce challenges and healthcare environment within which we will be required to operate in the forthcoming years

It is crucial that this document is “iterative” in nature and is reviewed on an ongoing basis. In addition, there will be a formal review in October and March of each year to ensure that the document reflects any workforce changes or revised challenges and that it continues to be “fit for purpose”.

RECOMMENDATION

The Board is asked to approve this Workforce Review 2016/2021.
<table>
<thead>
<tr>
<th><strong>How does the proposal support current Policy / Strategy / LDP / Corporate Objectives</strong></th>
<th>Supports delivery of the LDP outcomes, Quality Improvement and 2020 Vision and Staff Governance Standards</th>
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<td><strong>Workforce Implications</strong></td>
<td>Considered in Section 3 of the report</td>
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<td>To be confirmed following final decisions on workforce configuration</td>
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<td><strong>Route to Board</strong>&lt;br&gt;Which groups were involved in contributing to the paper and recommendations?</td>
<td>Partnership Forum, SMT, Staff Governance Committee</td>
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<td><strong>Risk Assessment</strong>&lt;br&gt;(Outline any significant risks and associated mitigation)</td>
<td>If the workforce strategy going forward is not fit for purpose this will impact upon the ability to deliver effective and quality services</td>
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<tr>
<td><strong>Assessment of Impact on Patient Experience</strong></td>
<td>Captures feedback on stakeholder experience and provides opportunity to improve this</td>
</tr>
<tr>
<td><strong>Equality Impact Assessment</strong></td>
<td>No identified implications at this stage</td>
</tr>
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The State Hospitals Board for Scotland

Workforce Plan 2016/2021

JUNE 2017
Executive Summary

Drivers for Change
This 2017/22 State Hospitals Board for Scotland (TSH) workforce plan identifies the internal and external drivers which will influence the shape of our workforce over the next five years and builds upon the work and stakeholder engagement which informed the original 2016/2021 plan. In constructing this, it draws on several areas of service development and associated workforce change:

1. The short term service changes associated with meeting the 17/18 CRES target
2. Short term service specific reviews initiated in 2017
3. Short and medium term developments in relation to the Health & Social Care Delivery Plan 2016 and focus on integrated working between National Boards and support of Regional Planning.
4. The broader NHS Scotland Shared Services Agenda which will impact upon the workforce in the coming years.
5. Completion of the Nursing and AHP leadership redesign initiated in 2017

The plan includes a review of progress in respect of the previously identified actions, along with additional workstreams which will be progressed in 2017/18 and beyond. Key stakeholders continue to be involved in terms of reviewing the plan and developing ongoing workstreams including members of the Senior Management Team, Partnership Forum and Clinical Forum.

The actions agreed continue to be aligned to the 5 key components of “Everyone Matters – 2020 Vision” of:

- Healthy Organisational Culture
- Sustainable Workforce
- Capable Workforce
- Integrated Workforce
- Effective Leadership and Management

The Structure of The Plan
To ensure consistency with national frameworks, the plan has been formatted in accordance with Scottish Government “Revised Workforce Planning Guidance”, CEL 32 (Scottish Government, 2011).

The Workforce plan features all development work and activities in support of and response to:

- Everyone Matters: 2020 Workforce Vision 2017/18 and beyond
- iMatter Board Report 2016
- Staff Governance Priorities 2017/18

The Mission of The State Hospital
The mission of the State Hospital is to provide high quality forensic mental health assessment, care, treatment and rehabilitation for male patients who require a high secure environment.
The Current Workforce
The current State Hospital (TSH) workforce is comprised of 595.9 whole time equivalent (WTE) / 643 Headcount (SWISS, December, 2016) and provides high secure mental health services for Scotland and Northern Ireland.

Historically the workforce has been predominantly male, however, in the past few years this profile has changed. In accordance with SWISS, March, 2016 figures the workforce now has a gender composition of 55.52%(357)Female and 44.48%(286) Male employees. This is in comparison to the profile at March 2015 where the gender composition was 54.39% (353) Female and 45.61% (296) Male.

Gender balance is an emergent workforce planning issue for nursing in particular, where the balance is 55% male / 45% females. Given that the patient population is all male and that there are gender specific issues in the delivery of care and searches, work will be taken forward in 2017 to assess the appropriate gender balance required and any implications for recruitment processes.

Details for all staff groups are contained within Table 1 below.

<table>
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<tr>
<th>Job Family</th>
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<tr>
<td>Allied Health Profession</td>
<td>13</td>
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<tr>
<td>Medical and Dental</td>
<td>14</td>
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<td>Nursing/Midwifery</td>
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<td>Senior Managers</td>
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<td>Support Services</td>
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Age Composition

Details for all staff groups are contained within Table 2.

Table 2:

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<th>Age group 40-44</th>
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<td>1</td>
<td>-</td>
<td>13</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>4</td>
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<td>Nursing / Midwifery</td>
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<td>3</td>
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<td>-</td>
<td>-</td>
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<td>31</td>
<td>20</td>
<td>19</td>
<td>25</td>
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</table>
The current age profile of our workforce identifies a significant number of staff that may opt to retire within the next 5 years. In addition, those staff now electing to work longer may require an enhanced level of employer support to do so.

Specific focus will be given over the coming year to resilience of senior leadership roles as a number of individuals have indicated their intention to retire within the next 12 to 18 months.

Recruitment to the majority of posts within the service continues to attract significant interest. The exception to this has been in specialist areas such as carpentry where recruitment and retention of staff has been challenging and alternative approaches to service delivery have been considered to address this. Dietetic posts have also proved difficult to recruit to and retain. Options are currently being explored to widen the basis of support in this area.

**Summary**
The State Hospital is committed to maintaining a world class High Secure Mental Health Service which puts patients at the centre of their care and focuses on positive health outcomes and recovery.

It will deliver this in a financial context that is particularly challenging and now more than ever requires the service to be as efficient as possible in delivering these high quality outcomes.

We will do this through working in partnership with our staff and other NHS Boards to identify opportunities for greater efficiency and improved performance.

In the next 12 months and in line with our Local Delivery Plan and Service Strategy, we anticipate a reduction of 8.00 WTE.

Workforce planning is an iterative process and is subject to change as plans for service change become more developed. To ensure the plan remains current we will continue to update it on an annual basis to reflect any changes in the planning assumptions and implications for workforce.
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1 INTRODUCTION

Service Context
TSH recognizes the importance of effective workforce planning and ensuring staffing levels are designed to meet patient’s health care needs, respond to fluctuations in demand and support staff and public confidence in the service. Of particular importance at the State Hospital is to ensure adequate opportunities for rehabilitation and recovery while maintaining the highest levels of security.

The State Hospital has very specialist requirements to address in delivering this service including the specialist training and competencies required of its staff and the need to ensure that critical clinical and security posts are covered on a 24/7 basis in accordance with variations in clinical and staffing needs.

Areas for Improvement
Several areas of current performance are of particular importance to sustain a high quality service over the course of the 5 year plan:

- High Levels Of Sickness Absence > 5%
- Over reliance on staff working additional hours to meet fluctuations in clinical demand and staff cover impacted by absence.

The redesign of nursing and AHP Leadership structures within the service will be fully complete in 2017. This will be underpinned by improved opportunities for staff development.

Service Improvement Review
Work was undertaken in 2015/16 to identify areas of service improvement in conjunction with our staff and staff side partners. The priorities identified and workforce changes were captured last year in the in the 2016 – 2021 workforce plan. In common with all NHS Boards TSH has also taken cognizance of the workforce issues highlighted by Francis (2013); Saville Report 2015; Vale of Leven 2014 and Bowles Report 2012. The themes from these reports were of particular relevance to the review of Nursing and AHP leadership arrangements and the review of business support. They are integral to delivery of our Quality ambitions and the development of a continuous improvement culture. Work is continuing in Partnership to improve performance in attendance management to help alleviate the need for additional hours.

Further work is being progressed in 2017 with our staff and stakeholders to develop an overarching 5 Year Service Strategy. Along with a clear statement of our mission and service values, the strategy will identify our key service improvement priorities and will be underpinned by our workforce plan and a range of priority specific strategies.
2 SIX STEPS METHODOLOGY TO INTEGRATED WORKFORCE PLANNING

The Six Steps Methodology to Integrated Workforce Planning (Skills for Health, 2008) is the workforce planning approach recommended by Scottish Government in CEL 32 (Scottish Government, 2011).

The six steps are defined as:

1. Defining the Plan
2. Mapping Service Change
3. Defining the Required Workforce
4. Understanding the Available Workforce
5. Defining an Action Plan
6. Implement, Monitor & Refresh

The rest of this section summarises TSH’s position regarding each of these steps.
Step 1: Defining the Plan

This is the critical first step in any planning process. You must be clear why a workforce plan is required and what it will be used for. You must determine the scope of the plan, whether it will cover a single service area, a particular patient pathway or a whole health economy and given this, be clear who is responsible for ensuring the plan is delivered and who else will need to be involved in the planning process (Skills for Health, 2008).

1.1 Purpose, Scope & Ownership

The 2016 – 2021 TSH workforce plan summarises the main organisational developments and the corresponding workforce changes required to support TSH over the next 5 years with specific focus on 2017 – 2019. It only includes staff directly employed by TSH.

1.2 Board Overview

The current TSH workforce of 595.9 whole time equivalent (WTE) / 643 Headcount (SWISS, March, 2016) provides high secure mental health services for Scotland and Northern Ireland. The hospital is based upon a single site incorporating 4 clinical Hubs and all other clinical and non-clinical support services departments.

1.3 Partnership Engagement in Workforce Review

The State Hospital has well established Partnership arrangements and work in partnership with Trade Unions and Professional Organisations. From the inception of this development review staff representative colleagues have been involved in developing the workstreams that have underpinned the Workforce Plan, via the Partnership Forum, and also inputting to the development of future workstreams.

A structured engagement process has also been adopted to enable the proposed workforce changes to have wider consultation with key stakeholders so that any conclusions reached are based upon the consideration of any responses received during this process.

The output from the workforce workstreams has been endorsed by the Senior Management Team prior to being issued for wider engagement. At the conclusion of the engagement process final papers are updated with the outcome of the engagement process and any amendments agreed by the Senior Management Team prior to implementation.

The workforce plan has been brought together by the Chief Executive and Human Resources Director following the wider partnership and engagement process described. It is endorsed by the Senior Management Team, Staff Governance Committee, the Partnership Forum and finally the TSH Board. Partnership engagement is therefore evidenced throughout the workforce planning process in TSH.
1.4 Review of Current Workforce

As at March 2016, TSH has an in-post workforce of 595.9 WTE and 643 headcount (SWISS, March 2016). This shows a decrease in workforce of 5.05 WTE and 6 headcount from March 2015. This difference can be accounted for in respect of vacancies which may have been in place as at March 2016 which were in the process of being recruited to. In addition some of the reduction may also be explained by review of vacancies linked to service redesign or identification of CRES savings.

The projected workforce changes submitted to ISD for 2016/17 indicated an overall increase of 17.41wte with specific Job Family changes as detailed within Table 4 below:

Table 4

<table>
<thead>
<tr>
<th></th>
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<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Medical (HCHS)</td>
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Summary of Projected Changes:

- Total staff in post was projected to increase by 17.41wte (based on the ISD return send June 16 for 16/17), in fact it only increased by 4.36wte
- Medical (HCHS) was projected to stay the same, but in effect there was a slight reduction of 0.15wte due to the effect of a leaver
- Nursing and midwifery was projected to increase by 5.56wte but actually increased by 7.15wte, this was to cover for planned retireals
- Allied health profession was projected to increase by 4.99wte but only increased by 0.87wte due to ongoing vacancies
- Other therapeutic services was projected to decrease by 0.50wte but actually increased 0.60wte there have been skill mix changes to the workforce
• Support services was projected to increase by 2.88wte but only increased by 0.23 due to vacancies

• Administrative services was projected to increase by 3.48wte but actually decreased by 3.34wte due to vacancies and also a recurring post saving
Step 2 : Mapping Service Change

This is the first of three interrelated steps. This is the process of service redesign in response to patient choice, changes in modes of delivery, advances in care or financial constraints. You must be very clear about current costs and outcomes and identify the intended benefits from service change. You should identify those forces that support the change or may hamper it. There must be a clear statement about whether the preferred model better delivers the desired benefits or is more likely to be achievable, given anticipated constraints (Skills for Health, 2008).

2.1 Update On 2016/17 Workforce Workstreams

Section 2.1 provides an update on the workstreams agreed for implementation over 2016/17. These are summarised in the table below the 2020 Vision themes.

<table>
<thead>
<tr>
<th>20/20 Vision - Objective</th>
<th>Area of Work Identified – 2016/2021 Plan</th>
</tr>
</thead>
</table>
| 1: Sustainable Workforce | a) To review nursing workforce capacity in relation to core workforce requirements  
                          b) To review Nursing leadership arrangements  
                          c) To review AHP workforce and leadership arrangements  
                          d) To review the Clinical Model  
                          e) To review the Patient Day  
                          f) To improve Staff Attendance |
| 2: Capable Workforce     | a) To develop a leadership programme that will nurture leadership skills and support capability within the workforce for promotional opportunities.  
                          b) Opportunities for secondment within Forensic Network |
| 3: Effective Leadership  | a) Review corporate leadership and governance structure  
                          b) Review business support functions |
| 4: Healthy Organisational Culture | This objective is included within the sustainable workforce work which is detailed above and also within the Values and Behaviours work which will continue to be progressed. |
| 5: Integrated Workforce  | This objective has a different focus from territorial Boards as integrated working within that area will encompass the establishment of integrated Health and Social Care activities. Within TSH this will incorporate effective internal integrated working, external arrangements within the Forensic Network and also the national Shared Services Agenda detailed above (1) |
| 6: Quality Improvement Skills | a) Develop a Quality Strategy |
2.1.1 2016/17 Review of Nursing Leadership Arrangements

Background
As previously reported this work resulted in a recommendation for the redesign of the management and leadership arrangements within Nursing.

In scope were Nursing Posts Bands 7 and above. The workstream leads took into account the leadership arrangements required at ward, hub and hospital wide levels. Day to day leadership at shift level (Team Lead) was considered via the wider Nursing workforce planning workstream.

The Nursing leadership workstream was set in the context of a significantly revised scope to the Nursing Director role, with this bringing the executive level professional and operational responsibilities into the one post.

The group considered the future shape of Nursing leadership roles in the context of the revised Nurse Director role, and what roles were required to optimise the delivery of safe, effective and patient care – the hallmark of the Quality Strategy for NHSScotland.

The group considered feedback gleaned during the roll out of iMatter, where Nursing staff at ward level had reported that they were unclear about line management arrangements at ward level, and that there was, at times, a blurring of leadership roles. The need to consider how best to ensure continuity of practise across our 4 hubs has also been taken into account.

Actions Completed
Following a consultation exercise with staff and trade union representatives an agreed structure, approved by SMT, has been implemented and has been in place with effect from 01/02/2017.

The new leadership arrangements are as follows:

Clinical Operations Manager, Professional Nurse Advisor, Lead Nurses, Senior Charge Nurses and Nurse Team Leaders are all in post.

In order to support both the new leadership arrangements and future succession planning a robust Leadership Development programme has been developed:

The programme extends over a 12-month period and the delivery method incorporates a blended approach that combines coaching, off-job training, master classes, action learning, self-directed learning and project-based activities to support skill development and learning transfer.

The programme design is underpinned by a collective leadership model that aims to:

- Develop shared and consistent leadership across the organisation
- Embed the vision and values of the organisation
- Ensure robust and consistent approaches to performance management
- Encourage and facilitate learning, quality improvement and innovation
- Promote a culture where leaders learn together, work collaboratively and see achievement of organisational objectives as a shared responsibility.

The content of the programme is centred on 5 core competence clusters that include:
1) Managing self
2) Leading people and teams
3) Managing performance
4) Leading change and service improvement
5) Managing services and operations

There is a body of evidence which links the positive contribution of senior nursing leadership to practice environment characteristics such as workplace culture, staffing levels and mix, inter-professional collaboration, job satisfaction, burn out and staff turnover to patient outcomes and productivity. The revised nursing leadership model from SCN level upwards has put in place a model that is fit for purpose in leading Nursing within The State Hospital.

2.1.2 2016 / 17 Review of Nursing Workforce Capacity

Background
The Nursing workforce planning group were tasked with developing a workforce plan which:

- Set out the requirements to meet the defined clinical needs
- Identified a reduction in requirement for staff to work additional hours
- Identified improvements in cost effectiveness of any additional hours required to meet exceptional demand.

The group considered posts within bands 3 to 6 and those staff at band 7 as a consequence of negotiator responsibilities. All Nursing bands above band 6 were considered and reported as part of the Nursing leadership workstream.

The workforce plan is based on the assumption that we continue to provide high secure care to an all male adult population. In addition, cognizance will always have to be taken of the level of beds within the Hospital to inform effective workforce planning.

An assessment was undertaken of projected workforce requirements to meet core clinical activity, respond to fluctuations in clinical needs, and ensure training requirements are met, as well as the target absence rate and other professional activities such as supervision. The assumptions made as they relate to the current (2011) workforce plan were tested. The 2011 plan was developed in advance of opening the ‘new’ Hospital and set out a workforce plan build up made up of assumed core ward nurse staffing levels, and took into account projected levels of, for example, clinical observation, clinical outings and staff training.

Actions Completed
Over the past year we have agreed and implemented a variety of approaches to ensure the nursing workforce is as flexible and equipped to meet the changing needs of the service.

This has included:
- Identifying a gap in the core nursing workforce for an 11 bed configuration
- Agreeing investment to allow a temporary increase in the budgeted workforce
- Being proactive in our recruitment taking cognizance of expected leavers throughout the year
- Seeing our year end establishment increase to 302wte from 292wte last year

The appointment of these staff was approved by SMT with the expectation that a robust monitoring system would be in place to map the reduction in the expenditure related to
excess/additional hours and the additional productivity provided by these posts. Ensuring we have an effective and efficient nursing workforce remains an ongoing challenge.

2.1.3 2016 / 17 Review AHP Workforce and Leadership Arrangements

Background
In scope were AHP leadership roles for the overarching AHP function, and specifically the leadership arrangement and roles required for Occupational Therapy and Dietetics. The workforce design below this level will be determined by the individual with the overarching responsibility for AHP staff. A full engagement process was undertaken with staff with their feedback influencing the final design of the revised structural arrangements.

The changed focus of the Nursing Director role was factored into discussions, as this now brings the executive Nursing and AHP leadership responsibilities into the one post. As a consequence of this extended focus, there is a need to ensure that there is overarching AHP leadership capacity, through which the Nursing Director can be supported and advised on matters as they relate to AHP service within the Hospital, and to also ensure capacity to link externally.

Actions Completed
The Lead AHP/OT post was evaluated and matched in April 2017 and advertised mid April. A proposal for the Occupational Therapy workforce has been developed and will be progressed over the next 3 months through agreed Partnership processes.

2.1.4 2016 / 17 Review of The Patient Day/Clinical Model

Background
The Clinical Forum was asked to review the Clinical Model in terms of continuity of care and ward configuration as part of the workforce planning exercise. An exercise was completed which included obtaining the views of both clinical staff and patients in respect of the current configuration of services and also future options for change.

This element was inextricably linked to the work being taken forward to progress a review of the Patient Day Activity within the Hospital and both items have now been linked and will be led by the Director of Nursing and AHP and the Medical Director as appropriate.

Actions Completed
This work will be ongoing in 2017/18 and beyond. There will be an initial focus on Lewis Hub as a potential “test of change” on this area of work. A proposed model has been designed which takes account of operational implications and is focussed upon the needs of the Lewis patient group. It is anticipated that this will be tested in May 2017 with learning from this experienced used to inform and design any further changes in the structure of the Patients Day.
2.1.5 2016 / 17 Review Of Promoting Attendance/Promoting Staff Health and Wellbeing

Background
The State Hospitals Board fully recognises the importance of promoting attendance at Work and is working to effect a significant improvement in our Sickness Absence Performance. It was agreed that the Partnership Forum, in line with the Promoting Attendance workforce workstream, would develop an action plan to identify the priority actions which are required to improve performance in this area.

Actions Completed
There are a number of actions which are being progressed and most recently an option appraisal has been completed in respect of providing targeted support for staff experiencing absence related to Common Mental Health Problems and also implementing the EASY approach to support staff within the current management of attendance policy framework. The EASY model which is currently in use within NHS Lanarkshire and NHS Western Isles has shown significant improvement in absence rates with the most effective element being telephone contact by trained staff on the first day of absence. The results being that 50% of staff return to work within 5 days.

As a result of considering the implementation of EASY analysis of our absence data confirms that the two most common reasons for absence are common mental health problems and musculoskeletal. Currently additional Physiotherapy sessions are provided within the Occupational Health Service to assist with musculoskeletal issues.

Work has also been progressed to explore the type of support required for employees experiencing common mental health problems as our data for 2015/16 shows us that one third of our staff were absent due to common mental health problems which equates to 97 individuals.

Research also undertaken internally on debriefing post incidents indicates that there may be the ability to improve upon our current practices. It is intended that this area of work will also be progressed.

2.1.6 2016 / 17 Leadership Programme Development

Background
Mention has already been made of the need to ensure that there is a robust leadership programme developed and implemented to deliver the aims of this workforce review.

Actions Completed
The development of a leadership programme commenced in 2016/17 with regard to supporting delivery of the revised nursing leadership structure. The principles of this model will be used to inform the design of a leadership programme that will support leaders in all areas of the Board. 2 sessions have already been provided for Senior Charge Nurses with good initial feedback from participants.
2.1.7 2016 / 17 Review Of Secondment Opportunities within the Forensic Network

Background
A Learning Exchange initiative was introduced as a pilot to support the development of new and existing Senior Charge Nurses. The programme allowed the opportunity to benchmark services and quality against other external services and to give an opportunity to share practice and develop professional networks.

Actions Completed
Two Senior Charge Nurses spent 2 days in medium secure services and discussed topics such as staffing, team performance, development and support and patient experiences. The Nursing and Allied Health Professions Advisory Committee (NAHPAC) heard detailed feedback from the staff involved, and agreed that this was an important and worthwhile initiative to share and develop practice across the forensic network.

2.1.8 2016 / 17 Review of corporate leadership, governance structure and business support functions

Background
The following detail outlines proposed high level changes to two elements of the organisation:

- The line management and co-ordination of business support related services.
- The alignment and reporting arrangements for governance and leadership groups. For the purpose of this exercise, the scope of business support was defined as Quality Assurance and Improvement, Planning, Performance and Risk.

As part of that over-arching workforce plan, two related workstreams were developed:

a) A Review of Business Support Arrangements:
The objective of the workstream was to review the business support function, agree its core purpose and develop recommendations to re-focus the existing support and leadership arrangements.

b) A Review of the Corporate Leadership and Governance Structure:
To include Directorate level leadership responsibilities within the organisation and the governance structure that provides assurance and direction.

Actions Completed
A paper is outlining the proposed amendments to the leadership and governance arrangements was considered and agreed at the June 2016 SMT meeting. Key recommendations around the separation of the Clinical Forum and Clinical Governance Group have been implemented.

The previous recommendation regarding the establishment of a single Business Support role is being progressed and should be completed in 2017.
2.2 2017/18 Actions To Support Everyone Matters – 2020 Vision

A number of priority workforce actions have been agreed for 2017 / 18 in support of local priorities and “Everyone Matters: 2020 Workforce Vision”.

These are set out against the 5 key priorities for action established in Everyone Matters (Scottish Government, 2013) along with a Quality Improvement priority to articulate relevant development work and activities:

2.2.1 Healthy Organisational Culture

To support the development of a Healthy Organisational Culture the following actions will be progressed during 2017/18.

- Recruitment processes will continue to be reviewed in order to determine how these can support a values based recruitment approach.
- To progress the findings and recommendations of the previous qualitative KSF project undertaken in 2015/16 will inform this work.
- To move to one single cycle date for iMatter and to consider how to support effectively this staff engagement and continuous improvement tool.
- Engagement and Involve Staff: An annual event will be in place to support comprehensive arrangements for engagement and local feedback. This will also include existing partnership working structures (Partnership Forum, HR&P Forum, Policy Group, Executive Walkabouts)
- Develop and implement a Values/Behaviour Action Plan to prioritise and focus actions informed by staff views and experience.

2.2.2 Sustainable Workforce

- Review Of Administrative Staff management and leadership arrangements
  This review is well underway and is being led by the Director Of Finance and Performance with support from the Clinical Operations Manager. A summary of findings and potential options is expected in June 2017.
- Review Of Activity Provision
  A review of patient needs and associated provision of activities has been requested by SAMT and will help inform any workforce changes associated with this area of service. Report and implications will be captured by June 2017.
- Review of Skye Centre Nursing Structure
  Following the principles set out in the review of Ward Nursing, a short review of the nursing structure in the Skye Centre will be completed in 2017.
- Review Of Administrative Departments Leadership Structure
  A brief assessment of options in relation to the leadership roles within non-clinical departments, with a particular focus on any succession planning requirements, will be undertaken as part of the 2017 departmental review.
Review and refresh the TSH workforce plan to ensure that workforce planning activity and reports are “fit for purpose” and informed by full engagement with key stakeholders and consider short, medium and long term needs.

Review and refresh the workforce section of the TSH Strategic Risk Register to assess and clearly articulate workforce risks and associated action to mitigate, reduce and minimise risk.

Review available workforce related information to develop a format which supplies high quality, relevant workforce management information to key stakeholders.

Maintain investment of management and staff time in the TSH Annual Personal Development Planning and Review process to inform the planning and prioritised delivery of current and future education, training and development programmes.

Ensure that workforce plans include an analysis of future education, training and development needs.

2.2.3 Capable Workforce

Refresh guidance to Managers, Supervisors and Staff throughout TSH on the purpose and outcomes which should be achieved from developmental appraisals of individual performance.

Refresh guidance on the importance of effective planning and preparation for appraisal. Conversations to ensure that appraisals are meaningful and focus on whether role, contribution and behaviours reflect TSH values.

Ensure NMC revalidation arrangements are in place.

2.2.4 Quality Improvement

Inform and support staff through the organisational learning framework. The framework highlights compulsory learning for all staff providing details of courses, course level, method of completion and validity period for all staff.

Review Corporate Induction Programme to include a values based component. Highlighting key areas for new staff including (but not limited to) values, patient rights, equality & diversity and patient safety.

Develop and deliver the multi-professional TSH Annual Learning Plan with activities and investment prioritised and planned in support of delivery against TSH’s strategic and operational priorities.

Develop a Strategic Plan for learning covering the period 2017/21 in the context of known and anticipated workforce intelligence, plans for service development / change and technological change/ development.
2.2.5 Integrated Workforce

National Board Planning and LDP development

Following the publication of the Health and Social Care Delivery Plan in December 2016, the Chief Executives of the National Boards have been meeting on a monthly basis to develop an understanding of how they can best support the delivery plan and collaborate more effectively to deliver efficiencies while improving service quality. The requirement to plan on a cross Board basis has been underpinned by the additional efficiency target of £15m recurring and the appointment by Paul Gray of lead Chief Executives to both the Regional Planning structures and the National Boards.

An early component of the potential for cross board collaboration was in the area of HR Services. Work was undertaken to review HR services across the Boards with the support of CAJA. An options paper has been developed and considered a number of variations. These were developed in conjunction with local staff. A communication will be issued in due course, but there is significant buy-in to the concept of establishing single systems e.g. through the implementation of for example eESS and building on collaborative working across the Boards. Any workforce implications will be emergent at this stage.

2.2.6 Effective Leadership and Management

- Maintain investment in the ongoing delivery of management and supervisory skills development programmes.

- Refresh full consideration and application of relevant Knowledge Skills Framework behavioural competencies to inform the focus, content and investment in individual personal development.

- Refresh the focus and content of individual behavioural objectives for Executive and Senior Managers to ensure understanding and demonstration of the NHS Scotland and TSH values and behaviours.

2.2.7 TSH General Workforce Strategies

In support of “Everyone Matters: 2020 Workforce Vision”, (Scottish Government, 2013) and the work undertaken by the Workforce Workstreams detailed above a formal Engagement process has been established along with a Transition Group to implement the workforce changes resulting from the work detailed within this plan.

This Plan will be the TSH 2021 Workforce Vision Implementation Plan for 2017/18. The Workforce plan will feature all development work and activities in support of and response to:

- Everyone Matters: 2020 Workforce Vision 2017/18 and beyond
- iMatter Board Report 2016
- Staff Governance Priorities 2017/18

The Implementation Framework 2015/16 uses the 5 key priorities for action established in Everyone Matters (Scottish Government, 2013) along with a Quality Improvement priority to articulate relevant development work and activities:
2.2.8 National Workforce Strategies

TSH workforce plan will need to take into consideration the potential impact on workforce arising from national strategies such as the National Shared Services Project. This national project encompasses support services such as HR, Procurement and general business support areas. All Boards are expected to participate in this project in order to ensure the most effective use of the resources available both in terms of finance and workforce.

A National Workforce Plan for NHS Scotland is to be published in Spring 2017 and will need to be considered within the context of this workforce plan.

In addition, during 2017/18 the Board will be required to identify additional CRES savings to contribute to the overarching NHSiS savings in common with other National Boards.

2.3 Hospital Population profile, Health profile

The hospital has provision for 144 patients across 12 wards. The average number of patients within the hospital fluctuates over time, however with the development of medium and low secure facilities within the Territorial Boards and Regions, the overall occupancy trend has been reducing.

Temporary Reduction In Staffed Beds

At the Senior Management Team meeting on 15th March 2017 a proposal to close Mull 3 was supported and a Special Board meeting was held on the on 23rd March 2017 to consider that recommendation. The Board agreed this temporary closure having taken into account data on trends in bed occupancy and transfer activity from the Hospital. Closure was assessed as feasible, albeit recognising that bed availability for mental illness admissions would be restricted.

A short life working group was established to plan and oversee the ward closure, with the aim of delivering this change with a patient centred focus, and in way that resulted in minimal disruption to patients and staff. A closure plan was drawn up and used to plan and monitor activities agreed to safely deliver the ward closure.

25 nursing staff were affected, all of whom were moved to other wards on the site, and have been targeted at the areas of greatest need. A reporting system has been established to closely monitor the impact of this resource reallocation.

Evaluation of staff experience has been planned, with our Organisational Development Manager taking this forward. 78 pieces of feedback were received from staff through the engagement exercise undertaken prior to the ward closure. These have been themed and feedback prepared for the staff group.

There will be no reduction in Nurse Staffing establishment associated with the temporary ward closure. Night shift numbers will be reviewed in line with the reduced number of wards in operation, but staff resource redeployed into day time activity. Medical sessions will be temporarily reduced by 6 sessions.
2.4 **Financial Challenges**

2.4.1 **National**  
Economic conditions mean public sector budgets will continue to be constrained. Meanwhile changes in clinical practice alongside new drugs and treatments and future changes to the national insurance and pension contributions becoming available are forecast to increase costs beyond inflation. Seeking further efficiencies in the delivery of services will continue be essential to sustaining a safe and effective healthcare system.

2.4.2 **Local**  
For 2017/18 a list of schemes that would enable the Board to deliver a balanced budget have been identified, though work is still necessary to ensure they are delivered and that the balance between recurring and non-recurring savings is addressed.

Within 2017/18 the main specific financial challenges identified include but are not restricted to:
- CRES 5%
- Equal Pay
- Locke v British Gas
- Negotiators
- Additional Hours

The table below details the projected workforce effect related to the immediate workforce changes detailed within this plan. These are based on indicative grading outcomes at this stage.

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<td></td>
<td></td>
<td>-0.50</td>
</tr>
<tr>
<td>Admin</td>
<td>-1.00</td>
<td>-0.20</td>
<td>-0.64</td>
<td>-1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-2.84</td>
</tr>
<tr>
<td>Support Services</td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
</tr>
<tr>
<td>Business Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-1.00</td>
<td>-2.00</td>
<td>0.60</td>
<td>-3.64</td>
<td>0.00</td>
<td>-2.25</td>
<td>1.00</td>
<td>-1.50</td>
<td>-8.99</td>
</tr>
</tbody>
</table>

This reflects anticipated changes which will be realised in year through the implementation of the nursing leadership and nursing capacity workforce plans. This involves a rebalancing of Bands at 6, 7 and 8A to ensure clarity of roles, responsibilities and leadership capacity.

2.5 **Drivers for Change**

In effect, the main drivers for change for TSH are:
- Completion of recommendations from the 2016/17 workforce review
- Additional workstreams identified for 2017/18
- Changes in clinical activity
• Changes in age and clinical dependency of patients
• Age profile of the workforce
• Gender Balance Of Nursing Staff
• Need to improve efficiency and achieve financial sustainability
• Health & Social Care Implementation Plan 2016
• National Shared Service Agenda for National Boards and Support Functions
Step 3 : Defining the Required Workforce

This step involves mapping the new service activities and identifying the skills needed to undertake them and the types and numbers of staff required. This will involve consideration of which types of staff should best carry out particular activities in order to reduce costs and improve the patient experience even where this leads to new roles and new ways of working (Skills for Health, 2008).

3.1 Workforce Projections

The workforce considerations for the job families not incorporated within Sections 2.1; 2.2 and 2.3 are detailed below. In addition it is crucial that the plan is reviewed in July / August to include finalised medium to longer term workforce projections submitted to ISD which will be published later in the year.

3.2 Medical & Dental

Junior Doctor rota’s are in line with the national guidance issues in relation to not having 7 day working practices.

During 2016/17 there were a number of retrials within this staff group. All vacancies were filled. In terms of future risks within this staff group there are none anticipated in 2017/18.

3.3 Other Therapeutic Services

3.3.1 Psychological Therapies

Psychological Therapies aims to provide an efficient and effective psychological service to the State Hospital patients. The Workforce plan will make sure that all patients get the assessment and access to interventions and treatments that they need to ensure that they can regain good mental health and reduce their risk of future offending. This plan will aim to form part of a larger organizational workforce plan.

Ownership
The plan will be consulted on within the psychological service as well as more widely with other colleagues.

Current service uses a range of grades and competences of staff to ensure all patients get timely access to the psychological therapy that they require. All staff have hub roles as well as service wide roles according to their skills and competences.

Group based interventions make use of a range of staff skills for maximum efficiency.

Performance measures: patients in treatment, no of groups delivered, provision of reports to CPAs, provision of risk assessment and management plans, attendance at CPAs, post intervention reports, evaluation of effectiveness of group based interventions, waiting times for engagement in therapy, as well as organizational performance measures e.g. PDPs, sickness absence.
3.3.2 Pharmacy

The current service is provided via a Service Level Agreement with NHS Lothian. The service is managed by the Medical Director in terms of service developments and the performance management of the service received. There continue to be no anticipated changes to the pharmacy workforce at this time.

3.4 Support Services

This job family includes General Services, Domestic, Portering, Stores Operatives, Laundry and Linen, Hotel Services, Maintenance and Estates.

As a result of the national review of Band 1 Posts 11 posts were re-banded from Band 1 to Band 2 with effect from 1 October 2016. This was based upon national guidance and revised job roles for these staff ensuring that they had extended roles at a Band 2 level.

It is important that appropriately trained staff is retained within the workforce with regard to the Maintenance and Estates staff who are responsible for carrying out a specialist role. In terms of future risks within this staff group there are succession planning considerations with regard to the Head of Estates.

3.5 Administrative Services

This group includes e-Health, medical secretaries, receptionists, e-Health including health records staff, administration support and junior and middle management staff.

TSH is continuing to make admin processes more efficient and will continue to consider skill mix and the need to fill vacancies as and when these arise. In addition, a workstream which will be progressed in 2017/18 will review the leadership arrangements for this staff group.

3.6 Senior Managers

The Scottish Government 2015 target of a 25% reduction in Senior Managers was reached in 2016/17. This saw a reduction from 9 as at 31 March 2010 to 6 as at 31 March 2017.
Step 4: Understanding the Available Workforce

This step involves describing the existing workforce in the areas under consideration, its existing skills and deployment, plus assessing any problem areas arising from its age profile or turnover. It may be the case that the ready availability of staff with particular skills, or, alternatively, the shortage of such staff itself contributes to service redesign and steps 2 and 3 will need to be revisited. Consideration should be given to the practicalities and cost of any retraining, redeployment and/or recruitment activities that could increase or change workforce supply (Skills for Health, 2008).

4.1 Workforce profile includes wte/headcount/turnover/age – (data source SWISS March 2016)

TSH workforce as at 31 March 2016 equates to 643 (headcount) and 595.9 WTE. Since March 2015 the workforce has decreased by a headcount of 6 and 5.4 WTE. The average turnover rate contained within ISD data for 2011/2016 for the total workforce is detailed in Table 8 below.

Table 8: Turnover Rates per job family

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>All staff</td>
<td>5.7</td>
<td>6.1</td>
<td>6.6</td>
<td>7.0</td>
<td>6.3</td>
</tr>
<tr>
<td>Medical and dental staff (HCHS)</td>
<td>6.7</td>
<td>14.3</td>
<td>7.1</td>
<td>7.7</td>
<td>8.3</td>
</tr>
<tr>
<td>Medical and dental support</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Nursing and midwifery</td>
<td>5.8</td>
<td>5.0</td>
<td>5.2</td>
<td>4.3</td>
<td>6.1</td>
</tr>
<tr>
<td>Allied health professions</td>
<td>7.9</td>
<td>66.7</td>
<td>17.6</td>
<td>35.0</td>
<td>15.4</td>
</tr>
<tr>
<td>Other therapeutic services</td>
<td>17.4</td>
<td>8.3</td>
<td>20.0</td>
<td>41.7</td>
<td>16.7</td>
</tr>
<tr>
<td>Personal and social care</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Healthcare science</td>
<td>100.0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ambulance services</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Administrative services</td>
<td>4.9</td>
<td>6.4</td>
<td>10.5</td>
<td>10.1</td>
<td>8.6</td>
</tr>
<tr>
<td>Support services</td>
<td>9.3</td>
<td>14.1</td>
<td>5.8</td>
<td>6.5</td>
<td>8.5</td>
</tr>
<tr>
<td>Unallocated / not known</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

This does show that for the biggest job family of Nursing and Midwifery the turnover rate is low. This may also link to the age profile of our nursing workforce where older staff may not make as many career moves as the younger workforce in terms of obtaining experience and moving through their careers.

A range of data is collated for the purposes of complying with the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012. TSH will review the data collation processes within 2017/18 to determine steps to better comply with this duty as there are currently gaps within the data collated. It also has to be acknowledged that whilst staff are asked to provide us with this type of data they are not obliged to tell us and this will have an impact upon our ability to achieve 100% compliance in relation to every Protected Characteristic.

Information has not been included for the Protected Characteristic of Pregnancy & Maternity. This Protected Characteristic offers a specific challenge as there are no agreed indicators or measures to be reported. The Equality and Human Rights Commission believe analysis and reporting of pregnancy/maternity data would be most relevant and appropriate in the domains of staff development and retention.
**Age Profile**

Table 10 below contain data available in terms of Age Profile as at 31 March 2016. In terms of workforce data the current position within TSH is as follows:

Table 10:

<table>
<thead>
<tr>
<th>Job Family</th>
<th>Age group 16-17</th>
<th>Age group 18-19</th>
<th>Age group 20-24</th>
<th>Age group 25-29</th>
<th>Age group 30-34</th>
<th>Age group 35-39</th>
<th>Age group 40-44</th>
<th>Age group 45-49</th>
<th>Age group 50-54</th>
<th>Age group 55-59</th>
<th>Age group 60+</th>
<th>Age group Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>44</td>
<td>54</td>
<td>69</td>
<td>82</td>
<td>111</td>
<td>143</td>
<td>76</td>
<td>59</td>
<td>643</td>
</tr>
<tr>
<td>Administrative Services</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>3</td>
<td>5</td>
<td>14</td>
<td>23</td>
<td>14</td>
<td>15</td>
<td>10</td>
<td>12</td>
<td>96</td>
</tr>
<tr>
<td>Allied Health Profession</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>-</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>13</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Nursing / Midwifery</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>25</td>
<td>28</td>
<td>38</td>
<td>33</td>
<td>57</td>
<td>103</td>
<td>42</td>
<td>21</td>
<td>350</td>
</tr>
<tr>
<td>Other Therapeutic</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>6</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>21</td>
</tr>
<tr>
<td>Senior Managers</td>
<td>0</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Support Services</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>9</td>
<td>11</td>
<td>10</td>
<td>16</td>
<td>31</td>
<td>20</td>
<td>19</td>
<td>25</td>
<td>142</td>
</tr>
</tbody>
</table>
4.2 Disability Profile

Table 11 provides some information with regards to the number of staff who consider themselves to have a long term health condition impacting upon their daily activities. This table shows that there are 5 or less in each of the Job Families of Administrative Services, Nursing and Midwifery and Support Services who consider themselves to meet the definition of Disability under the Equality Act.

It should be noted that TSH only holds information on Disability for 7.47% of the workforce.

Table 11:

<table>
<thead>
<tr>
<th>Job Family</th>
<th>Don’t know</th>
<th>Yes</th>
<th>No</th>
<th>Prefer not to say</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin Services</td>
<td>80</td>
<td>*</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>AHP</td>
<td>9</td>
<td>-</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Dental Support</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Healthcare Sciences</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>10</td>
<td>-</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Medical Support</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Nursing / Midwifery</td>
<td>305</td>
<td>*</td>
<td>27</td>
<td>26</td>
</tr>
<tr>
<td>Other Therapeutic</td>
<td>13</td>
<td>-</td>
<td>6</td>
<td>*</td>
</tr>
<tr>
<td>Personal &amp; Social Care</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Senior Managers</td>
<td>6</td>
<td>-</td>
<td>-</td>
<td>*</td>
</tr>
<tr>
<td>Support Services</td>
<td>106</td>
<td>*</td>
<td>7</td>
<td>31</td>
</tr>
<tr>
<td><strong>GRAND TOTAL</strong></td>
<td><strong>529</strong></td>
<td>*</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

% Breakdown (31 March 2016) 92.53% (information not known)

% Breakdown (31 March 2015) 92.44% (information not known)

Although we hold information on this Protected Characteristic the level of staff responding “no” may be subject to question. This is predicated on the assumption that the numbers of staff who could potentially fall within this Protected Characteristic is under recorded. The most commonly occurring (MODE) age bracket within the workforce is 40-44 and the results of Scotland’s Census 2011 indicates that the percentage of the population who consider themselves to have a long term health condition impacting on their day-to-day activities a lot is 10.70%, with a further 10.10% considering themselves to have a long term health condition impacting upon their day to day activities a little.

4.3 Gender Reassignment

No member of staff has declared that they have undertaken, or plan to undertake, gender reassignment surgery. Further analysis of this Protected Characteristic has therefore not been carried out.

4.4 Marriage and Civil Partnership

To date the Board has not routinely analysed this data in a structured manner. This will be reviewed in 2017/18 to determine how progress can be made in collating this data.

As a current global figure 43.6% of the workforce was married, with 10.9% (Male) and 32.7% (Female).
4.5 Race Profile

The Board holds ethnicity information on 53.43% of its workforce, a reduction of 0.04% when compared to the information published in April 2015. **Table 12** (Breakdown of workforce by Ethnicity and Job Family) below shows the percentage of the workforce by the Ethnicity categories listed in Scotland’s Census 2011, broken down into Job Families. This table shows that the majority of this improvement has been reflected within the Ethnicity category for staff who describes themselves as White Scottish.

**Table 12:**

<table>
<thead>
<tr>
<th>Administrative Services</th>
<th>White Scottish</th>
<th>White British</th>
<th>White Irish</th>
<th>White Other</th>
<th>Mixed</th>
<th>African</th>
<th>Asian</th>
<th>Other</th>
<th>Don’t Know</th>
<th>Prefer not to say</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>59</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Allied Health Profession</td>
<td>*</td>
<td>6</td>
<td>*</td>
<td>*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>*</td>
</tr>
<tr>
<td>Dental Support</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Healthcare Sciences</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>7</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>*</td>
</tr>
<tr>
<td>Medical Support</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Nursing/Midwifery</td>
<td>175</td>
<td>154</td>
<td>7</td>
<td>*</td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>17</td>
</tr>
<tr>
<td>Other Therapeutic</td>
<td>9</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>-</td>
<td>*</td>
<td>-</td>
<td>-</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Personal and Social Care</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Senior Managers</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Support Services</td>
<td>41</td>
<td>80</td>
<td>*</td>
<td>*</td>
<td>-</td>
<td>*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>19</td>
</tr>
</tbody>
</table>

% Breakdown (31 March 2016) 39.81% 47.58% 1.08% * 0.77% * - * - 6.68%

% Breakdown (31 March 2015) 39.59% 47.45% 1.23% * 0.77% * - * - 6.93%

Difference in % breakdown between 2016 and 2015 -0.22% 0.13% -0.15% * nil * - * - 0.25%
Data on the Ethnicity of 46.57% of the workforce is not available and it is therefore difficult to determine, other than in an indicative manner, if TSH has a workforce representative of the Ethnicity of the population of South Lanarkshire. Table 13 below indicates the difference between the % of the workforce in each category compared against the results of the 2011 Census results for South Lanarkshire. This appears to indicate that the ethnicity of the workforce is comparatively close to the Ethnicity of the population of South Lanarkshire.

Table 13:

<table>
<thead>
<tr>
<th>Category</th>
<th>White</th>
<th>White - Scottish</th>
<th>White - British</th>
<th>White - Irish</th>
<th>White - Other</th>
<th>Mixed</th>
<th>Asian</th>
<th>Other</th>
<th>Caribbean / Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative Services</td>
<td>-</td>
<td>60.82%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Allied Health Profession</td>
<td>-</td>
<td>46.19%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Dental Support</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Healthcare Sciences</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Medical Support</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Nursing/Midwifery</td>
<td>-</td>
<td>42.78%</td>
<td>1.94%</td>
<td>1.39%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other Therapeutic</td>
<td>-</td>
<td>33.33%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Personal and Social Care</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Senior Managers</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Support Services</td>
<td>-</td>
<td>54.42%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Grand Total</td>
<td>-</td>
<td>47.90%</td>
<td>1.86%</td>
<td>0.46%</td>
<td>1.39%</td>
<td>0.15%</td>
<td>-</td>
<td>0.15%</td>
<td>-</td>
</tr>
<tr>
<td>Scotland's Census 2011 (South Lanarkshire)</td>
<td>-</td>
<td>91.60%</td>
<td>3.80%</td>
<td>1.00%</td>
<td>0.90%</td>
<td>-</td>
<td>1.60%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Difference in % between The Board &amp; Scotland's Census</td>
<td>-</td>
<td>43.70%</td>
<td>-1.94%</td>
<td>-0.54%</td>
<td>0.49%</td>
<td>0.35%</td>
<td>-</td>
<td>-1.45%</td>
<td>-</td>
</tr>
</tbody>
</table>
4.6 Religion/Belief Profile

TSH holds Religion or Belief information on 39.65% of its workforce, a decrease of 1.64% when compared to the information available as at 31 March 2015. Table 14 (Breakdown of workforce by Religion or Belief and Job Family) below shows the percentage of the workforce by the Religion or Belief categories listed in Scotland’s Census 2011, broken down into Job Families. This table indicates that the majority of this increase has been within the total staff for whom data is unavailable. The remainder of the categories have remained broadly similar.

Table 14:

<table>
<thead>
<tr>
<th>Job Family</th>
<th>Don’t Know</th>
<th>Christian</th>
<th>Catholic</th>
<th>Church of Scotland</th>
<th>Roman Catholic</th>
<th>Christian - Other</th>
<th>Jewish</th>
<th>Hinduism</th>
<th>Judaism</th>
<th>Muslim</th>
<th>Sikh</th>
<th>Other</th>
<th>No Religion</th>
<th>Prefer not to say</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADMINISTRATIVE SERVICES</td>
<td>31</td>
<td>*</td>
<td>31</td>
<td>7</td>
<td>*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>16</td>
</tr>
<tr>
<td>ALLIED HEALTH PROFESSION</td>
<td>7</td>
<td>*</td>
<td>*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>*</td>
</tr>
<tr>
<td>DENTAL SUPPORT</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>HEALTHCARE SCIENCES</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>MEDICAL AND DENTAL</td>
<td>6</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>-</td>
<td>-</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>MEDICAL SUPPORT</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>NURSING/MIDWIFERY</td>
<td>202</td>
<td>-</td>
<td>60</td>
<td>29</td>
<td>6</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>41</td>
<td>22</td>
</tr>
<tr>
<td>OTHER THERAPEUTIC</td>
<td>11</td>
<td>-</td>
<td>-</td>
<td>*</td>
<td>*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>PERSONAL AND SOCIAL CARE</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>SENIOR MANAGERS</td>
<td>*</td>
<td>-</td>
<td>*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>*</td>
</tr>
<tr>
<td>SUPPORT SERVICES</td>
<td>57</td>
<td>-</td>
<td>41</td>
<td>*</td>
<td>6</td>
<td>*</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>*</td>
<td>18</td>
</tr>
<tr>
<td>GRAND TOTAL</td>
<td>314</td>
<td>-</td>
<td>132</td>
<td>36</td>
<td>12</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>75</td>
<td>50</td>
</tr>
</tbody>
</table>

% Breakdown (31 March 2016): 48.90% - 20.56% - 5.60% - 1.86% - 11.86% - 7.78%

% Breakdown (31 March 2015): 46.22% 21.10% 5.54% 2.31% 12.32% 8.32%

Difference in % breakdown between 2016 and 2015: 2.68% -0.54% 0.06% -0.45% -0.46% -0.54%
Table 15 indicates the difference between the % of the workforce in each category compared against the results of the 2011 Census for South Lanarkshire.

Table 15:

<table>
<thead>
<tr>
<th>Christian</th>
<th>Other Christian</th>
<th>Roman Catholic</th>
<th>Other Religion</th>
<th>Buddhist</th>
<th>Hinduism</th>
<th>Judaism</th>
<th>Muslim</th>
<th>Other</th>
<th>No Religion</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCOTLANDS CENSUS 2011 (SOUTH LANCASHIRE)</td>
<td>-</td>
<td>35.10%</td>
<td>22.20%</td>
<td>4.00%</td>
<td>-</td>
<td>-</td>
<td>0.80%</td>
<td>-</td>
<td>0.7%</td>
</tr>
<tr>
<td>Difference in % between The Board &amp; Scotland’s Census</td>
<td>6.30%</td>
<td>2.13%</td>
<td>1.76%</td>
<td>2.41%</td>
<td>-0.05%</td>
<td>0.26%</td>
<td>0.01%</td>
<td>-0.06%</td>
<td>-0.02%</td>
</tr>
</tbody>
</table>

Table 15 proposes that the majority of employees within TSH could be of a Christian Faith (i.e. Church of Scotland, Roman Catholic or Other Christian). It is possible that the percentage of the workforce reporting a Religion or Belief is higher than the percentage of the population in South Lanarkshire, where 30.6% responded that they hold no Religion or Belief.

### 4.7 Sex Profile

The State Hospital workforce consists of 356 female staff (55.37%) and 287 male staff (44.63%). Table 16 (Breakdown of workforce by Sex and Job Family) shows that there are wide variations within this breakdown between individual Job Families, with the female proportion of the workforce ranging from 21.42% within Medical and Dental to 92.31% within Allied Health Professions. Since 2015, there has been a decrease of 0.98% in the percentage of the female workforce.

**Table 16:**

<table>
<thead>
<tr>
<th>Job Family</th>
<th>Female Headcount</th>
<th>Female as % of Job Family</th>
<th>Male Headcount</th>
<th>Male as % of Job Family</th>
<th>Grand Total</th>
<th>Female Headcount</th>
<th>Female as % of Job Family</th>
<th>Male Headcount</th>
<th>Male as % of Job Family</th>
<th>Grand Total</th>
<th>Difference in % female between 2016 and 2015</th>
<th>Difference in % male between 2016 and 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADMINISTRATIVE SERVICES</td>
<td>80</td>
<td>83.33%</td>
<td>16</td>
<td>16.67%</td>
<td>96</td>
<td>82</td>
<td>83.67%</td>
<td>16</td>
<td>16.33%</td>
<td>98</td>
<td>0.34</td>
<td>-0.33</td>
</tr>
<tr>
<td>ALLIED HEALTH PROFESSION</td>
<td>12</td>
<td>92.31%</td>
<td>1</td>
<td>7.69%</td>
<td>13</td>
<td>11</td>
<td>84.61%</td>
<td>*</td>
<td>15.39%</td>
<td>13</td>
<td>7.00</td>
<td>-7.7</td>
</tr>
<tr>
<td>DENTAL SUPPORT</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>HEALTHCARE SCIENCES</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>MEDICAL AND DENTAL</td>
<td>3</td>
<td>21.43%</td>
<td>11</td>
<td>78.57%</td>
<td>14</td>
<td>*</td>
<td>15.39%</td>
<td>11</td>
<td>84.61%</td>
<td>13</td>
<td>6.03</td>
<td>-6.05</td>
</tr>
<tr>
<td>MEDICAL SUPPORT</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>NURSING/MIDWIFERY</td>
<td>149</td>
<td>42.57%</td>
<td>201</td>
<td>57.43%</td>
<td>350</td>
<td>151</td>
<td>42.18%</td>
<td>207</td>
<td>57.82%</td>
<td>358</td>
<td>0.51</td>
<td>-0.52</td>
</tr>
<tr>
<td>OTHER THERAPEUTIC</td>
<td>18</td>
<td>85.71%</td>
<td>3</td>
<td>14.29%</td>
<td>21</td>
<td>14</td>
<td>77.78%</td>
<td>4</td>
<td>22.22%</td>
<td>18</td>
<td>8.01</td>
<td>-8.01</td>
</tr>
<tr>
<td>PERSONAL AND SOCIAL CARE</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>SENIOR MANAGERS</td>
<td>2</td>
<td>28.57%</td>
<td>5</td>
<td>71.43%</td>
<td>7</td>
<td>*</td>
<td>14.28%</td>
<td>6</td>
<td>85.72%</td>
<td>7</td>
<td>14.29</td>
<td>-14.29</td>
</tr>
<tr>
<td>SUPPORT SERVICES</td>
<td>92</td>
<td>64.79%</td>
<td>30</td>
<td>35.21%</td>
<td>142</td>
<td>92</td>
<td>64.79%</td>
<td>50</td>
<td>35.21%</td>
<td>142</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>GRAND TOTAL</td>
<td>356</td>
<td>55.37%</td>
<td>287</td>
<td>44.63%</td>
<td>643</td>
<td>353</td>
<td>54.39%</td>
<td>296</td>
<td>45.61%</td>
<td>649</td>
<td>1.13</td>
<td>-1.13</td>
</tr>
</tbody>
</table>
The results from Scotland’s Census 2011 identifies the population breakdown of South Lanarkshire by gender was 51.9% female compared to 48.1% male. This breakdown was similar to the figure for the rest of Scotland and is not dissimilar to TSH workforce configuration.

4.8 Sexual Orientation Profile

The Board holds information on Sexual Orientation for 39.19% of its workforce, a decrease of 3.33% when compared to the information available in April 2015. Table 17 (Breakdown of workforce by Sexual Orientation) below shows the percentage of the workforce by the recognised Sexual Orientation categories. This data is measured across the total headcount of staff and is not broken down into Job Families.

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>In Post March 2016 (headcount)</th>
<th>In Post March 2015 (headcount)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bisexual</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>57</td>
<td>59</td>
</tr>
<tr>
<td>Gay</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>195</td>
<td>217</td>
</tr>
<tr>
<td>Lesbian</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Other</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Grand Total</td>
<td>252</td>
<td>276</td>
</tr>
</tbody>
</table>

Staff have responded indicating a non-heterosexual orientation but these are significantly small in number when compared to the total workforce. As questions relating to sexual orientation were not included in Scotland’s Census 2011 there is no hard information on the proportion of the population reporting to be Lesbian, Gay or Bisexual. Stonewall, the LGBT lobbying group believes a Government estimate of between 5 – 7% of the population is reasonable however it is recognised that obtaining information on an individual’s sexual orientation presents challenges. For example, in a recent Household Survey, carried out by the General Register Office for Scotland, only 31% of individuals returned their questionnaire. 2.2% of respondents declared a non-heterosexual orientation.

Although it is possible, based on the estimates available, that the percentage of the workforce declaring a non-heterosexual sexual orientation is lower than the population of South Lanarkshire, direct comparisons cannot be made.

4.9 Redeployment

A very small number of staff within TSH are on the formal redeployment register. The policy for redeployment is scheduled for review and part of the review will be to consider the establishment of a formal a formal redeployment group, in partnership, to deal with issues pertaining to the redeployment of staff whether this be related to ill health, capability or organizational change. The effectiveness of these arrangements will be monitored by the Partnership Forum.
4.10  Vacancies – potential skills gaps

It is not anticipated that given the low turnover rate coupled with the number of applications received when vacancies do arise that there is a difficulty in recruiting to posts within TSH.

However, what will need to be considered going forward is the approach to be taken in respect of succession planning. This relates to both promoted posts for which a certain skill set is required and also senior specialist posts within an area which has skills particularly pertinent to this setting.

4.11  Recruitment Initiatives

4.11.1  Work Experience/Youth Employment

Whilst educational placements are undertaken within TSH e.g student clinical placements TSH does not participate in providing Work experience opportunities in a broader sense. One of the factors influencing this is the high secure setting, client group and the age at which it would be seen as appropriate to provide individuals with access to the site. Currently TSH employs no-one below the age of 20 and only a total of 11 in the age range of 20-24. This may be for a variety of reasons such as the number of school leavers choosing to move into further and higher education rather than into the labour market, although such arguments should be balanced against higher youth unemployment being reported nationally.

4.11.2  Modern Apprenticeships

To increase employment for those aged up to 24 TSH is proposing to develop Modern Apprenticeships. It could also be the case that the high secure environment within TSH is not seen as being attractive or appropriate to the younger labour market. It is intended to take steps in 2017/18 to explore youth employment opportunities through the aforementioned scheme in discussion with Jobcentre Plus and other key stakeholders.

4.11.3  Internships

In previous years TSH has supported Interns within the nursing workforce albeit this has been a small number. TSH remains committed to supporting interns and if individuals wished to pursue an internship programme within TSH then this would be supported.

4.11.4  Volunteers

The Volunteer Service has increased in numbers to 28, with the range of roles developed over the past twelve months to include input within the wards, in addition to the Skye Centre. Interest remains steady from those wishing to provide voluntary input within the Hospital, with the majority of enquiries coming from university students seeking to consolidate theoretical learning in preparation for seeking employment / access to higher level learning. The screening process ensures that applications are relevant to this setting and that opportunities can be offered for student volunteers to gain the experiential skills required. Collaborative working with Third Sector organisations enable the organisation to adopt a targeted approach to recruitment to specialist areas.
4.12 Labour Market Intelligence

Some of the main features of the South Lanarkshire labour market are highlighted below (NOMIS):

- 79.1% of the South Lanarkshire population are economically active compared to 76.8% across Scotland.

- Unemployment in South Lanarkshire is 4.7%.

- In South Lanarkshire 37.8% of the population are within Soc 2010 Group 1-3 which includes Managers, Directors, Senior Officials, Professional Occupations and Associate Professional and Technical occupations. The Scottish level is 41.8%

- Administrative and skilled trades’ staffs makes up 26.0% of South Lanarkshire population. (Scotland level is 22.5%).

- Caring, leisure and service employments account for 18.2% of South Lanarkshire, and 18.5% Scotland population.

- The proportion of the population with National Vocational Qualifications (NVQ) 4 equivalent and above qualifications (e.g. HND, degree, Higher degrees, etc) is 37.8% the Scottish wide level is 42.5%

- The level of the population with no qualifications is 9.1% in South and in Scotland 9.00%.

- Average earnings in South Lanarkshire are (£531.1) and in Scotland (£527)

- The density of jobs (no. of jobs per resident between 16-64) is 0.64 in South Lanarkshire and in Scotland 0.80. The ratio of job seekers claimants to vacancies at job centre plus is 3.6 in South Lanarkshire and 3.3 in Scotland.
Step 5: Developing an Action Plan

This step involves reflecting on the previous three steps and determining the most effective way of ensuring the availability of staff to deliver redesigned services, even if this means some further service redesign. A plan for delivering the right staff, with the right skills in the right place needs to be developed with milestones and timescales. You should also include in your plan an assessment of anticipated problems and how you will build a momentum for change, including clinical engagement (Skills for Health, 2008).

5.1 Education and Training

TSH has a Corporate Training Plan which has been developed to support the Local Delivery Plan. The Plan aims to articulate a consistent approach to learning, training and development for the whole organisation. The Strategy has been communicated widely and a number of actions taken forward.

The two main priorities identified are Performance Management and Values and Behaviours. Work will be undertaken in 2017/18 to identify the actions needed to improve performance management arrangements and also to begin embedding the national values into the everyday business of the hospital. This will include redesigning our Corporate Induction programme to incorporate a values based approach. In addition as part of the overarching workforce review this will require targeted development and support for new leaders and managers and strengthening of learning around all aspects of quality improvement.

Within this context TSH will continue its commitment to the modernisation of services by supporting the practice and educational developments, succession planning career transitions and learning needs of the workforce thorough medical education, organisational development and practice development in conjunction with partnership working with other relevant partners such as NES to provide the local infrastructure to support staff development. TSH is also committed to the education developments of under and post graduates students who will be the future workforce of TSH.

5.2 Workforce Planning Capability

Effective healthcare workforce planning is essential to meet patient centred care and the challenges of future requirements within the healthcare sector. TSH understands the importance of planning the workforce to deliver service for current and future needs, regardless of whether staff are in a service, clinical or financial role.

Workforce planning must be strategic and integrate with service planning, financial planning, service redesign, education / training, recruitment, retention and role development.

Within TSH responsibility for overseeing the workforce planning process lies with the Human Resources Director and ultimately with the Chief Executive. In terms of governance Workforce reports are considered at Senior Management Team, Partnership Forum, Staff Governance Committee and the Board.

It is however, the responsibility of every manager of a service to be responsible for reviewing the short, medium and long term workforce needs of their areas to ensure that TSH can continue to meet the needs of the patients in our care within the financial and workforce resources available.

As stated previously this plan will be reviewed regularly to ensure that it is fit for purpose. This will include formal submission to Partnership Forum, Staff Governance Committee and the Board as
appropriate for consideration and agreement in terms of the strategic direction of the workforce within TSH.

5.3  Risk Assessment

Individual Directors are responsible for the identification, mitigation and, where possible, avoidance of risks. This includes risks associated with the workforce. Risks are recorded and managed through a robust corporate approach to Risk Management.

In addition, an Equality & Diversity Impact Assessment of the Workforce Plan has been undertaken. A copy of this is available on request.
Step 6: Implementing, Monitoring and Refresh

After the plan begins to be delivered, it will need periodic review and adjustment. The plan will have been clear about how success will be measured, but unintended consequences of the changes also need to be identified so that corrective action can be taken (Skills for Health, 2008).

6.1 Monitoring Process

TSH monitors and reports on workforce change on a regular basis. Steps will be taken in 2017/18 to prepare standard workforce reports although it has to be recognized that these reports can only be based upon the data currently available be this internally or externally.

Attached at Appendix II is the Implementation Plan containing the short, medium and long term actions arising from the workforce plan. This will be issued to monitor progress.

It is proposed to provide regular updates on workforce performance to the Partnership Forum and Senior Management Team as required.
3 CONCLUSION

As stated in the introduction, The State Hospital is committed to maintaining a world class High Secure Mental Health Service which puts patients at the centre of their care and focuses on positive health outcomes and recovery. As an organization TSH is recognized both nationally and internationally as a centre of excellence and the workforce plan must provide the framework within which this reputation may continue.

While the financial constraints on health care are shared in common with other NHS Services, the management team must address operational challenges which are, in combination, unique to the State Hospital. Examples of this include the need to ensure a highly specialist and finite workforce can respond flexibly and on every occasion to variations on clinical and workforce demands.

A history of high sickness absence within the workforce is a key focus for our attention and support as we seek to reduce reliance on additional hours and reinvest this in core staffing posts. We will only achieve this if the health and wellbeing of our staff improves.

The importance of developing an engaged workforce, supported by the implementation of iMatter, which will result in a higher level of job satisfaction for staff, better quality care and also improve performance in relation to staff attendance must also be supported. The changes made to the leadership structures and investment in leadership skills will help achieve this aspiration.

The challenges raised for us as senior management via iMatter has resulted in the progression of the work contained within this plan.

This Workforce Plan has identified issues with an ageing workforce. Actions which will be taken to consider this aspect in more detail will include:

- Consideration of what is needed to support succession planning to ensure that in the future we are able to increase the potential number of staff suitable for promoted or specialist posts both clinical and non-clinical in the future.
- This not only means the recruitment of individuals with the appropriate skills and qualifications but more importantly those who will be able to demonstrate the values and behaviours that we wish to see displayed within TSH.
- Dissemination of the updated guidance from STAC on Working Longer within the NHS.

This plan will serve as an iterative document which will continue to be refreshed and monitored in terms of its continued applicability to the challenges that we face as an employer.
REFERENCES


Scottish Executive (2005) national Workforce Planning Framework Guidance HLD 52 (2005), Scottish Executive 2005


Aim:
To optimise staff health and wellbeing and related attendance at work.

Measures:
1. Reduce monthly and rolling 12 month absence figure to achieve 2% or better.
2. Reduce in avoidable instances of ill health.
3. Improved performance on NOS survey.
4. Improved compliance with policy eg RTW.
5. Staff are managed through all stages of review appropriately.
6. The SLR outcomes are being delivered as specified.
7. An agreed QA framework is in place.

STAFF WELLBEING DRIVER DIAGRAM

Primary Drivers
- 1. The organization promotes a healthy working environment (infuse / procedural / values and behaviours)
- 2. Issues which may impact on staff health and wellbeing are identified early and appropriate support is offered.
- 3. Managers have the skills and competencies to support effective working relationships with their staff and ensure that wellbeing issues are identified and addressed.
- 4. Managers have the confidence, skills and competence to manage attendance appropriately in line with policy.
- 5. The organization has an effective policy framework to manage attendance at work.
- 6. Managers and staff have access to effective sources of support in promoting and addressing health and wellbeing issues.
- 7. Active surveillance of performance to ensure continuous improvement

Secondary Drivers
- Develop targeted actions to increase awareness eg communication briefings / annual health checks / etc.
- Reduce reliance on additional hours to meet service and clinical needs.
- Implement stress audits where indicated.
- Improve awareness of organisational values and behaviours.
- Improve line manager’s awareness of signs of stress in the workplace / musculoskeletal issues and symptoms.
- Consider staff support models in Boards with low S/A (e.g. Tayside).
- Invest in line management skills development / interpersonal skills / developing teams etc.
- Review current competency / skills levels.
- Develop and deliver mandatory training for managers and Trade Union Reps delivered in partnership.
- Provide training on business objects to access relevant data.
- Review policy to ensure it is fit for purpose.
- Develop template letters, checklists and supporting documentation.
- Determine levels of responsibility within the Policy Implementation framework.
- Review use of flexible working arrangements and access / usage of other HR policies.
- Review Occupational Health provision (current).
- Review and maintain Occupational Health Services.
- Review seat incident reports.
- Benchmarking of performance via monthly ISO statistics.
- Implement appropriate internal scrutiny arrangements to monitor performance.
- Ensure RTW interviews are undertaken and on time as per policy.
<table>
<thead>
<tr>
<th>ISSUE</th>
<th>ACTION</th>
<th>LEAD</th>
<th>TIMESCALE: Short, Medium and Long Term</th>
</tr>
</thead>
</table>
| **Sustainable Workforce**    | Implement Review of Nursing Capacity                                  | Governance Group: SMT Officer: Robert Alexander, Clinical Operations Manager Critical Contributors: Nurse Director, Senior Nurse, HR, Staff Representatives | Short – in year Approaches implemented:  
• Identified gap in existing core nursing workforce  
• Agreed temporary investment in workforce  
• Proactive recruitment in year Increased establishment from 292wte to 302wte |
| Implement Revised AHP Leadership and sub-structure Arrangements | Governance Group: SMT Officer: Mark Richards, Director of Nursing and AHP Critical Contributors: Interim General Manager, AHP, HR, Staff Representatives | Short – in year  
• Lead AHP/OT advertised April 2017  
Proposal for OT workforce developed to be progressed in 2017/18 – 3 months duration to conclusion |
| Implement Revised Patient Day Activity arrangements incorporated within Review of Clinical Model | Governance Group: SMT Officer: Lindsay Thomson, Medical Director Critical Contributors: Clinical Forum Members, Staff Representatives | Ongoing. Agreed initial focus on Lewis Hub as a test of change – May 2017 |
| Implement Agreed Action Plan for Promoting Attendance/Staff Health and Wellbeing | Governance Group: Partnership Forum Officer: Barbara Anne Nelson, Human Resources Director Critical Contributors: Senior Managers, Head of HR, Occ Health, Staff Representatives | Short to Medium Term for process issues  
Long Term for cultural change  
• Training sessions held for staff with responsibility in promoting attendance - Policy clarification achieved in Partnership |
<table>
<thead>
<tr>
<th>Task Description</th>
<th>Governance Group</th>
<th>Officer</th>
<th>Critical Contributors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review/Refresh Workforce Plan Oct 16 – Mar 17</td>
<td>All</td>
<td>Ongoing</td>
<td>Reviewed December 2016 and April 2017</td>
</tr>
<tr>
<td>Temporary Ward Closure</td>
<td>Governance Group: SMT, Partnership Forum, Board Officer: Jim Crichton, Chief Executive</td>
<td>Jim Crichton, Chief Executive</td>
<td>Critical Contributors: Clinical Operations Manager, Lead Nurses, Senior Charge Nurses, HR, Staff Representatives</td>
</tr>
<tr>
<td>Review of Therapy Provision</td>
<td>Governance Group: SMT Officer: Mark Richards, Director of Nursing and AHP</td>
<td>Mark Richards, Director of Nursing and AHP</td>
<td></td>
</tr>
<tr>
<td>HR Shared Services – National Boards and National Shared Services for Support Services</td>
<td>Governance Group: SMT, Board Officer: Jim Crichton, Chief Executive</td>
<td>Jim Crichton, Chief Executive</td>
<td>Barbara Anne Nelson, HR Director, Staff Representatives and other Support Services Managers as appropriate</td>
</tr>
<tr>
<td>Task</td>
<td>Responsible Party</td>
<td>Duration</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>-------------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>Refresh Workforce Section of TSH Corporate Risk Register to reflect workforce risk</td>
<td>HRD</td>
<td>Short – in year Completed</td>
<td></td>
</tr>
<tr>
<td>Review available workforce data</td>
<td>HRD</td>
<td>Short – in year Reviewed and gaps identified some of which may be resolved by implementation of eESS in line with national timetable</td>
<td></td>
</tr>
<tr>
<td>Continue to support KSF/PDP process</td>
<td>All</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Include future education training development needs in future workforce plan</td>
<td>HRD/ND/Training and Professional Development Manager</td>
<td>Short to Medium Commenced with Nursing Leadership changes</td>
<td></td>
</tr>
</tbody>
</table>

**Capable Workforce**

<table>
<thead>
<tr>
<th>Task</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop Leadership Programme</td>
<td>Governance Group: SMT Officer: Training and Professional Development Manager Critical Contributors: HR, OD, Staff Representatives, Stakeholders</td>
</tr>
<tr>
<td>Develop Secondment Opportunities within Forensic Network</td>
<td>Governance Group: SMT Officer: Robert Alexander, Interim General Manager Critical Contributors: HR, Staff Representatives, FN Manager</td>
</tr>
<tr>
<td>Refresh KSF guidance for Managers</td>
<td>Training and Professional Development Manager</td>
</tr>
</tbody>
</table>

- a) Support workforce review – Short – in year
  - Commenced with Nursing Leadership changes
- b) Medium to long term programme

Medium to Long Term Learning Exchange Initiative introduced as a pilot to support development of SCN’s
| Quality Improvement Skills | Develop a QI Strategy | Governance Group: SMT Officer: Robin McNaught, Director of Finance and Performance Management Critical Contributors: HR, QI support, Staff Representatives, Training and Professional Development Manager, Stakeholders | Short – in year  
- To be addressed along with Risk Strategy review  
To be finalised once Business Support role in place – Summer 2017 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Future effective process is in place to comply with mandatory/statutory training</td>
<td>Training and Professional Development Manager</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Review corporate induction to include a values based component</td>
<td>Training and Professional Development Manager</td>
<td>Short</td>
<td></td>
</tr>
<tr>
<td>Develop and deliver Corporate Training Plan</td>
<td>Training and Professional Development Manager</td>
<td>Ongoing</td>
<td></td>
</tr>
</tbody>
</table>
| Effective Leadership | Implement Revised Nurse Leadership Arrangements | Governance Group: SMT Officer: Mark Richards, Director of Nursing and AHP Critical Contributors: Interim General Manager, Senior Nurse, HR, Staff Representatives | Short – in year  
Fully implemented:  
- Clinical Ops Manager, Professional Lead Nurse Advisor, Lead Nurses, Senior Charge Nurses and Team Leaders in place |
<table>
<thead>
<tr>
<th><strong>Healthy Organisational Culture</strong></th>
<th><strong>Review the Corporate Leadership and Governance Structure</strong></th>
<th><strong>Governance Group: NHS Board Officer: Chief Executive</strong></th>
<th><strong>Critical Contributors: Chairs of Existing Governance Groups</strong></th>
<th><strong>Short – in year</strong>&lt;br&gt;• Paper agreed via SMT June 2016&lt;br&gt;Separation of Clinical Forum and Clinical Governance Group implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Review Business Support Function</strong></td>
<td><strong>Governance Group: SMT Officer: Chief Executive</strong></td>
<td><strong>Critical Contributors: Director of Finance and Performance, Nurse Director, HR, Staff Representatives, Stakeholders</strong></td>
<td><strong>Short – in year</strong>&lt;br&gt;Business Support Role in progress subject to HR processes</td>
<td></td>
</tr>
<tr>
<td><strong>Refresh the method of incorporating values and behaviours to underpin all objectives of Executive and Senior Managers</strong></td>
<td><strong>HRD/Chief Executive</strong></td>
<td><strong>Short – in year</strong>&lt;br&gt;Completed and discussed at appraisal review and objective setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Review recruitment processes to incorporate a values based approach.</strong></td>
<td><strong>HRD/Recruiting Managers</strong></td>
<td><strong>Short to Medium Term</strong>&lt;br&gt;• Piloted within nursing&lt;br&gt;To be developed further</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Identify centre resource to support iMatter</strong></td>
<td><strong>HRD</strong></td>
<td><strong>Short – in year</strong>&lt;br&gt;OD Manager performs this role</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Develop Values/Behaviour Action Plan</strong></td>
<td><strong>HRD/Partnership Forum</strong></td>
<td><strong>Short to Medium Term</strong>&lt;br&gt;Values and Behaviours Group established</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1 SITUATION

The attached Staff Governance Committee Annual report outlines the key achievements and key developments overseen by the Committee during 2016/17. The stock take also includes the Committee’s Terms of Reference, Reporting Structures and Work Programme.

2 BACKGROUND

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

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

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

3 ASSESSMENT

In the performance year 2016/17, The State Hospitals Board for Scotland’s Staff Governance Committee continued to focus its monitoring activities in respect of the above. The Committee members recognised their obligations to support a culture within The State Hospitals Board for Scotland where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the organisation and is built upon the principles of partnership.

4 RECOMMENDATION

The Board is asked to note and approve the Staff Governance Committee Annual Report.
<table>
<thead>
<tr>
<th><strong>MONITORING FORM</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?</td>
</tr>
<tr>
<td>Workforce Implications</td>
</tr>
<tr>
<td>Financial Implications</td>
</tr>
</tbody>
</table>
| Route To Clinical Governance Committee  
Which groups were involved in contributing to the paper and recommendations? | n/a |
| Risk Assessment  
(Outline any significant risks and associated mitigation) | n/a |
| Assessment of Impact on Stakeholder Experience | n/a |
| Equality Impact Assessment | n/a |
THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE ANNUAL REPORT

1 April 2016 – 31 March 2017
1. Introduction

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

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- 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 2016/17, 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 2016/17 are detailed below.

2. Committee Chair Members and Attendees

Committee Chair:
Bill Brackenridge (Chair of Committee, Non Executive Director)

Committee Members:
Nicholas Johnston (Non Executive Director)
Elizabeth Carmichael (Non Executive Director) (up to June 2016)
Maire Whitehead (Non Executive Director) (from August 2016)
Anne Gillan (Employee Director)
Donald Speirs (lay member, Royal College of Nursing)
Alan Blackwood (lay member, Prison Officers’ Association)
Tom Hair (lay member, UNISON)
Robert Alexander (Interim General Manager)

Ex-officio members:
Terry Currie (Chairman)
Jim Crichton (Chief Executive)
Barbara Anne Nelson (Human Resources Director) (up to March 2017)
John White (Interim Human Resources Director) (from April 2017)

Where required by the Chair or by other members of the Committee, appropriate members of staff were invited to be in attendance for the purposes of verbal updates, information sharing, presentations etc.
3. Meetings during 2016/17

During 2016/17 the Clinical Governance Committee met on 4 occasions, in line with its terms of reference (appendix 1). Meetings were held on:

- 2 June 2016
- 18 August 2016
- 1 December 2016
- 2 March 2017

4. Reports Considered by the Committee During the Year

The Committee received reports and monitored areas as follows:

- Staff Governance Self Assessment Submission 2015/16
- Staff Governance Action Plan for 2016/17;
- 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
- Monitoring the content and actions relating to Audit Reports covering Staff Governance matters
- Monitor the implementation and consider the outcome of iMatter, the NHS Scotland Staff Engagement Tool

4.1 Annual Reports

Staff Governance Action Plan submission 2015/16

The Staff Governance Action Plan return for 2015/16 provided assurance that The State Hospitals Board for Scotland had met its obligations under the Staff Governance Standards. Feedback from Scottish Government contained the following comments:

- In terms of overall experience of staff the Board were congratulated on the significant improvements which had been made as a result of the improvement work undertaken
- In terms of well informed the Board were again congratulated on the variety of methods adopted to communicate with staff
- In terms of appropriately trained and developed the Board were congratulated on our ongoing achievements in relation to KSF Reviews and PDP where the achievement of 81% completed by March 2015 was above the National Standard.
- There was a need to improve upon the area of staff feeling involved in decisions, dignity at work issues and staff feeling able to speak up and challenge

Staff Governance Action Plan 2016/17

The Action Plan for 2016/17 focused on outcomes relating to the priorities within Everyone Matters 2020 Vision relating to Healthy Organisational Culture, Sustainable Workforce, Capable Workforce, Integrated Workforce and Effective Leadership and Management. Main priorities/actions are detailed below:

- Implementation of Cycle 2 of iMatter
- Scope action required to embed NHS Scotland values within the Board
- Develop Workforce Plan
- Improve performance in attendance management
• 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.
• Addressing issues relating to Health, Safety and Wellbeing of staff
• Participation in the National Shared Services agenda as appropriate
• Scope progress with regard to review of PIN policies

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. In year 4 policies were either developed as new policies with reference to the relevant PIN guidance or involved a review of an existing policy.

**Occupational Health Service Annual Report**

The annual report was presented by the Occupational Health Clinical Team from SALUS, current provider of the OHS service level agreement at the December 2016 meeting.

**4.2 Progress Updates**

The committee received regular update reports and monitored issues relating to the following issues:

- Knowledge and Skills Framework
- Attendance Management

The Committee had a particular focus on the performance of the organisation in relation to attendance management. Additional reports were requested by members relating to an analysis of the highest level of absence experience in year along with further data in respect of the application of the Attendance Management Policy.

**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 75.15% which is an increase of 2.62% on the previous year’s performance of 72.53%.

**Attendance Management**

The State Hospitals Board for Scotland did not achieve the absence management standard of 5% in 2016/17. The end of year average absence percentage was 8.35%. The principal reasons for absence remained consistent with the previous year, with the two most common reasons for absence being anxiety/stress/depression and musculoskeletal conditions.

As previously stated the Committee paid particular attention and applied more scrutiny to this issue throughout the year and wished to be assured that all steps were being taken to reduce the level of absence being experienced.
4.3 Standing Items Considered by the Committee During the Year

Workforce Plan

The Committee monitored progress in the achievement of workforce plan targets. Work was further progressed in relation to developing a workforce report which was considered by the Committee in June 2016 prior to being submitted to the Board.

Fitness to Practise

A report was provided to assure the Staff Governance Committee that all professional staff were registered and fit to practise. This also included a follow up report to the Committee regarding a single situation where one employee did not have appropriate PVG Registration. The Committee were assured that this matter was dealt with timeously following a full risk assessment.

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. Members were also assured that the recording arrangements for all Employee Relations matters including Dignity at Work had been reviewed to ensure that all of the relevant data is captured.

2020 Workforce Vision

The implementation plan for 2020 workforce vision generated much debate, and informed the planning process for the Staff Governance Action plan 2016/17. 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);

Mandatory and Statutory Training

The Committee reviewed the arrangements for completing Mandatory Statutory training in order to ensure that these were robust and supported the Staff Governance Strand of the workforce being “Appropriately trained and developed”. This was a new Agenda item for the Committee but will continue to be reported on in terms of compliance in 2016/17.

5. Conclusion

The performance year 2016/17 has underlined the continuing need to focus our attention on key Staff Governance issues. The staff survey results 2015/16 formed the basis of the staff governance action plan for the year, 2016/17.

The main priority area in terms of Staff Governance performance management continues to be the pursuit of the Attendance Management target of 5% absence. In addition another priority is the completion of Personal Development Plans. Performance in these two areas will continue to be monitored rigorously by the Committee in the coming year against the background of the new approaches which have been developed and are being adopted to address these priorities.
The Scottish Workforce Advisory Group Secretariat agreed that the Scottish Government do not undertake the traditional annual Staff Governance Monitoring exercise for 2016/17. This was to allow a transitional year to focus on fully implementing iMatter and to develop a complementary Staff Governance Standard Monitoring process. The Staff Governance Committee acknowledged this change and complied with the interim requirement to provide relevant information. The primary purpose was to provide assurance of The State Hospitals progress in delivering the Staff Governance Standards and to inform the Annual Review process.

The terms of reference for the Staff Governance Committee were revised in 2016/17 to reflect an increase from 2 lay members to 3 and this amendment was duly approved by the Audit Committee.

From the review of the performance of the Staff Governance Committee, it can be confirmed that the Committee has met in line with the Terms of Reference, and has fulfilled its remit. Based on assurances received and information presented to the Committee, adequate and effective Staff Governance arrangements were in place throughout the year.

I offer my thanks for the continuing support and encouragement of Committee members and also to those members of staff who have worked on the Committee’s behalf during 2016/17.
THE STATE HOSPITALS BOARD FOR SCOTLAND
STAFF GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

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

2 COMPOSITION

2.1 Membership

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

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

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

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

Membership will be reviewed annually.

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

2.2 Appointment of Chair

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

2.3 Attendance

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

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

This revision: Approved June 2016
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.
1  SITUATION

To provide a report containing a summary of the work overseen by the Remuneration Committee. The attached Remuneration Committee Annual report outlines the key achievements and key developments overseen by the Committee during 2016/17. The stock take also includes the Committee’s Terms of Reference, Reporting Structures and Work Programme.

2  BACKGROUND

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

Each year the committee undertakes a review of Remuneration arrangements, consisting of:

- A review of the committee’s work programme for forthcoming years.
- A review of the committee’s terms of reference. An annual report summarising the work of the remuneration committee.

3  ASSESSMENT

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

The Remuneration Committee reports to the Audit Committee. The committees Terms of reference are subject to annual review. The programme of work is largely determined by the requirement to implement executive and senior managers pay with reference to relevant SGHD instruction and performance appraisal. In addition oversight of the application and award of discretionary points is a routine consideration of the committee as is consideration of ad-hoc issues relating to remuneration.

4  RECOMMENDATION

The Board is asked to note and approve the Remuneration Committee Annual Report.
| How does the proposal support current Policy / Strategy / LDP / Corporate Objectives? |   |
| Workforce Implications | n/a |
| Financial Implications | n/a |
| Route To Clinical Governance Committee  
Which groups were involved in contributing to the paper and recommendations? | n/a |
| Risk Assessment  
(Outline any significant risks and associated mitigation) | n/a |
| Assessment of Impact on Stakeholder Experience | n/a |
| Equality Impact Assessment | n/a |
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 2016/17, The State Hospitals Board for Scotland’s Remuneration Committee continued to focus its monitoring activities in respect of the above, with particular regard to the performance, pay and terms and conditions of Executive and Senior managers.

2  COMMITTEE CHAIR MEMBERS AND ATTENDEES

**Committee Chair:**
Terry Currie, NHS Board Chair

**Committee Members:**
Maire Whitehead, Non-Executive Director
Elizabeth Carmichael, Non-Executive Director
Bill Brackenridge, Non Executive Director
Nicholas Johnston, Non Executive Director
Anne Gillan, Non Executive Director / Employee Director

**Ex-officio members:**
Jim Crichton, Chief Executive
Barbara Anne Nelson, HR Director
Jean Wade, Board Secretary

3  MEETINGS DURING 2016/17

During 2016/17 the Remuneration Committee met on three occasions, in line with its terms of reference (appendix 1). Meetings were held on:

- 23 June 2016
- 25 August 2016
- 8 December 2016

4  REPORTS CONSIDERED BY THE COMMITTEE DURING THE YEAR

- Approval of the Performance Management arrangements and Performance Appraisals for Executive Directors for the performance year 2015-16.
- 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 2016/17.
• Consultants discretionary points were reported on and approved.
• Consideration of ad-hoc issues relating to remuneration including: Calculation of redundancy payment in accordance with section 16 AfC; national issues – Equal Pay Claims, Calculation of Holiday Pay; Job Evaluation arrangements and the application of Factor 16 (Working Environment).

5 CONCLUSION

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

I would like to thank the Committee members for their contribution to the meetings in 2016/17.
THE STATE HOSPITALS BOARD FOR SCOTLAND

REMUNERATION COMMITTEE

TERMS OF REFERENCE

TITLE

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

COMPOSITION

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

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

In addition there will be in attendance:

- Chief Executive
- Human Resources Director
- Board Secretary

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

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

Executive Director Lead

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

- support the Chair in ensuring that the Committee Remit is based on the latest guidance and relevant legislation;
- liaise with the Chair in agreeing a programme of meetings for the business year, as required by its remit;
- oversee the development of an Annual Workplan for the Committee which is congruent with its remit and the need to provide appropriate assurance at the year-end, for endorsement by the Committee and approval by the Board;
- agree with the Chair an agenda for each meeting, having regard to the Committee’s Remit and Workplan;
- oversee the production of an Annual Report, informed by self assessment of performance against the Remuneration Committee Self Assessment Handbook, on the delivery of the Committee’s Remit and Workplan for endorsement by the Committee and submission to the Board.
4 Where issues with financial implications are to be discussed at the Remuneration Committee the implications will first have been discussed with the Finance Director and, where appropriate, the Finance Director may be invited to attend meetings of the Remuneration Committee.

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

FUNCTIONS

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

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

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

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

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

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

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

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

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

13 To consider any redundancy, early retirement 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.

Approved June 2015
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

Meetings of the Committee will be called by the Chair of the Committee with items of business circulated to members one week before the date of the meeting.

The Committee will seek specialist guidance and advice as appropriate.

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

REGULARITY OF MEETINGS

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

The Remuneration Committee will report to the Board.

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

Annual Report

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

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

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.

A Report, marked as ‘confidential’, on each meeting of the Remuneration Committee will be issued to the Non Executive Directors of the Board.
Minutes of the meeting of the Staff Governance Committee held on Thursday 1 June 2017 at 9.45am in the Boardroom, The State Hospital, Carstairs.

**Present:**
- Non Executive Director          Bill Brackenridge (Chair)
- Board Chair         Terry Currie
- Employee Director        Anne Gillan
- Non Executive Director        Nicholas Johnston
- Non Executive Director        Maire Whitehead

**In attendance:**
- Clinical Operations Manager       Robert Alexander
- Chief Executive         Jim Crichton
- Board Secretary         Jean Wade
- Interim HR Director        John White

1 **APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS**

No apologies were received. Bill Brackenridge welcomed everyone to the meeting and introduced John White, Interim HR Director, who was attending the Committee for the first time since his appointment.

2 **CONFLICTS OF INTEREST**

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

3 **MINUTES OF THE PREVIOUS MEETING HELD ON 2 MARCH 2017**

The Minutes of the previous meeting had been received and noted by the Board at their meeting on 4 May 2017.

The Committee approved the Minutes of the previous meeting on 2 March 2017 as an accurate record.

4 **ACTION POINTS AND MATTERS ARISING FROM THE PREVIOUS MEETING**

Members noted that the Action Points from the last meeting were progressing or complete.

**EASY Implementation Progress Report:**
Members received a report from John White which provided a draft high level implementation plan. It was noted that there were a number of underpinning actions which were required to be in place to support this implementation plan and this detail was currently being finalised.

John White confirmed that Phase 1 of the EASY Project was progressing as planned with no major issues of concern. In the first month, 18 referrals had been made. A report would be received from SALUS Occupation Health in August in respect of the compliance rate together with other relevant statistics. It was noted that staff were in acceptance of the EASY process and recognised the high sickness levels at the Hospital.

Members noted the EASY Implementation Progress Report.

5 **ATTENDANCE MANAGEMENT**

Members received a report from John White which provided an update on Attendance Management.
Members reviewed the report and the accompanying data and noted that the SWISS sickness absence figure from 1 March 2017 to 31 March 2017 was 7.26% with the long/short term split being 3.04% and 4.22% respectively. The total hours lost for this period was 7,151.37, which equates to 43.94 wte staff.

The current rolling 12 month sickness figure was 8.35% for the period 1 April 2016 to 31 March 2017. The total hours lost for this period was 97,892.74 which equates to 50.20 wte staff.

Industrial injuries represented 0.32% of available hours (3,729.52) from 1 April 2016 to 31 March 2017.

Members discussed a range of issues of the data provided and in relation to the causes of absences, noted that all NHSS Boards had a focus on common mental health issues which was the highest absence reason over the past year.

It was agreed that, in future reports, it would be useful to include in Chart 3, the last year’s rolling figure month by month.

Action: John White

Members noted the Attendance Management Report.

6 STAFF GOVERNANCE STANDARD MONITORING FRAMEWORK 2016-17

Members received a report from John White seeking approval of the Staff Governance 2016-17 Monitoring Return. It was noted that the traditional annual Staff Governance Monitoring exercise for 2016-17 would not be undertaken by Scottish Government. This would allow a transitional year to focus on fully implementing iMatter and to develop a complementary Staff Governance Standard Monitoring process.

John White summarised the content of the Return which had been completed from information gathered from a number of sources and there was clear evidence of positive progress during 2016-17.

A number of issues were discussed in relation to the iMatter Employee Engagement Index Score, which at 74%, John White confirmed that the Hospital was not an outlier; the eKSF Standard which was below 80% and that a recovery plan was in place; and in terms of culture, this was improving.

Other issues discussed related to the status of the Board’s compliance with PIN Policies’ implementation, some of which were out of date and some of which were delayed. John White confirmed that he was working through the Policy priorities and a number were being taken forward currently.

The Committee approved the final Staff Governance 2016-17 Monitoring Return for submission to Scottish Government Health Department on 1 June 2017.

7 REVIEW OF WORKFORCE PLAN 2016-2021

Members received a report from Jim Crichton who summarised the final Workforce Review report to cover the period 2016/2021. The objectives of the Review were noted and the importance of the document being iterative in nature and was reviewed on an ongoing basis were acknowledged.

The areas still to be completed included AHP Leads, Senior Charge Nurse roles, which would phase out, the Business Support role and OT transitional elements. Members noted that cultural changes were kept in view and the importance of staff being aware of their roles was acknowledged.

Some suggestions to the content were made and Jim Crichton confirmed that he would include these in the final report prior to it being presented to the next meeting of the Board in June.

Action: Jim Crichton
It was noted that Scottish Government were expected to indicate changes to the format of the report and this was expected to be confirmed during 2017-18.

Members approved submission of the report to the Board on 29 June 2017 for formal approval, subject to inclusion of the changes agreed.

8 FITNESS TO PRACTICE ANNUAL REPORT

Members received for information, the Fitness to Practice Annual Report from Nicholas Johnston, Chair of the Clinical Governance Committee. The Clinical Governance Committee had received the report at their meeting on 11 May 2017 and recommended that it was shared with Staff Governance Committee for their information.

There were no issues of concern.

Members noted the Fitness to Practice Annual Report.

9 LEARNING FROM COMPLAINTS & FEEDBACK - CLINICAL GOVERNANCE COMMITTEE REPORT

Members received for information, the Learning from Complaints & Feedback Report from Nicholas Johnston, Chair of the Clinical Governance Committee. The Clinical Governance Committee had received the report at their meeting on 11 May 2017 and recommended that it was shared with Staff Governance Committee.

Members noted the area of concern related to the number of complaints received in Quarter 3 in respect of the impact of staff resourcing issues on patient activities in the Skye Centre. The situation had improved since the report was received, however, the Clinical Governance Committee was alerted to the issue highlighted.

A number of issues were discussed in relation to the recruitment underway for specific posts in the Skye Centre; the difficulties with regard to recruitment to the specialist roles in the Woodcraft Department and the Gardens and Pet Therapy Department; and that the use of staff from the Skye Centre at times of staff shortages was part of the management of resources on the wards and for outings etc.

Members agreed that the importance of improved attendance levels was of prime importance to avoid the detrimental impact on direct patient care on occasion.

Members noted the Learning from Complaints & Feedback – Clinical Governance Committee Report.

10 ANNUAL REPORT OF THE STAFF GOVERNANCE COMMITTEE FOR THE YEAR ENDED 31 MARCH 2017

Members received for their approval the Annual Report of the Staff Governance Committee for the year ended 31 March 2017 which would be submitted to the Board at their meeting on 29 June 2017.

Members reviewed the Annual Report and approved its submission to the Board at their next meeting in June.

Action: John White

11 HEALTH, SAFETY AND WELFARE COMMITTEE – APPROVED MINUTES OF MEETINGS HELD ON 31 JANUARY 2017 AND 14 MARCH 2017

Members received and noted for their information, the approved Minutes of the Meetings of the Health, Safety and Welfare Committee which took place on 31 January 2017 and 14 March 2017.
In respect of the Minutes of the Meeting held on 31 January 2017, the issue of the fire evacuation procedure in the Skye Centre was raised and Jim Crichton would ask Doug Irwin to provide Maire Whitehead with some clarity on this matter.

Action: Jim Crichton

12 PARTNERSHIP FORUM – APPROVED MINUTES OF MEETINGS HELD ON 17 JANUARY 2017 : 28 FEBRUARY 2017 AND 18 APRIL 2017

Members received and noted for their information, the approved Minutes of the Meetings of the Partnership Forum which had taken place on 17 January 2017, 28 February 2017 and 18 April 2017.

Members were pleased to note the full discussion that had taken place at each meeting in respect of PDP completions.

13 ANY OTHER BUSINESS

Bill Brackenridge expressed his disappointment that no Staff Side Representatives had attended the meeting and no apologies had been received.

Anne Gillan confirmed that she would follow up the non attendance.

Action: Anne Gillan

14 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 17 August 2017 at 9.45am in the boardroom, The State Hospital, Carstairs.
THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 29 June 2017
Agenda Reference: Item No: 13
Sponsoring Director: Finance & Performance Management Director
Author(s): Head of Financial Accounts
Title of Report: Annual Report of the Audit Committee
Purpose of Report: For Approval

1 SITUATION

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

2 BACKGROUND

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

The report outlines the work of the Committee, including:

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

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

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

3 ASSESSMENT

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

4 RECOMMENDATION

The Board is asked to note and approve 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>
</thead>
<tbody>
<tr>
<td>M Whitehead (Chair until 15 September 2016)</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 2016/17.</td>
</tr>
<tr>
<td>E Carmichael (Chair from 16 September 2016)</td>
<td></td>
</tr>
<tr>
<td>W Brackenridge</td>
<td></td>
</tr>
<tr>
<td>E Carmichael</td>
<td></td>
</tr>
<tr>
<td>A Gillan</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 2016/17 was approved by the Committee at its meeting on 23 June 2016. 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 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 2015/16 from the Chief Internal Auditor.
- Received the Annual Report and audit certificate for the 2015/16 audit from Scott Moncrieff.
- Reviewed the Standing Financial Instructions, Standing Orders and Scheme of Delegation, and recommended these for approval to the Board.
• Reviewed its Terms of Reference.
• Review the log of waivers of standing financial instructions.
• Considered the Fraud Incident Log.
• Reviewed Counter Fraud Service Alerts.
• Reviewed and noted progress against CEL11(2013) Strategy to Combat Fraud and review the Fraud Action Plan.
• Reviewed progress made with the 2016/17 National Fraud Initiative.
• Reviewed and noted the Policy Management update.
• Received national Audit Scotland reports and performance audit studies, relating to the Health Service and to the wider public sector.
• Reviewed and noted the report and planned actions on the Security Audit.
• Reviewed and noted update of Efficiency / Productivity / Best Value.
• Reviewed and approved the recommendations from the Effectiveness of Audit Committee Self Assessment Checklist.
• Met in private with Internal and External Auditors.
• Reviewed the recommendations received from National Services Scotland from their service audit reports.
• Reviewed the recommendations received from NHS Ayrshire & Arran from the service audit report on the National Single Instance (NSI) system.
• Reviewed and approved the Accounting Policies.
• Reviewed the annual reports from the Governance Committees.
• Reviewed the annual report on Risk Management.
• Reviewed and noted outstanding actions arising from Critical Incident Review (CIR) and Significant Untoward Incident (SUI) reports.
• 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 Resilience arrangements.
• Submitted minutes of meetings to the Board throughout the year.
• Reviewed and approve the restructure of the Local Delivery Plan (LDP)
• Received updates from the Human Resources Director in relation to the progress on the Sickness Absence audit report.
• Reviewed and noted the progress against the 2015 – 2020 Property & Asset Management Strategy and Capital Planning reports.
• Reviewed and noted the Procurement Annual Report.
• Reviewed and noted the Corporate Risk Register.
• Reviewed and approved the National Fraud Initiative Self Appraisal Checklist.
5 Corporate Governance

During 2016/17 the Board's Internal Auditors reported on the following significant areas of work:

- Long Term Financial Planning
- Effectiveness of Committees
- Patients' Funds
- Governance Statement readiness
- Staff Scheduling
- Sickness Absence Follow Up Review
- 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.

E Carmichael
AUDIT COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Audit Committee
29 June 2017
**MONITORING FORM**

<table>
<thead>
<tr>
<th>How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?</th>
<th>It is an important assurance process to the Board in considering the effectiveness of internal controls.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce Implications</td>
<td>None</td>
</tr>
<tr>
<td>Financial Implications</td>
<td>None</td>
</tr>
<tr>
<td>Route to the Board (Committee)</td>
<td>Paper prepared by Head of Financial Accounts and reviewed by Chair of Audit Committee</td>
</tr>
<tr>
<td>Which groups were involved in contributing to the paper and recommendations?</td>
<td></td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>No significant risks identified</td>
</tr>
<tr>
<td>(Outline any significant risks and associated mitigation)</td>
<td></td>
</tr>
<tr>
<td>Assessment of Impact on Stakeholder Experience</td>
<td>None</td>
</tr>
<tr>
<td>Equality Impact Assessment</td>
<td>No identified implications</td>
</tr>
</tbody>
</table>
1 SITUATION

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.

2 BACKGROUND

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 2017.

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

3 ASSESSMENT

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 29 June 2017, and confirms that the Annual Accounts for the year ended 31 March 2017 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 29 June 2017.

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.

The Annual Report section of the accounts has been amended in 2016/17 to include a Parliamentary Accountability Report – referencing losses and special payments, significant claims, and service fees and charges.
The Accountability Report continues to include a Corporate Governance Report which comprises the Directors’ Report, Statement of Accounting Officer’s Responsibilities, Statement of Board Members’ Responsibilities, Governance Statement and Remuneration Report.

3.1 REVIEW OF SYSTEM OF INTERNAL CONTROL

The Statutory Annual Accounts for the year 2016/17 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.

The Governance Statement included in the Annual Accounts complies with a letter from Scottish Government Health and Social Care Department (SGHSCD).

3.2 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 are required to confirm that they have discharged the above responsibilities during the financial year and in preparing the accounts.

3.3 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 2016/17 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 Management Director and the Chief Executive.
3.4 ASSURANCE STATEMENT

On the basis of work undertaken by the Audit Committee in respect of the financial year 2016/17, 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 Performance Report and Accountability Report in respect of the Accounts, and the adoption of the Annual Accounts for the year ended 31 March 2017 by the Board.

4 RECOMMENDATION

The Audit Committee recommend that the Board:

**Adopt** the Annual Accounts for the year ended 31 March 2017 and **approve** submission to the Scottish Government Health and Social Care Directorate.

**Authorise:**
- a) the Chief Executive to sign the Performance Report
- b) the Chief Executive to sign the Accountability Report
- c) the Chief Executive and Finance and Performance Management Director to sign the Balance Sheet.
<table>
<thead>
<tr>
<th><strong>How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?</strong></th>
<th>Scottish Government requirement to publish the Accounts of the Board.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workforce Implications</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Financial Implications</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Route to the Board (Committee)</strong> Which groups were involved in contributing to the paper and recommendations?</td>
<td>Paper prepared by Head of Financial Accounts and reviewed by Finance &amp; Performance Management Director</td>
</tr>
<tr>
<td><strong>Risk Assessment</strong> (Outline any significant risks and associated mitigation)</td>
<td>No significant risks identified</td>
</tr>
<tr>
<td><strong>Assessment of Impact on Stakeholder Experience</strong></td>
<td>None identified</td>
</tr>
<tr>
<td><strong>Equality Impact Assessment</strong></td>
<td>No identified implications</td>
</tr>
</tbody>
</table>
1 SITUATION

This report presents the Hospital’s Property and Asset Management Strategy for the period 2017-2022.

2 BACKGROUND

All Health Boards are required to submit a PAMS to Scottish Government describing how it uses its assets efficiently, safely and in a way that contributes to health improvement. The 2017–2022 PAMS is attached, which has been submitted to SG subject to the Board’s approval.

3 ASSESSMENT

The PAMS used to be submitted annually, however this changed in 2015 with an update reported in 2016, followed by a full revision for 2017 under renewed guidelines which changed the reporting format required – providing a more prescribed format than previously issued. While previous PAMS were primarily an update of the preceding year’s document, this year a more fundamental rewrite has been required.

While the majority of the Hospital’s Asset Management requirements are routine on a year-on-year basis, the PAMS makes reference to the work ongoing – currently at the stage of developing the Outline Business Case (OBC) – for the Perimeter Security and Enhanced Internal Security Systems Project, for which the Initial Agreement was submitted and approved in 2016/17. This is scheduled to run until 2021 at a cost of approximately £5m.

The PAMS process is led by the Health Finance and Infrastructure team, from whom we now await feedback on our submission.

4 RECOMMENDATION

Members are asked to approve the PAMS for 2017-2022.
**How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?**

Ensures that the Board’s PAMS links strategically with the LDP and complies with SG regulation.

**Workforce Implications**

None currently

**Financial Implications**

Recurring capital budget of approximately £260k; OBC being developed for project funding of approximately £5m for 2017-2021.

**Route to the Board (Committee)**

Which groups were involved in contributing to the paper and recommendations?

Paper prepared by Head of Estates and Facilities / Estates Co-ordinator, and reviewed by Security Director and Finance & Performance Management Director

**Risk Assessment**

(Outline any significant risks and associated mitigation)

No significant risks identified

**Assessment of Impact on Stakeholder Experience**

None identified

**Equality Impact Assessment**

No identified implications.
The State Hospitals Board for Scotland

Property and Asset Management Strategy (PAMS)

2017 - 2022
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Executive Summary

The State Hospitals Board for Scotland

The State Hospitals Board for Scotland is a special health board proving high security mental healthcare for Scotland and Northern Ireland. It occupies a single site of approximately 65Ha. It has 140 beds and approximately 700 staff (586.20 WTE).

A major rebuild of The State Hospital completed in 2012; 90% of the site is less than 9 years old, with the remaining 10% refurbished.

Its buildings include patient accommodation, off ward therapy areas, offices, carers’ facilities, security buildings and estates buildings. In addition its other assets include IM&T, Estates and Security equipment and infrastructure. The value of the organisation’s assets is £81m.

Assets and Investment

Uniquely, a high proportion of the hospitals assets are related to security; the majority of the security equipment and infrastructure was replaced or refurbished over the process of rebuilding. IT is also a significant element of the organisation’s assets. Both areas will require significant investment over the life of this PAMS as high value assets approach end of life.

The OBC with regard to the planned perimeter security upgrade is now underway, and work is ongoing to scope the extent of the IT requirements.

PAMS

The State Hospital PAMS includes consideration of assets in the following categories:

- Land
- Buildings
- Security Equipment and Infrastructure
- Medical Equipment
- Estates Equipment and Infrastructure
- IM&T Hardware and Infrastructure
- Vehicles

and gives further consideration of:

- Service Changes
- Sustainability
- Backlog maintenance requirements

Organisational Strategy

The Hospital’s strategy is described by The State Hospital’s Local Delivery Plan (LDP). The LDP is The State Hospital’s description of how it will achieve the key deliverables of the Route Map to the 2020 Vision for Health and Social Care.

Through compliance with The Asset Management Policy for NHSScotland, The State Hospital PAMS will in turn ensure that the strategic aims are supported by the performance management, maintenance and replacement of assets as required.
**Governance and Performance Management**

The condition & performance of the hospitals assets is undertaken through a range of information systems including the Estates Asset Management System (EAMS) and the regularly updated asset register.

The Health Facilities Scotland KPI dashboard is regularly reported to the hospital’s Senior Management Team. Property and asset performance is considered annually by the Boards Audit Committee, and the PAMS is reviewed and approved by The State Hospital’s Board.

**Current Status and Issues**

The majority of the organisation’s asset base is its buildings, all of which have been replaced or refurbished within the last eight years.

The demand for high security beds remains stable and is likely to continue to remain so, though the hospital has been able to operate across 11 of its 12 wards through 2016/17, and 10 of 12 from early in 2017/18.

The national work streams around integration and shared services may have some impact for the organisation, but are unlikely to impact significantly on assets.

This means that the PAMS is primarily focussed on monitoring and maintaining the condition and performance of those new assets and maintaining or replacing other, more minor, assets.

A range of other important pieces of work are required to support the strategy; amongst these some key issues are:

- Concluding the submission of the OBC with regard to the security perimeter project, and evaluating ongoing IM&T priorities;
- Monitoring the assets for changes in the speed of deterioration and the backlog maintenance requirement;
- Reviewing the future use of non-clinical buildings;
- Setting realistic energy and carbon reduction targets;
- Monitoring for long term change in demand for beds at The State Hospital and across the Network;
- Continuing to engage with national work on Health and Social Care integration and shared services and monitoring for impact;
- Taking the opportunity to implement the wind turbine energy project should funding become available.
1. Introduction

The PAMS supports the delivery of the clinical and corporate strategies and is to be approved at Board level at the meeting of 29th June 2017.

In order to ensure an effective link between the Hospital’s operational activities, planned objectives and national strategy, the PAMS Board lead is the Finance and Performance Management Director, who has direct involvement in its preparation, supported by the Hospital’s Head of Estates & Facilities and Estates Officer.

The performance of assets is seen as critical by The State Hospitals Board. For the hospital to meet its strategic objectives it is essential that existing and planned investment is targeted and effectively utilised. The Board considers the contribution, performance and risks of the PAMS and associated assets annually through reporting to the Board’s Audit Committee and the PAMS is approved by The State Hospital’s Board.

The PAMS follows the most recent Scottish Government guidance (2017) and describes how the organisation uses its assets efficiently, safely and in a way that contributes to health improvement as articulated in the Scottish Governments 2020 vision for high quality health. The PAMS does this by examining “Where are we now”, looks ahead to “Where do we want to be” and takes cognisance of risks, opportunities and potential barriers to achieving these aims in “How will we get there”.

The strategic agenda for healthcare services in Scotland is set by The Healthcare Quality Strategy for NHSScotland. The Local delivery Plan for The State Hospital details how the organisation intends to meet the requirements of this strategy and other key strategies.

The strategic aims of the hospital align with the “HEAT” targets of

- Health Improvement
- Efficiency and Governance Improvements
- Access to Services
- Treatment appropriate to individuals

- and are set within the overall context of the Quality ambitions set out in the NHSScotland Quality strategy;

- Person centred
- Safe
- Effective

The Asset Management Policy for NHSScotland establishes the policy environment and key performance indicators for asset management, which include the submission to the Scottish Government of annually updated asset management strategies. The policy provides a framework against which the planning, delivery, management and disposal of assets is undertaken. The framework (The National Asset and Facilities Performance Framework), provides quality outcomes for assets and facilities that align with the 2020 vision through the quality outcomes of the quality strategy. The performance framework includes consideration of the physical environment, statutory compliance, costs, and the PAMS.
**Part A: Where are we now?**

The State Hospitals PAMS includes consideration of assets in the following categories:

- Land
- Buildings
- Security Equipment and Infrastructure
- Medical Equipment
- Estates Equipment and Infrastructure
- IM&T Hardware and Infrastructure
- Vehicles

Section 2 details the current state of the Board’s assets to inform the future need for improvement and investment in these assets.

While section 2.3 outlines identified project work; the principal item of note therein is the Perimeter Security and Enhanced Internal Security Systems Project.

The Initial Agreement for this project was submitted and approved in 2016/17, and the preparation of the Outline Business Case is currently underway for submission in the summer of 2017. The project is for replacing nearly obsolete frontline security systems and enhancement of other security systems, and is scheduled to run until 2021 with a total budget of approximately £5m.
2. **Current Asset Arrangements**

### 2.1. Current Assets

The NHSS requires that each Health Board submit an annually reviewed Property and Asset Management Strategy (PAMS) covering the coming 5 – 10 years. The PAMS should meet defined criteria demonstrating that investments are:

- Carefully considered and planned
- Contributing to organisational aims
- Used effectively and efficiently
- Monitored and maintained appropriately
- Decommissioned, disposed of & replaced effectively and efficiently

The majority of the organisation’s asset base is its buildings, all of which have been replaced or refurbished within the last 9 years.

- The demand for high security beds remains stable and is likely to continue to remain so, though the hospital has been able to operate across 11 of its 12 wards for part of the last two years.
- The national work streams around integration and shared services may have some impact for the organisation, but is unlikely to impact significantly on assets.

This means that the PAMS is primarily focussed on monitoring and maintaining the condition and performance of those new assets and maintaining or replacing other, more major, assets. A range of other important pieces of work are required to support the strategy; amongst these some key issues are:

- Monitoring the assets for changes in the speed of deterioration and the backlog maintenance requirement. Some of the conditions of these assets have changed from Moderate to Significant and are being addressed at present through the capital funding process (see Table 12 for breakdown by risk). This is part of a bigger project to upgrade the perimeter security and provide enhanced security systems at the hospital. The project is in the region of £5m and is described as part of this PAMS.
- Setting realistic energy and carbon reduction targets
- Monitoring for long term change in demand for beds at The State Hospital and across the Network
- Concluding and implementing reviews of vehicles & workforce
- Concluding reviews of the IM&T network and planning investment and implementation
- Continuing to engage with national work on Health and Social Care integration and shared services and monitoring for impact
- Taking the opportunity to implement the wind turbine energy project should funding become available

**Overview of Asset Responsibilities**

The following is an overview of all of The State Hospitals assets. All buildings and assets are owned.
Table 1: All Assets

<table>
<thead>
<tr>
<th>Property Assets</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>1 no.</td>
</tr>
<tr>
<td></td>
<td>23,602 sq.m.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Equipment (Replacement Cost)</th>
<th>Vehicles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac defibrillators £16,500</td>
<td>Owned</td>
</tr>
<tr>
<td>Low value medical equipment £56,100</td>
<td>Leased</td>
</tr>
<tr>
<td>Other high value items (dental equipment) £17,500</td>
<td>Staff Car Scheme</td>
</tr>
<tr>
<td>Total £90,100</td>
<td>Total</td>
</tr>
</tbody>
</table>

Overview of Property Assets

The following table shows the Net Book Value of The State Hospitals buildings.

Table 2: Net Book Value – Buildings Only

<table>
<thead>
<tr>
<th>No. of Sites</th>
<th>Net Book Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>05 Mental Health Hospital</td>
<td>1</td>
</tr>
</tbody>
</table>

The following table shows the age profile of The State Hospitals buildings.

Table 3: Age Profile

<table>
<thead>
<tr>
<th>Count of Blocks</th>
<th>Area (m²)</th>
<th>% of Total Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 50 years old</td>
<td>3</td>
<td>429.79</td>
</tr>
<tr>
<td>10-29 years old</td>
<td>3</td>
<td>2,100.37</td>
</tr>
<tr>
<td>Up to 10 years old</td>
<td>11</td>
<td>21,072.26</td>
</tr>
<tr>
<td>TOTALS</td>
<td>17</td>
<td>23,602.42</td>
</tr>
</tbody>
</table>
Overview of Vehicle Assets

The State Hospital currently have 13 vehicles; 12 of which are owned (5 of which are classed as agricultural); 1 is a staff car lease.

The details of the vehicle fleet are as follows:

Table 4: Details of Owned Vehicles

<table>
<thead>
<tr>
<th>Age (by number of vehicles)</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 2 years</td>
<td>3</td>
</tr>
<tr>
<td>2 to 5 years</td>
<td>2</td>
</tr>
<tr>
<td>&gt; 5 years</td>
<td>7</td>
</tr>
<tr>
<td>Fuel type:</td>
<td></td>
</tr>
<tr>
<td>Petrol</td>
<td>2</td>
</tr>
<tr>
<td>Diesel</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 5: Details of Leased Vehicles

<table>
<thead>
<tr>
<th>Age (by number of vehicles)</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 2 years</td>
<td>1</td>
</tr>
<tr>
<td>2 to 5 years</td>
<td></td>
</tr>
<tr>
<td>&gt; 5 years</td>
<td></td>
</tr>
<tr>
<td>Fuel Type:</td>
<td></td>
</tr>
<tr>
<td>Diesel</td>
<td>1</td>
</tr>
</tbody>
</table>

The hospital is currently reviewing the hospital fleet. Within the last two years we have been working in conjunction with NHS National Services Scotland and have reduced the fleet by four vehicles and replaced three vehicles. We are currently looking to replace two vehicles with one multipurpose vehicle designed to suit the needs of the service. As part of this fleet review, we looked at replacing the existing vehicles with electric vehicles; however we were unable to find a suitable electric alternative.

Overview of Medical Equipment

The hospital has very little medical equipment which is mostly low value; these assets have been valued at just under £18k (2016/17 valuation).

Our low value equipment consists of dental equipment (instruments etc), defibrillators, ultrasound therapy machine and ophthalmic equipment; replacements will be funded via the revenue budget as and when required.
The following are our high value equipment:

**Table 6: Medical Equipment**

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Expected Replacement Cost</th>
<th>Expected Replacement Year</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental chair &amp; equipment</td>
<td>£15k</td>
<td>2021/2022</td>
<td>Capital funding</td>
</tr>
<tr>
<td>Ophthalmic screening equipment</td>
<td>£8k</td>
<td>2020/2021</td>
<td>Capital funding</td>
</tr>
</tbody>
</table>

The hospital does not have any leased medical equipment.

**Overview of IM&T Assets**

The hospital's Data Storage and Backup solution is in need of replacement. There is no need to replace this with a “like for like” solution as due to changing technology a more cost effective solution will be sought. The hospital has recently replaced the wired network and will not need replaced again for a minimum of 5 years.

**Table 7: IM&T Assets**

<table>
<thead>
<tr>
<th>Asset</th>
<th>Expected Replacement Cost</th>
<th>Expected Replacement Year</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wired Network</td>
<td>£200K</td>
<td>2022/2023</td>
<td>Revenue funding</td>
</tr>
<tr>
<td>Data storage &amp; Backup</td>
<td>£200k</td>
<td>2017/2018</td>
<td>Revenue funding</td>
</tr>
<tr>
<td>Wireless Network</td>
<td>£60k</td>
<td>2018/2019</td>
<td>Revenue funding</td>
</tr>
<tr>
<td>PC’s &amp; Laptops</td>
<td>£35k</td>
<td>2018/2019</td>
<td>Capital funding</td>
</tr>
</tbody>
</table>

The hospital does not have any leased IT equipment.
2.2. Current Asset Locations

The State Hospitals Board for Scotland is the sole provider of high security mental healthcare for adult males in Scotland, also providing the same service for Northern Ireland. It is a Special Health Board and provides 140 beds, with approximately 700 staff (586.20 WTE). It occupies a single site in South Lanarkshire (see Figure 1).

Figure 1: Geographical Location of The State Hospital

Given that the patients do not have access to other services or communities, the Hospital redevelopment addressed the clinical model aspiration of ensuring the site, as far as possible, meets all of the patients needs (e.g. therapeutic, vocational, social, spiritual and physical wellbeing) via a range of therapeutic, educational, diversional, health and recreational services. The site configuration and security features mean that the majority of patients are able to access the grounds and attend therapy departments without requiring escorting staff.

All assets are located at The State Hospitals site (see Figure 2).
2.3. Current Developments

The following table shows details of projects complete within 2016/17, current projects, and identified future projects for 2017/18.
<table>
<thead>
<tr>
<th>Project</th>
<th>Value</th>
<th>Funding Route</th>
<th>Benefits / Expected Benefits</th>
<th>Project Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lighting upgrades to LED (internal and external)</td>
<td>£14k</td>
<td>Revenue Budget 2016/2017</td>
<td>Reduction of both electricity consumption and impending backlog.</td>
<td>Complete</td>
</tr>
<tr>
<td>Building Analytics software for Building Management System (BMS)</td>
<td>£41k</td>
<td>Revenue Budget 2016/2017</td>
<td>Improve environment / comfort settings for building users, reduce maintenance and improve energy efficiency.</td>
<td>In Progress</td>
</tr>
<tr>
<td>Structural engineer initial survey to meet SFT guidelines</td>
<td>£5k</td>
<td>Revenue Budget 2016/2017</td>
<td>To confirm buildings are structurally sound.</td>
<td>In Progress</td>
</tr>
<tr>
<td>Bus Lay Bys – Consultancy Fees</td>
<td>£10k</td>
<td>Capital Budget 2016/2017</td>
<td>Was part of planning application for hospital re-development.</td>
<td>Complete</td>
</tr>
<tr>
<td>Replacement Personal Attack Alarms (PAA)</td>
<td>£53k</td>
<td>Capital Budget 2016/2017</td>
<td>To ensure continuity of PAA system until 2021 when system will be replaced.</td>
<td>Complete</td>
</tr>
<tr>
<td>IT Infrastructure Upgrade</td>
<td>£36k</td>
<td>Capital Budget 2016/2017</td>
<td>Ensures we have modern equipment that can support the latest software and can also be fully supported by the manufacturer.</td>
<td>Complete</td>
</tr>
<tr>
<td>IT Network / Firewall Upgrade</td>
<td>£117k</td>
<td>Capital Budget 2016/2017</td>
<td>Increased network security, monitoring and network bandwidth.</td>
<td></td>
</tr>
<tr>
<td>IT Equipment Patient Movement Tracking System (PMTS) – Phase 1</td>
<td>£62k</td>
<td>Capital Budget 2016/2017</td>
<td>Replacement of obsolete system. New system will have considerable additional functionality over the previous version.</td>
<td>Complete</td>
</tr>
<tr>
<td>Replacement and rationalisation of vehicles – Phase 1</td>
<td>£49k</td>
<td>Capital Budget 2016/2017</td>
<td>Replacement of end of life vehicles as part of fleet review.</td>
<td>Complete</td>
</tr>
<tr>
<td>Project</td>
<td>Value</td>
<td>Funding Route</td>
<td>Benefits / Expected Benefits</td>
<td>Project Status</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------</td>
<td>------------------------</td>
<td>----------------------------------------------------------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Bus Lay Bys – Construction Phase</td>
<td>£78k</td>
<td>Capital Budget 2017/2018</td>
<td>Was part of planning application for hospital re-development.</td>
<td>In Progress</td>
</tr>
<tr>
<td>Water Tanker Fill Point</td>
<td>£10k</td>
<td>Capital Budget 2017/2018</td>
<td>Part of Business Continuity Plan</td>
<td>Not started – awaiting confirmation of funding</td>
</tr>
<tr>
<td>PMTS – Phase 2</td>
<td>£62k</td>
<td>Capital Budget 2017/2018</td>
<td>New system will have additional reporting &amp; security controls that are unavailable in the existing system.</td>
<td>In Progress</td>
</tr>
<tr>
<td>Network / Firewall / Web Proxy</td>
<td>£74k</td>
<td>Capital Budget 2017/2018</td>
<td>Increased network security, monitoring and network bandwidth.</td>
<td>In Progress</td>
</tr>
<tr>
<td>Replacement and rationalisation of vehicles – Final Phase</td>
<td>£60k</td>
<td>Capital Budget 2017/2018</td>
<td>Replacement of end of life vehicles as part of fleet review.</td>
<td>In Progress</td>
</tr>
<tr>
<td>Perimeter Security &amp; Enhanced Internal Security Systems Project</td>
<td>£5m</td>
<td>Capital Funded phased over 4 years starting 2017/2018</td>
<td>Replacing near obsolescence of frontline security systems and enhancement of security systems</td>
<td>In Progress</td>
</tr>
</tbody>
</table>

The projects which are identified above meet energy, sustainability and environmental improvements along with ensuring continuity of service by investing in the IT infrastructure and frontline security systems.
3. Asset condition & performance

The size of The State Hospital coupled with its function mean that it holds no high value assets other than the buildings, IT systems and Security systems. Full details of asset values are at table 9. The hospital also operates a small vehicle fleet. Medical equipment forms an almost negligible part of the asset base.

Chart 1: NBV Board’s Assets

The hospital’s major redevelopment project completed in 2011/12 means that 90% of the buildings on site are less than 9 years old, with remaining buildings refurbished within the same timescale.

The State Hospital holds assets worth approximately £81m as below:

---

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Table 9: NBV Board’s Assets (Detail)

<table>
<thead>
<tr>
<th>Asset Category</th>
<th>2016 / 2017 NBV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus Land</td>
<td>£ 194,000.00</td>
</tr>
<tr>
<td>Operational Land</td>
<td>£ 717,000.00</td>
</tr>
<tr>
<td>Buildings</td>
<td>£ 66,333,359.65</td>
</tr>
<tr>
<td>Vehicles</td>
<td>£ 105,373.78</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>£ 17,977.28</td>
</tr>
<tr>
<td>IM&amp;T</td>
<td>£ 1,432,642.87</td>
</tr>
<tr>
<td>Security &amp; Site Services</td>
<td>£ 6,638,311.42</td>
</tr>
<tr>
<td>Plant &amp; Machinery</td>
<td>£ 4,963,658.36</td>
</tr>
<tr>
<td>Furniture &amp; Fittings</td>
<td>£ 593,615.84</td>
</tr>
<tr>
<td>Assets under construction (Capital Projects)</td>
<td>£ 123,926.39</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>£ 81,119,865.59</td>
</tr>
</tbody>
</table>

As illustrated in Chart 1 and Table 9, the majority of the hospitals asset value is Buildings.

3.1. State of the Board’s property assets

The following table (Table 10) shows the current state of the Board’s property assets compared with last year’s figures and the targeted figure.

Table 10: Current Status of Board’s Property Assets

<table>
<thead>
<tr>
<th>Current Net Book Asset Value (all assets)</th>
<th>2016 / 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property</td>
<td>£ 66,333,359.57</td>
</tr>
<tr>
<td>Other</td>
<td>£ 717,000 (operational land), £ 194,000 (surplus land)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£ 67,244,359.65</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Floor Area ('000's sq.m)</th>
<th>Previous</th>
<th>Current</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Floor Area ('000's sq.m)</td>
<td>23,602</td>
<td>23,602</td>
<td>23,602</td>
</tr>
<tr>
<td>Age (% less than 50 years old)</td>
<td>98.18%</td>
<td>98.18%</td>
<td>100%</td>
</tr>
<tr>
<td>Condition (Good – category A or B)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Estate Utilisation (Fully Utilised)</td>
<td>88.17%</td>
<td>87.08%</td>
<td>90%</td>
</tr>
<tr>
<td>Functional Suitability (Good – A or B)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Backlog Maintenance:

<table>
<thead>
<tr>
<th>Including inflation uplift</th>
<th>Inflation not applied during previous year</th>
<th>£5.044m</th>
<th>£53k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excluding inflation uplift</td>
<td>£5.042m</td>
<td>£5.042m</td>
<td>£50k</td>
</tr>
</tbody>
</table>
Details of the Boards property assets are as follows:

### Table 11: Estate Size

<table>
<thead>
<tr>
<th></th>
<th>Area (Sq.m)</th>
<th>% of Total Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>05 Mental Health Hospital</td>
<td>18,691.33</td>
<td>79.19</td>
</tr>
<tr>
<td>23 Offices</td>
<td>1,899.45</td>
<td>8.05</td>
</tr>
<tr>
<td>24 Support Facilities</td>
<td>3,011.64</td>
<td>12.76</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>23,602.42</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

All of the Boards property assets are owned.

### Chart 2: Age Profile of Estate

The following chart illustrates the age profile of the estate. 1.82% of the estate is over 50 years old. This consists of Islay (staff development & conference centre); the site itself in which the hospital occupies and the railway bridge. The hospital does not own the railway bridge however is responsible for any maintenance to the bridge therefore it is included in the data.

The majority if the hospital is less than 10 years old.
Chart 3: Estate Condition

The following chart illustrates the condition of the estate. All of the buildings are currently condition B (Satisfactory) however, elements of the site require significant investment for replacement / improvement which are described later in the Backlog Maintenance section 3.3.

![Estate Condition Chart]

Chart 4: Estate Utilisation

The following chart illustrates the space utilisation across the site. 6.18% of the site is currently classed as E – Empty / Not Used; this is due to one of our wards being temporarily closed along with a patient recreational activity area.

![Space Utilisation Chart]
Chart 5: Estate Functional Suitability

The following chart illustrates functional suitability across the site. 95% of the site is classed as A – Very Satisfactory with only 5% classed as B – Satisfactory. The 5% relates to some of the older buildings which have changed use over the years, and are not currently being used for what they were originally intended for.

Patient Satisfaction Survey Results

N/A as State Hospital patients are not included in this survey.

Chart 6: Performance improvement of property assets

The following chart illustrates the performance changes of property assets comparing last year to this year.
There have been some minor changes with most KPI’s remaining the same as last year. The biggest change is in the SCART score. Details as follows:

- Condition – remains the same
- Quality – remains the same
- Patient rating – N/A (patients not included in this survey)
- Age - remains the same
- PAMS Quality – 2015 score 360.3
- SCART Scope – 95.2% down to 69.37% (see section 3.2 below for detail)
- Backlog per sq. m - £213.62 has increased to £213.73 as inflation has been applied to our backlog. No additional backlog items have been added during 2016/17.
- Significant and High Risk Profile – No High Risks, slight increase in cost of significant risks due to inflation.
- Functional suitability – remains the same
- Space Utilisation – slight decrease in “fully utilised” from 88.17% to 87.08%

3.2. Statutory Compliance and Assurance

The accountability arrangements and organisational structure ensure that:

- Information, control and governance systems are in place
- All appropriate authorisation systems are complied with
- All relevant legislation is identified, assessed and complied with
- All statutory and mandatory policies are in place and complied with
- All relevant information is reported through the Boards systems

All of which are regularly assessed and monitored through relevant groups and committees reporting to the Senior Management Team and Board as appropriate.

Operational Management of asset management systems; environmental management systems and statutory compliance systems (SCART) is overseen by The Security Director and relevant stakeholders, particularly the Facilities Department. An organisational chart demonstrating accountability arrangements and information systems within the Facilities Department is at Figure 3.
In addition, the Security Director is responsible to the Board for resilience issues and Health and Safety which results in regular informal and formal discussion taking place regarding the state of all assets. The Head of Estates and Facilities attends the Business Continuity Group, Health Safety and Welfare Committee and Infection Control Committee.

**SCART Process**

The SCART Champions for the site are the Estates Officer and the Head of Estates & Facilities who carry out all SCART Audits in conjunction with Estates operational staff.

At present The State Hospital is in the process of utilising the new SCART tool and completing all the additional question sets. To date approximately 79% of the site has been audited using the new SCART tool with no high risks being identified. The average SCART score for the buildings already audited is 87.81% giving a Board overall average score of 69.37%. The hospital is working towards having 100% of the site audited within 2017/18.

As there have been no high risks identified, there has been no requirement to report directly to the Board. The small areas of non-compliance are very minor and are related to appropriate signage in areas of the hospital which require a permit to work to gain access, therefore pose no real risk.
No fire safety matters have been identified within SCART. All fire risk assessments are entered into the 3i Risk Manager system. The hospital has had recent audits by the Scottish Fire & Rescue Service and have a written confirmation for each building that they are broadly compliant.

No statutory compliance backlog items have been identified in both SCART and EAMS.

### 3.3. Backlog Maintenance

The following table (Table 12) shows all backlog maintenance costs, split by risk from 2012/13 to present financial year.

#### Table 12: Total Backlog

<table>
<thead>
<tr>
<th>Year</th>
<th>Low Risk Items</th>
<th>Moderate Risk Items</th>
<th>Significant Risk Items</th>
<th>High Risk Items</th>
<th>Total Backlog</th>
<th>Annual Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 / 2018</td>
<td>0.001200</td>
<td>0.006602</td>
<td>5.036590</td>
<td>0.000000</td>
<td>5.044392</td>
<td>Increase</td>
</tr>
<tr>
<td>2016 / 2017</td>
<td>0.001130</td>
<td>0.006215</td>
<td>5.034444</td>
<td>0.000000</td>
<td>5.041789</td>
<td>Increase</td>
</tr>
<tr>
<td>2015 / 2016</td>
<td>0.001130</td>
<td>0.206903</td>
<td>0.125635</td>
<td>0.000000</td>
<td>0.333668</td>
<td>Increase</td>
</tr>
<tr>
<td>2014 / 2015</td>
<td>0.001000</td>
<td>0.184700</td>
<td>0.103700</td>
<td>0.000000</td>
<td>0.289400</td>
<td>Reduction</td>
</tr>
<tr>
<td>2013 / 2014</td>
<td>0.001000</td>
<td>0.208140</td>
<td>0.126000</td>
<td>0.000000</td>
<td>0.335140</td>
<td>Reduction</td>
</tr>
<tr>
<td>2012 / 2013</td>
<td>0.001000</td>
<td>0.232000</td>
<td>0.156000</td>
<td>0.000000</td>
<td>0.389000</td>
<td>Reduction</td>
</tr>
</tbody>
</table>

There has been a significant increase in backlog costs (around £5m) between financial years 2015/16 and 2016/17. This is due to the impending work which forms part of the “Perimeter Security & Enhanced Internal Security Systems” project which had the Initial Agreement approved by Scottish Government on 4th April 2017. This project will address all the significant backlog issues associated with the hospitals Clinical use blocks (see Table 13 below). The investment in the project will reduce the £5m backlog over a four year period.

#### Table 13: Clinical / Non-Clinical Backlog Split

<table>
<thead>
<tr>
<th>Year</th>
<th>Use</th>
<th>Low</th>
<th>Moderate</th>
<th>Significant</th>
<th>High</th>
<th>Unreported</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 / 2018</td>
<td>Clinical</td>
<td>£</td>
<td>£1,800.60</td>
<td>£ 5,000,000.00</td>
<td>£</td>
<td>£</td>
<td>£ 5,001,800.60</td>
</tr>
<tr>
<td>2017 / 2018</td>
<td>Non-Clinical</td>
<td>£1,200.40</td>
<td>£4,801.60</td>
<td>£ 36,589.86</td>
<td>£</td>
<td>£</td>
<td>£ 42,591.86</td>
</tr>
<tr>
<td></td>
<td></td>
<td>£1,200.40</td>
<td>£6,602.20</td>
<td>£ 5,036,589.86</td>
<td>£</td>
<td>£</td>
<td>£ 5,044,392.46</td>
</tr>
</tbody>
</table>

There has been a slight increase in backlog costs between 2016/17 and 2017/18 for non-clinical areas only which is due to 6.23% inflation increase.

The £42k backlog associated with the hospitals non-clinical use blocks will be managed through the internal revenue budget.

There are no statutory compliance related backlog issues at present.
The hospital has some areas of agreed surplus agricultural land. Disposal is ongoing with the surplus land being advertised for sale in separate lots. As this is agricultural land, the disposal of this land will have no impact on our current backlog issues, these issues are solely related to buildings.

The hospital does not have any buildings which are classed as redundant or vacant.

At present the hospital has no high risk backlog issues. The significant backlog issues will be addressed through the “Perimeter Security & Enhanced Internal Security Systems” project before they become classed as high risk.

Recently the hospital had lifecycle surveys carried out by Thomson Gray which covers almost 60% of the site and the majority of our clinical areas. The data is in the process of being uploaded onto the 3i EAMS system and is therefore not included in this PAMS. The surveys have shown minor areas of work to be carried out (e.g. small areas of internal decoration in non-patient areas) having very little impact on the existing backlog costs. This will be managed internally through the revenue budget.

These surveys were funded by the hospitals revenue budget however an application has been made to NSS Health Facilities Scotland for additional surveys to be carried out during 2017/18. The lifecycle surveys will give the hospital reliable and meaningful data to enable the accurate forecast of future impending backlog via the Capital Planning System.

3.4. Environmental Management Strategy

Sustainable Development Group

The hospitals’ Sustainable Development Group (SDG) has responsibility for climate change / environmental management. At present the hospital has an environmental management statement however, requires a strategy to be fully developed and implemented.

The SDG is currently being restructured to include a range of green champions across the operational site as well as key staff from areas with particular expertise including Estates and Facilities, Risk Management, Finance and Procurement who are committed to driving the climate change agenda forward. Ultimately this should support the organisation to achieve its carbon footprint target reduction by:

- Governing the projects identified - identifying risks, challenges and blockages and resolving them; identifying and measuring benefits from projects
- Awareness raising and
- Annual review of the programme of projects, and generation of new ideas

In doing this, the Group will oversee the following matters:

- Policy and strategy issued from a wide range of statutory and non-statutory sources: evaluating this and identifying any actions required
- Carbon management programme
- Environmental action plan
- Environmental risk register
- Monitoring and review of all relevant supporting policies
- Sustainability reporting to Senior Management Team (SMT) / Board
- Communication plan to develop a culture of energy saving and environmental awareness
- Appropriate training for staff
Information Reporting and Systems

Updates are provided to SMT as and when required and the SMT would agree funding and advise the SDG on projects to be taken forward.

As the hospital are in the process of restructuring and establishing the SDG group, ongoing monitoring of performance change is carried out by Estates & Facilities. This is done by utilising a variety of data sources such as E-Sight, EMART, data from contractors and internal monitoring procedures. Some example E-Sight Reports can be found in Appendix 1 along with a sample of an internally produced spreadsheet. From the reports shown in Appendix 1, it is clear to see that the hospital are making savings in consumption however, these are not always reflected in cost savings as contract prices have increased.

As this performance is monitored in both consumption and cost it is regularly discussed with Management Accounts colleagues and members of the hospitals SMT.

Carbon Management Plan

The hospital has a Board approved Carbon Management Plan which requires to be updated on an annual basis.

Good Corporate Citizenship Model

At present the hospital does not use the Good Corporate Citizenship Model as it was previously felt that this tool was unsuitable for our hospitals environment. When the tool is re-launched we will evaluate suitability of this tool and compatibility with the hospitals needs.

Corporate Greencode

The hospital utilises the Corporate Greencode environmental management tool to ensure that all environmental aspects have been identified and that any relative legislative risks are identified and addressed. This is reviewed monthly when legislative updates are published. The hospital currently has no high risk environmental issues.

Waste Management

The Waste Scotland Regulations (2012) states that “All businesses, public sector and not-for-profit organisations are required to present metal, plastic, glass, paper and card (including cardboard) for separate collection from 1 January 2014” with no waste going to landfill by January 2021.

The hospital has been compliant with these regulations since they became mandatory in January 2014. Source segregation is carried out for dry mixed recyclates, glass, metal and wood. The domestic type waste collected from our hospital is treated as Refuse Derived Fuel (RDF) therefore what recycling materials can be salvaged are removed, with the rest of the waste then being processed for fuel. This means that we have zero waste going to landfill.

Transport Review

As described previously in section 2.1 the hospital are currently reviewing the vehicle fleet. Within the last two years we have been working in conjunction with NHS National Services Scotland and have reduced the fleet by four vehicles and replaced three vehicles. We are currently looking to replace two vehicles with one multipurpose vehicle designed to suit the needs of the service. As part of this fleet review, we looked at replacing the existing vehicles with electric vehicles; however we were unable to find a suitable electric alternative. The
vehicles replaced were old, inefficient diesels and have been replaced with brand new, more efficient vehicles which give the hospital a carbon savings.

**Public Sector Climate Change Reporting**

The Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Order 2015 requires NHS Boards to prepare annual reports on compliance with their climate change duties, and to send these reports to the Scottish Ministers within 8 months from the end of each financial year. This data is captured annually via the Mandatory Public Sector Climate Change Reporting portal.

As the Mandatory Public Sector Climate Change Reporting portal captures data on all carbon emissions associated with The State Hospital, we use this to review our performance year on year.

**Energy Saving Targets**

The State Hospitals energy targets are now percentage reduction targets from a baseline year through to financial year 2020. Targets will apply to absolute energy consumption and to GHG emissions from energy use only. The baseline year is an average of the three years 2011/12 – 2013/14. There is a ‘basic’ and ‘stretch’ target which are shown at table 14 below.

**Table 14 : “Basic” and “Stretch” Energy Targets**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>The State Hospitals Board for Scotland: Energy &amp; GHG Reduction Targets for 2020/21 (against 3-year average baseline 2011/12, 2012/13 and 2013/14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Basic</td>
</tr>
<tr>
<td>Energy Consumption (kWh/m²)</td>
<td></td>
</tr>
<tr>
<td>Electricity</td>
<td>-6.0%</td>
</tr>
<tr>
<td>Fossil Fuel</td>
<td></td>
</tr>
<tr>
<td>Biomass</td>
<td></td>
</tr>
<tr>
<td>Combined</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-3.4%</td>
</tr>
<tr>
<td>Greenhouse Gas Emissions (kgCO₂e/m²)</td>
<td>113.00</td>
</tr>
<tr>
<td>Criteria</td>
<td>The State Hospitals Board for Scotland: Percentage of Total Energy Consumption from Renewable Energy Sources</td>
</tr>
<tr>
<td>Percentage of heat consumption from renewable energy sources</td>
<td>55.6%</td>
</tr>
<tr>
<td>Percentage of electricity consumption from renewable energy sources</td>
<td>0%</td>
</tr>
<tr>
<td>Percentage of total consumption from renewable energy sources</td>
<td>39.6%</td>
</tr>
</tbody>
</table>

The basic target is based on what The State Hospital thinks could be achieved if the investment for energy efficiency projects remains at current levels; although the changes
made in the new hospital leave us with less scope for improvement, we have been able to make changes that allow us to set a "basic" target of -3.4%. The stretch target should be based on what the Board thinks could be achieved if all identified projects receive 100% funding. The State Hospital projects identified via the Carbon Management Plan are as follows:

- Occupational Health building – heating connection
- Indoor lighting controls on patient areas
- External building lighting to be turned off between 10pm – 7am
- Harris building – heating control
- PV panels – Essential Services, Family Centre, Reception buildings
- Erection of wind turbine

The plan has identified annual savings, both in terms of £’s and tCO2, other potential income such as Feed in Tariff (FiT) and Renewable Heat Incentive (RHI), lifetime savings, payback periods and a risk assessment for each project.

In addition, to energy consumption targets, we are required to specify the percentage of energy consumption in 2020/21 to be delivered from renewable energy sources. A significant proportion of State Hospital energy use is from renewable resources due to the use of biomass as our main heating fuel. This has also enabled us to be awarded the Renewable Heat Incentive, resulting in an income in the region of £110k per annum, part of which has been re-invested in spend to save schemes e.g. LED Lighting.

New Energy Projects

In the past year the hospital has invested in upgrading lighting with LEDs both internally and externally. Further lighting upgrades are planned for 2017/18. The hospital has also invested in Building Analytics software for the Building Management System (BMS). This system has a variety of benefits / features:

- ensures the BMS runs at optimum settings
- highlights areas outwith set parameters for potential energy savings
- monitors and reports on the ongoing condition of plant and equipment which in turns reduces the requirements for cyclical planned maintenance
- highlights areas of potential plant / equipment failures

These projects will help to reduce our consumption and carbon footprint and assist with meeting targets. The updated Carbon Management Plan for 2017/18 will include these projects.
3.5. **State of the Board’s Office Accommodation**

Scottish Futures Trust (SFT), working on behalf of HFS, undertook a review of office accommodation across NHSScotland in 2013. The review reports average office space per user as being approx. 11m², with a 2020 target of 10m². The State Hospital average amount per user was significantly in excess of this figure.

SFT worked with The State Hospital to identify opportunities for introducing smarter ways of working and the following contributing factors, opportunities and constraints were identified:

- **Clinical Model**
  
  An essential part of the clinical model is co-locating the clinicians working with patients. The four patient accommodation areas have office accommodation immediately above them, allowing this co-location. The most efficient use of office accommodation would be likely to disrupt this model.

- **Managing demand**
  
  The State Hospital is the sole provider of high secure mental healthcare for Scotland and Northern Ireland. The nature of its business means that this care cannot be provided by another site. The accommodation for staff and patients needs to be able to absorb any increase in demand.

- **Design of new hospital**
  
  The design for the new hospital included an allocation per office user of approximately 12m². Although some offices are of a size that means occupancy could be increased, many are not.

- **Split site working**
  
  A number of State Hospital staff work between The State Hospital and other sites and, due to the nature of their work – e.g. security, confidentiality – require a single office.

- **Difficulties in use by others**
  
  Many organisations are able to flexibly sell, lease or lend their excess capacity to other organisations. Due to the secure nature of The State Hospital this is not possible.

It is important to note that the nature of a high secure service and site means that, by definition, patients who require that service cannot be housed elsewhere. As The State Hospital is the sole provider of high secure mental healthcare in Scotland and Northern Ireland any peaks in service demand must be met by the hospital and services and assets must retain sufficient capacity to be able to absorb any such peak.

The State Hospital has a capacity of 140 beds, though there are 144 useable rooms. The additional 4 rooms provide contingencies for both the whole site and locally within each accommodation area. Some changes have taken place in the way that the service has been delivered over the last year; the occupied beds at the hospital have remained at or around 110 for long enough that we have been able to retract and operate across 11 of the 12 wards from early 2016/17. This allows the other wards to be closed on a temporary basis for maintenance and decorating, including the potential as decant wards enabling longer term planning for maintenance and refurbishment.
The apparent reduction in demand for high secure beds is not of sufficient volume or duration to allow permanent change; the change to operation across 11 wards is something that can be reversed quickly if necessary. It is also important to note that the bed numbers at The State Hospital are complicated by the fact that 1 ward is specifically for patients with a learning disability, with the remaining beds for patients with a mental illness.

### Table 15: Annual Office Space and Cost Comparison

<table>
<thead>
<tr>
<th>Year</th>
<th>Space Standard (per NIA m²)</th>
<th>Desk to WTE/ FTE %</th>
<th>Accommodation Budget Costs incl. VAT (£ per m² NIA)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WTE/ FTE Desks</td>
<td></td>
<td>Rent</td>
</tr>
<tr>
<td>2016</td>
<td>12.3</td>
<td>11.7</td>
<td>104.7%</td>
</tr>
<tr>
<td>2015</td>
<td>12.2</td>
<td>11.7</td>
<td>104.4%</td>
</tr>
</tbody>
</table>

#### 3.6. State of the Board’s Medical Equipment

The hospital has very little medical equipment which is mostly low value and has an asset value at just under £18k (2016/17 valuation). At this moment in time the hospital does not have any competing investment needs for medical equipment and does not have any leased medical equipment.

The low value equipment consists of dental equipment (instruments etc), defibrillators, ultrasound therapy machine, ophthalmic equipment; replacements of which will be funded via the revenue budget as and when required.

The small amounts of high value equipment consists of ophthalmic screening equipment and a dental chair & equipment which are expected to require replacement in financial year 2020/21 (£8k) and 2021/22 (£15k).

#### 3.7. State of the Board’s Vehicular Fleet

The State Hospital has a fleet of 12 owned vehicles (this includes 5 agricultural vehicles) and 1 leased vehicle.

Within the last year part of the fleet has been replaced and the fleet size reduced.

The minibus for transporting visitors within the site is almost 10 years old and is in a poor state of repair. It is regularly off the road due to repairs being carried out to the bodywork or tail lift. The current vehicle is very rarely filled to capacity and therefore will be replaced within the next 6 months with a smaller multipurpose vehicle. This vehicle will be fitted with a ramp and tracking to accommodate a bariatric wheelchair.
The tables at Section 2.1, (Tables 4 & 5) give a summary of the vehicles split by fuel type, mileage and age. Although almost half of the vehicles are over 5 years old they are low mileage and well maintained so the risk associated with their age is mitigated.

### 3.8. State of the Board’s IM&T Assets

The hospital’s IM&T assets are actively managed, maintained and replaced when unsupportable or end of life.

The hospital has recently replaced the network firewall and entire wired network estate due to equipment age and security concerns. The new equipment will ensure the security of the hospital’s inward and outward facing network connections for a minimum of five years.

The data storage and backup solution is now at the end of its life and is in need of replacement. There is no need to replace this with a “like for like” solution as, due to changing technology, a more cost effective solution will be sought.

The wireless network will soon be at the end of its life and will need replaced. As security is vital to the hospital, the wireless network needs to continue to meet modern security standards. Replacing this system when at end of life will ensure the continued security of the hospital network.

The desktop estate is regularly refreshed in line with eHealth Infrastructure standards recommendations. This ensures that the hospital has equipment that is supported and under warranty. Machines and equipment will also be able to run the latest software effectively while ensuring the security of the device.

### Table 16: IM&T Assets

<table>
<thead>
<tr>
<th>IM&amp;T Asset</th>
<th>Replacement Value £M</th>
<th>Percentage Value %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cabling Networks (Wired outlets)</td>
<td>£0.072</td>
<td>6.7%</td>
</tr>
<tr>
<td>Network Server Infrastructure (circuits, switches and routers, etc)</td>
<td>£0.600</td>
<td>55.8%</td>
</tr>
<tr>
<td>Servers</td>
<td>£0.200</td>
<td>18.6%</td>
</tr>
<tr>
<td>Communication Systems (Telephony)</td>
<td>£0.012</td>
<td>1.1%</td>
</tr>
<tr>
<td>Desktops</td>
<td>£0.108</td>
<td>10.0%</td>
</tr>
<tr>
<td>Mobile Devices</td>
<td>£0.043</td>
<td>4.0%</td>
</tr>
<tr>
<td>Peripherals (printers)</td>
<td>£0.041</td>
<td>3.8%</td>
</tr>
<tr>
<td></td>
<td><strong>£1.076</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

### 3.9. State of the Board’s Security Assets

The physical security systems at the hospital were reviewed and refreshed over 2007 – 2008 in order to ensure they continued to be fit for purpose into the future and to enable and complement the major redevelopment of the hospital that took place across 2009 – 2012.

Areas of physical security in the hospital are:
• The 1.7km site perimeter systems; other than the reception building the perimeter consists of a 5.2m high security fence combined with underground and fence mounted detection systems, dedicated thermal image / optical CCTV and a linked lighting system.
• Communication and alarm systems; the hospital uses hand held radios and has a bespoke Personal Attack and Alarm system

Elements of this security have been assessed by an independent expert as now approaching the end of its life and requiring replacement to ensure that the existing level of security is maintained.

In addition to these end of life issues a revised threat assessment has taken place which has identified a changing picture of threat, including radicalisation and extremism, which needs to be considered over the life of any revisions to the security provision.

The opportunity exists to introduce internal CCTV to clinical areas which will improve safety and security for staff and patients.

Finally, the improvement in technological security systems gives the opportunity to provide security in more sophisticated ways.

In the “Perimeter Security & Enhanced Internal Security System” Initial Agreement submitted to Scottish Government Capital Investment Group, the preferred option is to:

• Replace existing detection and observation systems around the inner secure perimeter due to imminent obsolescence
• Increase detection and observation systems at the outer secure perimeter and the public areas at the front of the hospital to improve public facing security
• Introduce CCTV to the clinical areas of the hospital to increase ability to respond to incidents, complaints and concerns
• Replace the Personal Attack Alarm and radio communication systems due to imminent obsolescence

At a cost of approximately £5m (excluding optimism bias of 20%) over 4 – 5 years.

A “do minimal” option removes the increased detection and observation at the outer secure perimeter and the public areas at the front of the hospital and removes the introduction of CCTV to the clinical areas of the hospital. Retained elements would maintain the existing level of security without any significant improvement. This option has a projected cost of £3.1m (excluding optimism bias of 20%)

Remaining options of “do nothing” or increasing other domains of security are ineffective, increasing revenue costs beyond affordability whilst allowing the deterioration of the security delivered to the point where the service is no longer viable with the associated effect being the breakdown of the Forensic Mental Health system in Scotland. The option of outsourcing has been rejected as it does not add value or transfer risk.

3.10. State of other Independent Facilities

The State Hospital does not operate any independent facilities therefore this section is N/A.
4. Competing Asset-based Investment Needs

As noted above, the principal capital investment priority for The State Hospital’s strategic plan is the Perimeter Security and Enhanced Internal Security Systems Project.

The Initial Agreement for this project was submitted and approved in 2016/17, and the preparation of the Outline Business Case is currently underway for submission in the summer of 2017. The project is for replacing nearly obsolete frontline security systems and enhancement of other security systems, and is scheduled to run until 2021 with a total budget of approximately £5m.

While there are a number of other asset-based capital investment requirements, these are addressed by the Hospital’s Capital Group, chaired by the Finance and Performance Management Director and with representation from Estates, Facilities, Security, Finance, HR, IM&T, Clinical and Staff Side. The Capital Group reports to the Senior Management Team.
Part B: Where do we want to be?

The State Hospital is in the fortunate position of having all assets on a relatively small single site with new or recently refurbished buildings that are all at or above condition “B” and a controlled backlog maintenance requirement. The State Hospitals Board plans to continue to ensure the assets continue to support the achievement of the strategic aims it is therefore critically important that we do not become complacent and must continue to effectively monitor suitability, quality, performance and condition.

Regular consideration needs to take place of:

- Significant national or local plans, key targets and deliverables
- Possible changes to need or linked services provided by others
- Risks and challenges.
5. National Context for Service Change

The Scottish Government has developed a Route Map to the 2020 Vision for Health and Social Care, providing 12 priority areas for improvement and 25 key deliverables. The specialist nature of The State Hospital means that some of the priority areas and deliverables are not applicable; and the Route Map as it applies to the Hospital is shown below at table 17.

Table 17: State Hospital Route Map to 2020 Vision

<table>
<thead>
<tr>
<th>Triple Aim</th>
<th>Quality Ambitions</th>
<th>12 Priority Areas for Improvement</th>
<th>25 Key Deliverables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care</td>
<td>Person-centred</td>
<td>Person-centred care</td>
<td>1 Person Centred Health &amp; Care Collaborative Implemented</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2 Information and support to enable people at home and during times of transition</td>
</tr>
<tr>
<td></td>
<td>Safe</td>
<td>Safe Care</td>
<td>3 Further increase in safety in Scottish hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>4 New broader measure of safety developed (SPSI)</td>
</tr>
<tr>
<td>Health of the</td>
<td>Prevention</td>
<td></td>
<td>5 Maternity, mental health and primary care components of the Scottish Patient Safety Programme implemented with measurable improvements</td>
</tr>
<tr>
<td>Population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value &amp; Sustainability</td>
<td>Workforce</td>
<td>21 2020 Vision for NHSScotland workforce</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>22 Detailed action plan agreed to deliver 2020 Workforce Vision</td>
<td></td>
</tr>
<tr>
<td>Innovation</td>
<td></td>
<td>23 A new fund to provide pump-priming for innovative approaches to healthcare</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>24 A new procurement portal will be established to encourage working with SMEs and third sector</td>
<td></td>
</tr>
<tr>
<td>Efficiency &amp; Productivity</td>
<td>25 Recommendations to increase shared services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The key deliverables for the organisation based on the 2020 Route Map are overleaf at Table 18.
<table>
<thead>
<tr>
<th>25 Key Deliverables</th>
<th>TSH Executive Lead Contact</th>
<th>LDP mapping</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Person Centred Health &amp; Care Collaborative Implemented</td>
<td>Director of Nursing and AHP</td>
<td>Section 7</td>
</tr>
<tr>
<td>2 Information and support to enable people at home and during times of transition</td>
<td>Director of Nursing and AHP</td>
<td>Section 7</td>
</tr>
<tr>
<td>3 Further increase in safety in Scottish hospitals</td>
<td>Director of Nursing and AHP</td>
<td>Section 8</td>
</tr>
<tr>
<td>4 New broader measure of safety developed (SPSI)</td>
<td>Director of Nursing and AHP</td>
<td>Section 8</td>
</tr>
<tr>
<td>5 Maternity, mental health and primary care components of the Scottish Patient Safety Programme implemented with measurable improvements</td>
<td>Director of Nursing and AHP</td>
<td>Section 8</td>
</tr>
<tr>
<td>19 Early detection of cancer</td>
<td>Medical Director</td>
<td>Section 9</td>
</tr>
<tr>
<td>20 New restrictions on tobacco advertising</td>
<td>Medical Director</td>
<td>Section 9</td>
</tr>
<tr>
<td>21 2020 Vision for NHSScotland workforce</td>
<td>HR Director</td>
<td>Section 10</td>
</tr>
<tr>
<td>22 Detailed action plan agreed to deliver 2020 Workforce Vision</td>
<td>HR Director</td>
<td>Section 10</td>
</tr>
<tr>
<td>23 A new fund to provide pump-priming for innovative approaches to healthcare</td>
<td>General Manager</td>
<td>Section 10</td>
</tr>
<tr>
<td>24 A new procurement portal will be established to encourage working with SMEs and third sector</td>
<td>Finance and Performance Management Director</td>
<td>Section 10</td>
</tr>
<tr>
<td>25 Recommendations to increase shared services</td>
<td>Finance and Performance Management Director</td>
<td>Section 10</td>
</tr>
</tbody>
</table>

Health and social care integration with the associated focus on care at home is likely to have a major impact on much of the service delivered by territorial Health Boards; in addition, the Shared Services Review may have some impact on some of the support services based at hospital sites. These national streams of work will be closely monitored for impact. At present national work streams and our key deliverables and their implementation are unlikely to have a significant effect on the hospitals assets, which will continue to be based around delivery and support of delivery of high secure mental healthcare at the current site. As actions against these deliverables are reported and discussed at the SMT and Board, any implications for assets will be identified at an early stage. Review of the Clinical Model is ongoing, which further considers how our services are configured to meet need; it is not thought that this will have any significant affect on assets.

The SFT “Smarter ways of working” programme identified that The State Hospital has office space that is significantly in excess of the national average; although many of the opportunities for improvement available to other Boards are not available to the hospital, we continue to look for improvements where possible.
6. Local Context for Service Change

The State Hospital is part of the Managed Care Network for Forensic Services (“The Network”). The Network is hosted at the hospital and The State Hospital's Medical Director is also the Medical Director of The Network. This position gives the hospital a central and well informed place in the planning and delivery of forensic services in Scotland. In addition, State Hospital staff attend strategic and governance meetings of the English High Security Hospitals, allowing us to remain well informed about service changes across the UK.

As described in section 3.5, the hospital is currently operating across 11 wards through 2016/17. National demand for high secure services has dropped slightly, but not far enough or for long enough that it can be regarded as sufficiently robust for long term planning.

Most of the patients who move on from the hospital are returned to prison or rehabilitated through medium secure units, and the medium secure estate has sufficient capacity to ensure that patients are usually able to move within appropriate timescales. The potential for geographically reconfiguring medium secure beds exists, and should this occur the system may become more efficient. The change to healthcare delivery across the prison service, with the responsibility for healthcare now vested with Health Boards, has improved communication and continuity, but has had no impact on the requirement for high security beds.

As regards legislation, demographics and the care and treatment delivered to those requiring mental healthcare in conditions of security, there is unlikely to be any changes that would significantly affect the assets required to support that care within the life of this PAMS.

7. Competing Service-based Investment Needs

The hospital endeavours to work in partnership with staff, patients, carers and other stakeholders. Any significant change in the delivery of services will be fully consulted on with those affected. This is particularly high on the agenda of the Board, as previous changes affecting patients have resulted in legal challenge, particularly relating to consultation.

A previous example of effective stakeholder engagement was the development and delivery of the new hospital, when consultation and engagement took place with staff, patients and carers, a model that improved the process and outcome.
Part C: How do we get there?


With the exception of this project, and any IM&T priorities identified from ongoing review, The State Hospital is unlikely to require any significant service change across the life of this PAMS and beyond. The Board is informed on this position by close links with major national work streams and its close connections with the Network. Our journey to “Where we want to be” will be dependent on capital funding continuing at recent levels and additional funding being made available for some highlighted projects - while revenue funding continues to be available at the same time as savings targets are met.

Investment project management arrangements are shown below at Figure 4, and structures are in place to:

- Monitor and report on asset performance
- Identify and plan for changes in need
- Engage effectively with stakeholders
- Prioritise any competing investment needs
- Implement any investment plans

Figure 4: Investment Project Management Arrangements
8. The Strategic Asset Plan

A Strategic Asset Plan has been produced for Perimeter Security and Enhanced Internal Security Systems Project.

The Strategic Assessment for this is attached at Appendix 2.

The Strategic Assessment ensures that the project will progress in a strategic and integrated manner, and has been prepared in line with latest Scottish Government guidance.

There are no other currently planned projects within The State Hospital which are of a value sufficient to be requiring a Strategic Assessment Plan to be prepared, and there is currently no other significant future change foreseen.

9. Prioritised Investment & Disposal Plans

9.1. Prioritisation of Investment Proposals

The main investment proposal for The State Hospital over the next 5 years is the “Perimeter Security & Enhanced Internal Security Systems” project which has an estimated cost of £5m.

Following approval of the Initial Agreement by Scottish Government on 4th April 2017, the hospital are now working towards submission and Board approval of an Outline Business Case.

The project addresses the planned update of the Hospital’s existing perimeter and security systems, to re-examine the original assessment of risks and make recommendations as to necessary investment, planned for 2017/18 to 2020/21. Further work has taken place internally to re-examine security threats to the hospital and additional work commissioned to establish how those threats may be mitigated, including review of CCTV requirements, which will be reflected in the business case.

The following table (Table 19) is a forecast of the capital spend over the duration of the project:

Table 19: Proposed Forecast Investment

<table>
<thead>
<tr>
<th>Phase</th>
<th>Commencement</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1</td>
<td>2017 – 18</td>
<td>Consultancy Fees</td>
<td>£0.15m</td>
</tr>
<tr>
<td>Phase 2</td>
<td>2018 – 19</td>
<td>Fence Works, CCTV to perimeter, External detection &amp; observation</td>
<td>£2.05m</td>
</tr>
<tr>
<td>Phase 3</td>
<td>2019 – 20</td>
<td>Internal CCTV, Gates and Radios</td>
<td>£1.5 m</td>
</tr>
<tr>
<td>Phase 4</td>
<td>2020 – 21</td>
<td>PAA system</td>
<td>£1.3m</td>
</tr>
</tbody>
</table>

A Strategic Assessment and ranked prioritisation (utilising the Capital Planning System (CPS)) for this project can be found in Appendix 2.

The hospital are currently looking at inputting all of its investment proposals (i.e. projects carried out from annual capital allocation received by the Board) through the CPS to assist internally with prioritisation of projects.
9.2. Investment Plans

The main investment plan for The State Hospital over the next 5 years is the “Perimeter Security & Enhanced Internal Security Systems” project as described earlier.

Other proposed investment projects which address backlog maintenance and replacement of ageing and inefficient assets are shown in Table 20 below.

Table 20: 5 Year Investment Plan

<table>
<thead>
<tr>
<th>Investment Projects likely to be revenue based (Hub, NPD, etc) - include total capital value, upfront costs, and equivalent capital spend</th>
<th>5+ Year Investment Plan (£millions)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Capital / Board Funding Projects:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Perimeter Security &amp; Enhanced Internal Security Systems</td>
<td>5</td>
<td>0.15</td>
</tr>
<tr>
<td>Project approved by Scottish Government (£5m approved funding for this project)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Consultancy</td>
<td>0.12</td>
<td>0.03</td>
</tr>
<tr>
<td>Consultancy fees for Perimeter Security &amp; Enhanced Internal Security Systems Project (funded from Boards existing Capital allocation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Energy Efficiency Projects</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>Various lighting upgrades (to be funded internally from revenue)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bus Lay byes</td>
<td>0.078</td>
<td>0.078</td>
</tr>
<tr>
<td>Funded internally from existing Capital allocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water Tanker Fill Point</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>Funded internally from existing Capital allocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Islay Building - damp on walls</td>
<td>0.0036</td>
<td>0.0036</td>
</tr>
<tr>
<td>Significant backlog - to be funded internally from revenue if budget allows</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Health - outer wall skin has blown due to wet rot</td>
<td>0.008981</td>
<td>0.008981</td>
</tr>
<tr>
<td>Significant backlog - to be funded internally from revenue if budget allows</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
9.3. Disposal Plans

As described in Section 3.3 the hospital has some areas of agreed surplus agricultural land. Disposal is ongoing with the surplus land being advertised for sale in separate lots. As this is agricultural land, the disposal of this land will have no impact on our current backlog issues, these issues are solely related to buildings. The planned disposals are expected to happen within 2017/18 however may happen later depending on market conditions.

Table 21: Planned Disposals

<table>
<thead>
<tr>
<th>Planned Disposals (£millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus Agricultural Land</td>
</tr>
<tr>
<td>Total Disposal Receipts</td>
</tr>
</tbody>
</table>

Occupational Health - insulation on cold water pipework

<table>
<thead>
<tr>
<th>Investment in Other Assets:</th>
<th>Total Capital Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Equipment</td>
<td>0.041</td>
</tr>
<tr>
<td>Vehicles</td>
<td>0.06</td>
</tr>
<tr>
<td>Any Other Investment Plans</td>
<td></td>
</tr>
<tr>
<td>Projects:</td>
<td>Total Capital Value</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Various e-Health projects:</td>
<td></td>
</tr>
<tr>
<td>PMTS (Patient Movement Tracking System)</td>
<td>0.062</td>
</tr>
<tr>
<td>Network / Firewall / Web Proxy</td>
<td>0.074</td>
</tr>
<tr>
<td>IT Hardware</td>
<td>0.030</td>
</tr>
</tbody>
</table>

Total Investment Requested

<table>
<thead>
<tr>
<th>Total Investment Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.543583</td>
</tr>
</tbody>
</table>
10. Implementation Plans

While there are a number of asset-based capital investment requirements, these are addressed by the Hospital’s Capital Group, chaired by the Finance and Performance Management Director and with representation from Estates, Facilities, Security, Finance, HR, IM&T, Clinical and Staff Side.

The Capital group reports to the Senior Management Team.

The accountability arrangements and organisational structure ensure that:

- Information, control and governance systems are in place
- All appropriate authorisation systems are complied with
- All relevant legislation is identified, assessed and complied with
- All statutory and mandatory policies are in place and complied with
- All relevant information is reported through the Boards systems

All of which are regularly assessed and monitored through relevant groups and committees reporting to the Senior Management Team and Board as appropriate.
10.1. Asset Resource Arrangements

As noted in section 3.2, operational Management of the Hospital's estate, asset management systems, environmental management systems and statutory compliance systems is overseen by the Security Director and relevant stakeholders, particularly the Estates and Facilities department.

An organisational chart is undernoted:

Figure 5: Estate and Facilities Organisation Chart

The increase in demands for reporting from information systems has dramatically increased the demand on estates staff. The size of The State Hospital and its Estates and Facilities Department means this increased workload falls on a smaller pool than in other Boards.

Resources are now under review by senior management to address current requirements including the OBC for the Perimeter Security and Enhanced Internal Security Systems Project, the likely additional future requirements in this regard – for example focussed project management skills – are also under review by senior management in order to ensure that adequate resources are in place for the project to be taken forward effectively and in line with expectations.
10.2. Risks and Constraints to successful delivery of the PAMS

The wider healthcare environment and The State Hospital face significant challenges in coming years. In order to meet these challenges and continue to meet the needs of our patients it is important that our assets remain effective in supporting our service.

There are:

- Risks that we need to address
- Work streams nationally that we need to remain engaged with
- Work streams within the organisation that we need to commission or conclude
- Practices that we need to continue

Potential service risks are explored above; it is unlikely that there will be any significant changes to the service The State Hospital is required to provide within the life of this PAMS.

The organisation does face financial challenges, as absence and overtime remain high and savings targets need to be met. Although financial balance was achieved in 2016/17, a high proportion of the savings delivered was non-recurring, and further work is required to deliver ongoing savings and to redress this balance. Any savings targets that have the potential to affect asset performance must be carefully risk assessed. There is also a need to support proactively the national strategy in relation to the eight NHSScotland National (Special) Boards working more collaboratively and efficiently through shared services and other efficiencies, including the financial commitment by the National Boards collectively to contribute an additional £15m savings in 2017/18.

At present there are no risks associated with the PAMS that are of sufficient significance to warrant inclusion on the corporate risk register. This will be reviewed as part of the PAMS review and regular risk review.

Figure 6: Risk Process

1. Identification
   what are the risks?

2. Assessment
   what is the likelihood and impact of the risks occurring?

3. Control
   what can we do to reduce the likelihood and impact of the risks occurring?

4. Monitoring
   has the situation changed and are the mitigation measures working?
10.3. Next Steps

The principal project included in The State Hospital's PAMS is that for the Perimeter Security and Enhanced Internal Security Systems.

This is now at the stage of preparation of the Outline Business Case, which will be completed and submitted in the summer of 2017, as indicated in sections 2.3, 4, 9.1, 9.2 and Appendix 2.

All other aspects of the PAMS will be addressed within the normal course of business of the Capital Group and the Estates and Facilities department.
Electricity Consumption

Yearly Comparison by Quarter

Region: NHS STATE HOSPITAL
Site: THE STATE HOSPITAL
Meter: Electricity - (Profile Class 00)

Period From: 01 January 2017
Period To: 31 March 2017
Units: kWh, £

<table>
<thead>
<tr>
<th>Period</th>
<th>This Year Consumption</th>
<th>Last Year Consumption</th>
<th>Difference</th>
<th>This Year Cost</th>
<th>Last Year Cost</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>740,128</td>
<td>760,396</td>
<td>-2.67%</td>
<td>£90,220.40</td>
<td>£90,631.46</td>
<td>-0.45%</td>
</tr>
<tr>
<td>Totals</td>
<td>740,128</td>
<td>760,396</td>
<td>-2.67%</td>
<td>£90,220.40</td>
<td>£90,631.46</td>
<td>-0.45%</td>
</tr>
</tbody>
</table>
Biomass Consumption

Yearly Comparison by Quarter

<table>
<thead>
<tr>
<th>Region:</th>
<th>NHS STATE HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site:</td>
<td>THE STATE HOSPITAL</td>
</tr>
<tr>
<td>Meter:</td>
<td>Biomass - [840kW] - Heat Meter</td>
</tr>
<tr>
<td>Period From:</td>
<td>01 January 2017</td>
</tr>
<tr>
<td>Period To:</td>
<td>31 March 2017</td>
</tr>
<tr>
<td>Units:</td>
<td>kWh, £</td>
</tr>
</tbody>
</table>

As illustrated in the chart above a 5.22% saving was achieved in biomass consumption during Q1 however only a 0.63% saving was achieved in cost. This was due to the contract being re-tendered and the costs increasing in the new contract.
## Oil Consumption

<table>
<thead>
<tr>
<th></th>
<th>Total Consumption in Litres</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>19,145</td>
<td>£14,338.75</td>
<td>21,140</td>
<td>£11,987.39</td>
<td>26,180</td>
</tr>
<tr>
<td>May</td>
<td>7,999</td>
<td>£5,917.01</td>
<td>17,361</td>
<td>£10,175.38</td>
<td>13,278</td>
</tr>
<tr>
<td>June</td>
<td>2,420</td>
<td>£1,793.35</td>
<td>11,396</td>
<td>£6,558.15</td>
<td>7,090</td>
</tr>
<tr>
<td>July</td>
<td>2,297</td>
<td>£1,663.65</td>
<td>5,699</td>
<td>£3,093.09</td>
<td>3,780</td>
</tr>
<tr>
<td>August</td>
<td>9,905</td>
<td>£7,172.83</td>
<td>4,400</td>
<td>£2,222.00</td>
<td>15,555</td>
</tr>
<tr>
<td>September</td>
<td>9,052</td>
<td>£6,500.05</td>
<td>9,520</td>
<td>£4,812.26</td>
<td>11,117</td>
</tr>
<tr>
<td>October</td>
<td>11,015</td>
<td>£7,569.29</td>
<td>14,012</td>
<td>£7,003.24</td>
<td>11,894</td>
</tr>
<tr>
<td>November</td>
<td>22,981</td>
<td>£14,570.38</td>
<td>32,209</td>
<td>£15,681.09</td>
<td>37,205</td>
</tr>
<tr>
<td>December</td>
<td>40,243</td>
<td>£23,703.39</td>
<td>29,573</td>
<td>£13,081.81</td>
<td>37,699</td>
</tr>
<tr>
<td>January</td>
<td>39,956</td>
<td>£20,811.89</td>
<td>47,012</td>
<td>£19,134.78</td>
<td>35,253</td>
</tr>
<tr>
<td>February</td>
<td>38,625</td>
<td>£21,148.40</td>
<td>43,414</td>
<td>£17,417.67</td>
<td>43,078</td>
</tr>
<tr>
<td>March</td>
<td>32,114</td>
<td>£18,161.30</td>
<td>42,938</td>
<td>£18,706.49</td>
<td>26,559</td>
</tr>
<tr>
<td>TOTALS</td>
<td>235,752</td>
<td>£143,350.28</td>
<td>278,674</td>
<td>£129,873.36</td>
<td>268,688</td>
</tr>
</tbody>
</table>

As illustrated in the table above the hospital have saved almost 10,000 litres in heating oil 2016/17 compared to 2015/16 however due to cost increases in oil, costs were almost £17k more in 2016/17.
PROJECT: Perimeter Security & Enhanced Internal Security Systems

What are the Current Arrangements:
Physical, Procedural and Relational Security Arrangements in place to maintain perimeter security as well as internal security arrangements

What is the need for change?
End of life of elements of physical security as well as technological and equipment obsolescence.

Opportunity to enhance security measures.

What benefits will be gained from addressing these needs?
Minimal detriment to service

Enables efficient and effective maintenance support

Supports effective incident investigation and reporting

Provides best in class security measures

How do these benefits link to NHSScotland’s Strategic Investment Priorities?

Prioritisation Score

Person Centred

Safe

Effective Quality of Care

Health of Population

Value & Sustainability

TOTAL SCORE

4

5

4

3

3

79

What solution is being considered

Service Scope / Size
Complete refresh / upgrade of high secure perimeter and associated systems. Installation of internal CCTV systems in clinical areas.

Service Arrangement
Keeps perimeter secure and enhances security measures.

Service Providers

NHS

Impact on Assets
Assets will be upgraded, refurbished and replaced where appropriate. Installation of additional assets.

Value & Procurement
Estimated £5m via traditional Procurement route / Frameworks 2.
<table>
<thead>
<tr>
<th>Rank</th>
<th>Score</th>
<th>Budget Year</th>
<th>Override</th>
<th>Name</th>
<th>Est Cost (GBP)</th>
<th>Board</th>
<th>Site</th>
<th>Block Name</th>
<th>ID</th>
</tr>
</thead>
</table>
1 SITUATION

1.1 The Senior Team and the Board consider the Revenue and Capital plans, and financial monitoring. This report provides information on the financial performance to 31 May 2017.

1.2 The three-year financial plan for 2017/18 – 2019/20 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 2017/18 based on achieving £1.402m efficiency savings, as referred to in the table in section 3. Recognition of recurring posts, saved through recent workforce reviews, amounting to £0.315m is reflected in the base budgets, so in effect that brings the total savings target to £1.717m.

In addition, there is a requirement for all 8 National Boards to contribute additional savings in 2017/18 of £15m through a range of non-clinical service reviews. Subject to the outcome of these reviews, there is a likely additional savings requirement for the State Hospital for approximately £0.440m.

2 BACKGROUND

2.1 Revenue Resource Limit Outturn

The Board is reporting an under spend position of £0.009m to 31 May 2017. The Nursing overtime and unachieved savings contributes to the overspend in Nursing & AHP’s. Changes in Nursing Leadership are addressing the issues. The following tables recognise the dissolution of the General Manager Directorate.

The current overall position is summarised in the table below –
2.2 Outturn
The forecast outturn trajectory to date (as set in the LDP) was an over spend of £0.067m, against the actual under spend of £0.009m – therefore the position is better than planned by £0.076m. Increased medical sessions recharged to other Boards (since base budgets were set) have aided the forecast position (this was to reflect the change in service needs due to a second ward closure).

2.3 Revenue Resources
The annual budget of £34.816m matches the total revenue allocation currently anticipated from Scottish Government.

3 ASSESSMENT
YEAR TO DATE POSITION - BOARD FUNCTIONS

3.1 Medical Services
Annual Budget £2.2m. Year to date under spend of £0.053m.
Mainly in connection with reductions to EPAs, and increased external sessions recharged since base budget was set, these ongoing changes are to reflect savings to be made due to the ward closure.

3.2 Nursing and AHPs – see table below.
Annual Budget £17.9m. Year to date over spend of £0.091m.

<table>
<thead>
<tr>
<th>Nursing and AHP’s</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>
<th>Budget WTE</th>
<th>Actual WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward Nursing</td>
<td>14,014</td>
<td>2,340</td>
<td>2,409</td>
<td>(69)</td>
<td>294.40</td>
<td>312.32</td>
</tr>
<tr>
<td>Nursing Resources</td>
<td>90</td>
<td>15</td>
<td>20</td>
<td>(5)</td>
<td>2.00</td>
<td>2.00</td>
</tr>
<tr>
<td>H &amp; C Admin</td>
<td>689</td>
<td>115</td>
<td>101</td>
<td>13</td>
<td>18.94</td>
<td>18.94</td>
</tr>
<tr>
<td>Directors PAs</td>
<td>227</td>
<td>38</td>
<td>39</td>
<td>(1)</td>
<td>5.60</td>
<td>5.60</td>
</tr>
<tr>
<td>Skye Centre</td>
<td>1,594</td>
<td>256</td>
<td>233</td>
<td>33</td>
<td>10.61</td>
<td>10.61</td>
</tr>
<tr>
<td>AHPs</td>
<td>572</td>
<td>95</td>
<td>76</td>
<td>19</td>
<td>12.95</td>
<td>10.61</td>
</tr>
<tr>
<td>Advocacy</td>
<td>222</td>
<td>20</td>
<td>24</td>
<td>(4)</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Involvement &amp; Equality</td>
<td>209</td>
<td>35</td>
<td>25</td>
<td>10</td>
<td>3.40</td>
<td>2.00</td>
</tr>
<tr>
<td>Nursing Support</td>
<td>362</td>
<td>60</td>
<td>57</td>
<td>3</td>
<td>3.95</td>
<td>3.95</td>
</tr>
<tr>
<td><strong>Total Nursing and AHP’s</strong></td>
<td><strong>17,073</strong></td>
<td><strong>2,994</strong></td>
<td><strong>3,075</strong></td>
<td><strong>(91)</strong></td>
<td><strong>384.88</strong></td>
<td><strong>390.06</strong></td>
</tr>
</tbody>
</table>

The overspend is due to very high levels of clinical activity and staff sickness (that which exceeds what is built in to the establishment). Clinical activity is currently running at 1,061hrs average per week above that which is budgeted for. In relation to sickness absence the year to date average in nursing is 9.4%, which equates to 490hrs per week above what is budgeted. In addition to these statistics, on a weekly basis the Directors’ group look at activity data collated for activity around nursing establishment, patient outings, training, and facility time. Programmed monthly savings are not yet realised.

Vacancies in Skye Centre and Occupational Therapy (AHPs) are currently offsetting some of this pressure.
3.3 **Security and Facilities – see table below.**
Annual Budget £5.6m. Year to date under spend of £0.004m.

<table>
<thead>
<tr>
<th>Security &amp; Facilities</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>
<th>Budget WTE</th>
<th>Actual WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilities</td>
<td>4,037</td>
<td>673</td>
<td>663</td>
<td>10</td>
<td>85.88</td>
<td>81.28</td>
</tr>
<tr>
<td>Security</td>
<td>1,527</td>
<td>255</td>
<td>261</td>
<td>(6)</td>
<td>40.77</td>
<td>40.76</td>
</tr>
<tr>
<td>Total Security &amp; Facilities</td>
<td>5,564</td>
<td>927</td>
<td>923</td>
<td>4</td>
<td>126.63</td>
<td>122.04</td>
</tr>
</tbody>
</table>

3.4 **Corporate Functions – see table below.**
The total budget for Corporate Functions is £9.2m – reporting an under spend of £0.043m.

<table>
<thead>
<tr>
<th>Corporate Functions</th>
<th>Annual Budget £'k</th>
<th>YTD Period Budget £'k</th>
<th>YTD Actuals £'k</th>
<th>YTD Variance (budget - actual) £'k</th>
<th>Establishment Budget WTE</th>
<th>Period WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Total</td>
<td>5,167</td>
<td>1,469</td>
<td>1,417</td>
<td>4</td>
<td>89.03</td>
<td>83.32</td>
</tr>
<tr>
<td>Chief Exec.</td>
<td>3,137</td>
<td>523</td>
<td>480</td>
<td>43</td>
<td>38.57</td>
<td>37.62</td>
</tr>
<tr>
<td>Finance</td>
<td>2,934</td>
<td>391</td>
<td>392</td>
<td>(1)</td>
<td>37.13</td>
<td>33.84</td>
</tr>
<tr>
<td>Human Resources</td>
<td>791</td>
<td>132</td>
<td>111</td>
<td>21</td>
<td>13.33</td>
<td>11.96</td>
</tr>
<tr>
<td>Misc Income</td>
<td>(100)</td>
<td>(17)</td>
<td>(40)</td>
<td>(23)</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Central Commitments</td>
<td>225</td>
<td>(30)</td>
<td>(23)</td>
<td>(63)</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Cap Charges</td>
<td>2,786</td>
<td>469</td>
<td>451</td>
<td>9</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

This corporate area covers support departments.

**Capital Charges** will come back in line at the end of the first quarter.

**Central commitments** – these are mainly phased to March.

**Miscellaneous Income** RHI income is coded here initially.

**Chief Executive** under spend is mainly in connection with research spend less than planned (however this budget will move to Finance Directorate in the first quarter), also vacancies in Psychology.

**Forensic Network & School of Forensic Mental Health** sits within this Directorate, the Scottish Government earmark this funding. Income has also been deferred to 2017/18, any underspend is accrued monthly, to reflect the projected breakeven, due to timing of course income and expenditure.

**Finance** An unexpected rates reduction has contributed to savings.

**Human Resources** under spend is mainly around Learning Centre mandatory course fees timing and a vacancy within this department.

4 **EFFICIENCY SAVINGS TARGET**

4.1 **To balance the financial plan in 2017/18 the Board is required to release £1.717m of cash from budgets through efficiency savings.** As noted in 1.2 above, £0.315m is recognised in the recurring base budgets, with £1.402m savings still to be realised. This does not take into account any contribution we have to make towards the Territorial Boards.
4.2 The following table shows the year to date position, with savings currently under achieved by £0.060m.

<table>
<thead>
<tr>
<th>Efficiency &amp; Productivity Workstreams:</th>
<th>Savings Annual Target LDP</th>
<th>Savings Achieved YTD, as at May 17</th>
<th>Savings still to be Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017-18 Rec £'000s</td>
<td>2017-18 Non-Rec £'000s</td>
<td>Total £'000s</td>
</tr>
<tr>
<td>Service productivity</td>
<td>51</td>
<td>29</td>
<td>80</td>
</tr>
<tr>
<td>Drugs &amp; Prescribing</td>
<td>0</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Procurement</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Workforce</td>
<td>231</td>
<td>158</td>
<td>63</td>
</tr>
<tr>
<td>Support Services (Non-Clinical)</td>
<td>99</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Estates &amp; Facilities</td>
<td>56</td>
<td>61</td>
<td>117</td>
</tr>
<tr>
<td>Shared Services</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>200</td>
<td>0</td>
<td>200</td>
</tr>
<tr>
<td>Total In-Year Efficiency Savings</td>
<td>633</td>
<td>769</td>
<td>1,402</td>
</tr>
</tbody>
</table>

5 CAPITAL RESOURCE LIMIT

Capital allocations anticipated from Scottish Government amounted to £0.269m.

The plan is over committed but we are considering a request for authorisation from Scottish Government to transfer a small amount of the revenue budget to capital should resources permit.

6 CONCLUSION

6.1 Revenue

Monthly meetings between Head of Management Accounts and CE/Directors/Budget Holders, with quarterly reviews involving the Finance and Performance Management Director, allow negotiations for savings to be taken. A financial plan action list is kept up to date by the Head of Management Accounts following monthly budget meetings to record any deviations from plan, either expected pressures or benefits, to make the Board aware of the effects on the financial outturn; and for comparison purposes against the LDP trajectory variances.

The Board is asked to note the under spend position for the first two months. We have however projected a year-end breakeven in the LDP.
6.2 Capital

To note a planned breakeven at the year end.

7 RECOMMENDATION

The Board is asked to note the content of this report.
<table>
<thead>
<tr>
<th><strong>How does the proposal support current Policy / Strategy / LDP / Corporate Objectives</strong></th>
<th>Monitoring of financial position</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workforce Implications</strong></td>
<td>No workforce implications – for information only</td>
</tr>
<tr>
<td><strong>Financial Implications</strong></td>
<td>No financial implications – for information only</td>
</tr>
<tr>
<td><strong>Route to Board</strong></td>
<td>Head of Management Accounts</td>
</tr>
<tr>
<td>Which groups were involved in contributing to the paper and recommendations?</td>
<td></td>
</tr>
<tr>
<td><strong>Risk Assessment</strong></td>
<td>No significant risks identified</td>
</tr>
<tr>
<td>(Outline any significant risks and associated mitigation)</td>
<td></td>
</tr>
<tr>
<td><strong>Assessment of Impact on Stakeholder Experience</strong></td>
<td>None identified</td>
</tr>
<tr>
<td><strong>Equality Impact Assessment</strong></td>
<td>No identified implications</td>
</tr>
</tbody>
</table>
1 SITUATION

This report presents a high level summary of organisational performance for the year from April 2016 until March 2017 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 LDP Standards now replace the system of HEAT targets and Standards with the vast majority of LDP Standards being former HEAT targets. The only LDP standards directly relevant to the State Hospital are as follows: Psychological Therapies Waiting Times; GP access and Sickness Absence. Additional local KPIs are reported to the Board and included in this report.

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). It should be noted that due to the low number of patients, natural variations in the population can have an effect on the sample and small changes in our Key Performance Indicators (KPI) figures can look more significant when presented as percentages. These limitations should be borne in mind when considering this comparative data.

2 BACKGROUND

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

3 ASSESSMENT

No 1 Patient have their care and treatment plans reviewed at 6 monthly intervals: There have been fluctuations in performance in the course of 2016/17 and the figure for March 2017 was 91% compared to 98% in the previous year against a target of 100%. It is difficult to determine the reasons for the drop in performance but there have been a number of RMO changes this year that could result in delays as the new RMOs get to know their patients. The Health Records Department is alert to the issue and renewed auditing should improve the figures this year.

No 2 Patients will be engaged in psychological therapy: Performance dropped below the 90% target in the first three quarters before improving to 96.4% in Q4. On average 88% of patients were engaged in psychological interventions at any one time over the year. There are no patients that have never been involved in a psychological intervention in
2016. The percentages dropped over the course of the year below 90% due largely to the number of patients in the hospital falling. For example, with patient numbers being at times as low as 112, there only need to be 12 patients having a break from treatment or waiting to be discharged for the target of 90% not to be met.

In addition to the new admissions and planned discharges, it is also not feasible – nor necessarily desirable - to have patients constantly engaging in psychological therapy. A break between interventions is useful both to take stock and review as well as plan the way forward. The falling patient numbers mean that it will not be possible to meet the 90% engaged in treatment target consistently. It is important to have a realistic target so to avoid engaging patients just to meet the target and to ensure that all work undertaken is focussed and meaningful. A new target of 85% of patients will be engaged in psychological treatment has been agreed by SMT.

No 3 Patients will be engaged in off-hub activities:
Performance remains at a similar level with between 79.3% of patients engaged in activities, compared with 81% in the previous year. A service improvement approach to the delivery of an active day model for our patients is progressing, with this commencing on 20th June 2017. This will deliver an integrated staffing model to improve access to activity for our patients, and the outcome of this should be increased access to, and uptake of activities. The staffing model and activities provided within the Skye Centre has been reviewed, focused on the re-provision of woodwork department as a multi function space. The Occupational Therapy workforce has been reviewed, with appointment made to leadership role.

No 4 Annual Physical Health Review and No 10 Access to Primary Care:
The Health Centre consistently meets its targets.

No 5 Patients will undertake 90 minutes of exercise each week:
It is evident from Appendix 2 that the availability of reliable data about patients’ physical activity has been a challenge for some years. However, there has been significant progress on this issue over the past year. The Physical Health Steering Group set up a Project Team including Clinical Staff and representatives from e-Health and the Skye Centre to develop and pilot a Physical Activity Monitoring System. The Project Team successfully conducted a 3-month pilot on Arran Hub of a new process that integrates physical activity recording within the RiO Electronic Patient Administration System. Senior Management Team have approved the process and it is being rolled out across the Hospital in stages, with Lewis Hub now being supported with implementation. The monitoring system is not being introduced in isolation and the Project Team are focussed on raising awareness of the both the LDP target and the range of physical activity opportunities available to patients with the Hospital.

The data emerging from the pilot is encouraging and will provide evidence at a population level of the number of patients meeting the current target. A new report is also being developed that will provide personalised analysis for individual patients, which will be easily accessible by all staff and is to be incorporated into the weekly Clinical Team Meeting so that appropriate interventions can be set.

No 6 Healthier BMI:
Patients who have a healthier BMI decreased from 15% in the previous year to 13.6% (the June 2016 figure was 12.6%). The physical health inequality of our patient group is significant; reducing obesity and increasing physical activity are paramount in addressing this issue. In the past year we have:

• Relocated exercise equipment in the grounds of the Hospital to improve access to same.
• Piloted a new way of recording physical activity levels in one of our Hubs (as detailed above).
• Agreed the implementation of a programme of work through our Supporting Healthy Choices workstream, including healthy lifestyle plans, and changing our approach to supermarket procurement.
• Implemented revised stock within our Hospital shop, becoming the first NHS board to achieve the Healthy Retail Standard.
• Continued to invest in our cohort of Health Champions through the delivery of an ongoing programme of learning and development, and raining awareness of their roles.
• Continued in our aim to improve the healthcare environment including access to ward-based exercise equipment.

Our aims for 2017/18 include:
• Additional ways in which to provide patients with the necessary support, education and information that enables them to make healthy choices to maintain and promote their own physical health.
• Refining and scaling up data recording methods of physical health activity, interventions and outcomes.
• Continuing with Health Promotion events to be scheduled throughout the coming year delivered by Health Centre Staff.
• Implementing individualised healthy lifestyle plans for every patient.
• Implementing refined approach to weight loss interventions, which draws upon evidence based approaches and which supports weight loss and maintaining a healthy weight.
• Evaluating the impact of our Health Champions model.
• Influencing meaningful stakeholder engagement in the Supporting Healthy Choices and Clinical Model projects.
• Delivering the Healthy Living Group on each hub.

No 7 Sickness absence;
The State Hospitals Board fully recognises the importance of promoting attendance at Work and is working to effect a significant improvement in our Sickness Absence Performance.

In the reporting period 1 April 2016 to 31 March 2017 the rate of absence was 8.35%. The total hours lost for this period is 97,892.74, which equates to 50.20 wte staff. Industrial injuries represented 0.32% of available hours (3,729.52) from 1 April 2016 to 31 March 2017. This rate is unacceptable and unsustainable due to the impact upon the delivery of quality patient care, the wellbeing of our staff and the financial impact in terms of replacement and overtime payments.

There are a number of actions, which are being progressed, and most recently, an option appraisal has been completed in respect of providing targeted support for staff experiencing absence related to Common Mental Health Problems and also implementing the EASY approach to support staff within the current management of attendance policy framework. The EASY model which is currently in use within NHS Lanarkshire and NHS Western Isles has shown significant improvement in absence rates with the most effective element being telephone contact by trained staff on the first day of absence. The results being that 50% of staff return to work within 5 days.

As a result of considering the implementation of EASY analysis of our absence data confirms that the two most common reasons for absence are common mental health problems and musculoskeletal. Currently additional Physiotherapy sessions are provided within the Occupational Health Service to assist with musculoskeletal issues. Work has also been progressed to explore the type of support required for employees experiencing common mental health problems as our data for 2015/16 shows us that one third of our staff were absent due to common mental health problems which equates to 97 individuals. Research also undertaken internally on debriefing post incidents indicates that there may be the ability to improve upon our current practices. It is intended that this area of work will also be progressed. It is expected that these proven interventions will result in improved performance in this area.

No 8 Staff have an approved PDP:
As of 31 March 2017, 73% of staff met the standard of having had a performance development planning and review meeting conducted within the previous 12 months and having an up-to-date
PDP in place. The standard achieved at 31 March 2017 was slightly below the 80% target as a result of the implementation of a new leadership structure within the nursing directorate in February 2017. The compliance level had previously been 84.3% at 31 January 2017, however, a number of annual reviews within the nursing directorate that were due within the period Feb-Mar 2017 did not take place as scheduled due to staff movement and changes in line management arrangements. Senior Charge Nurses within all wards have been made aware of this issue and steps have been taken to rectify the situation and progress completion of the overdue PDPs. This includes incorporating PDP completion levels as a key measure in the performance framework for SCNs. Progress updates on PDP completions are reported to the Senior Management Team and Partnership Forum on a monthly basis to monitor departmental and organisational compliance levels. Departmental managers in any area that falls below a 75% compliance threshold in any month are required to submit a report to the Senior Management Team explaining reasons for non-compliance and providing details of the actions they plan to take to address the non-compliance and achieve the 80% minimum target. Progress update reports are also reported to and reviewed by Partnership Forum on a monthly basis and the Staff Governance Committee on a quarterly basis.

No 9 Patients are transferred using CPA:
This happened consistently throughout the year.

No 10 – refer to No 4:

No 11 Patients will commence psychological therapies <18 weeks from referral date:
All patients commenced treatment within this timescale.

No 12 and 13 – New indicators to be agreed.

KPI: A monthly feedback meeting takes place in each Hub and in the Skye Centre, which explicitly covers patient and carer feedback received and the action taken in response to same.

The learning from feedback report is available to all Clinical Leads, Skye Centre Manager, and Lead Nurses through being members of the SMT. A review of the Hub Operational Policy was agreed at SMT on 21st June. This review will cover the roles and responsibilities of Hub teams to consider and respond to feedback on a formalised basis. The Skye Centre Management Team will mirror the approach agreed for the Hubs. Clinical Effectiveness will be asked to qualitatively evaluate the feedback and actions taken in response.

KPI: All patients will have a minimum of a weekly one to one discussion with their key worker documented in their records.

The recording of 1:1 key-worker discussion as a specific function of RiO has now been agreed by the Electronic Patient Record group. This will be implemented over the next 2 months.

KPI: The percentage of patients attending annual and intermediate CPAs

Data will be sourced from Clinical Effectiveness who already produce this information for the Clinical Outcome Indicators report to the Clinical Forum. This high level data will be reported to the Board as a trend over time given the difficulty in determining a hard target at this point (i.e. the ability, appropriateness or willingness of patients to attend full review etc). However, the comparative data across hubs that is already produced (and demonstrates significant differences in practice) will be fed into the Hub Management Teams for their consideration and response. A review of the Hub Operational Policy was agreed at SMT on 21st June. This review will cover the roles and responsibilities of Hub teams to consider and respond to performance data on a formalised basis.
No 14 Patients will have their clinical risk assessment reviewed annually. Performance has remained slightly below the 100% target throughout the year. A new system has been put in place from April 2017 whereby the dates being monitored will be in line with the significant date for the patient (e.g. date of renewal of detention, or annual report) rather than one year from the last completed risk assessment. This may lead to some discrepancies in the first instance but this will even out. Monitoring is now also more robust for patients not on a final disposal from court, which will also improve completion. Given the improvements within the Health Records Department (full staffing complement), more auditing and better recording systems will be developed over the next year, working closely with Clinical Effectiveness and other departments.

No 15 Attendance by clinical staff at case reviews. The table below provides comparative data on the extent to which professions met their Local Delivery Plan attendance target.

<table>
<thead>
<tr>
<th>LDP Target</th>
<th>Target</th>
<th>16/17</th>
<th>15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>RMO</td>
<td>90.0%</td>
<td>96.8%</td>
<td>95.4%</td>
</tr>
<tr>
<td>*Medical</td>
<td>100.0%</td>
<td>99.5%</td>
<td>99.1%</td>
</tr>
<tr>
<td>KW/AW</td>
<td>80.0%</td>
<td>71.8%</td>
<td>74.8%</td>
</tr>
<tr>
<td>*Nursing</td>
<td>100.0%</td>
<td>97.3%</td>
<td>95.9%</td>
</tr>
<tr>
<td>OT</td>
<td>80.0%</td>
<td>47.9%</td>
<td>48.6%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>60.0%</td>
<td>74.5%</td>
<td>75.7%</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td>80.0%</td>
<td>72.3%</td>
<td>74.3%</td>
</tr>
<tr>
<td>*Psychology</td>
<td>100.0%</td>
<td>96.2%</td>
<td>97.2%</td>
</tr>
<tr>
<td>Security</td>
<td>60.0%</td>
<td>59.6%</td>
<td>70.6%</td>
</tr>
<tr>
<td>Social Work</td>
<td>80.0%</td>
<td>75.5%</td>
<td>78.4%</td>
</tr>
</tbody>
</table>

* Where the KW/AW, RMO or Clinical Psychologist is unable to attend a patient’s Case Review another representative from that profession should attend in their place.

The Security Director advises that Security Managers continue to cover shifts 7 days per week, 0700 – 2100. This demand means attendance at case reviews is adversely affected, particularly at times of annual leave or other absence. The 100% requirement to supply a report to the meeting is met and case reviews for patients of higher concern are prioritised.

New KPIs: Staff Overtime Performance Indicators

A weekly process is being established which at the start of each week sets out the expected / forecast level of activity, leave and overtime for the forthcoming week, with justification required for variance / increase from budget – broken down with attributable hours.

At the end of each week, the actual level of activity, leave and overtime is to be reported. Variance from expected / forecast level will be given, with any justification as required for variance / increase – again broken down with attributable hours.

This is underpinned by a weekly resource meeting, held with Senior Charge Nurses and Lead Nurses, and led by the Clinical Operations Manager. Ward level rostering has been fully implemented. A weekly written report is provided to the Executive Team. Discussions are progressing with NHS Lothian to develop a reporting dashboard specific to nursing resources, and which will pull and report information directly from SSTS.

Business Intelligence and Data Warehouse

The part-time Senior Project Manager and other e-Health Team resources have been committed to the Patient Movement Tracking System (PMTS) development. The application has now been developed and over 300 staff are being trained throughout June prior to the system going live in July. Once this application has been implemented, the team can focus on the Business Intelligence Project, which had been deferred until resources could be properly allocated to it. The
Information Analysts have been conducting initial research on the Business Intelligence applications available but a full Requirements Analysis will be undertaken with stakeholders in order to identify the best solution.

4 RECOMMENDATION

The Committee is asked to note the contents of this report.
<table>
<thead>
<tr>
<th><strong>How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?</strong></th>
<th>Monitoring of Key Performance Indicator Performance in the TSH Local Delivery Plan (2017-2020).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workforce Implications</strong></td>
<td>No workforce implications - for information only.</td>
</tr>
<tr>
<td><strong>Financial Implications</strong></td>
<td>No financial implications - for information only.</td>
</tr>
<tr>
<td><strong>Route to the Board (Committee)</strong></td>
<td>Leads for KPIs contribute to report.</td>
</tr>
<tr>
<td>Which groups were involved in contributing to the paper and recommendations?</td>
<td>Leads for KPIs contribute to report.</td>
</tr>
<tr>
<td><strong>Risk Assessment</strong></td>
<td>There is a dependency on the proposed Data Warehousing project. While we can identify other ways of obtaining and analysing data there will be continue to be limitations on the timeliness and granularity of the information reported.</td>
</tr>
<tr>
<td>(Outline any significant risks and associated mitigation)</td>
<td>There is a dependency on the proposed Data Warehousing project. While we can identify other ways of obtaining and analysing data there will be continue to be limitations on the timeliness and granularity of the information reported.</td>
</tr>
<tr>
<td><strong>Assessment of Impact on Stakeholder Experience</strong></td>
<td>The gaps in KPI data which make it difficult to assess.</td>
</tr>
<tr>
<td><strong>Equality Impact Assessment</strong></td>
<td>Implications to be identified.</td>
</tr>
</tbody>
</table>
## Key Performance Indicators

### 2016/17: Comparison across Q1-4

<table>
<thead>
<tr>
<th>Item</th>
<th>Item</th>
<th>Principles</th>
<th>Performance Indicator</th>
<th>Target</th>
<th>Q1 Apr-Jun</th>
<th>Q2 Jul-Sep</th>
<th>Q3 Oct-Dec</th>
<th>Q4 Jan-Mar</th>
<th>LEAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8</td>
<td></td>
<td>Patients have their care and treatment plans reviewed at 6 monthly intervals</td>
<td>100%</td>
<td>96.5</td>
<td>90.2</td>
<td>94.4</td>
<td>91</td>
<td>LT</td>
</tr>
<tr>
<td>2</td>
<td>8</td>
<td></td>
<td>Patients will be engaged in psychological treatment</td>
<td>90%</td>
<td>88.8</td>
<td>79.6</td>
<td>88.3</td>
<td>96.4</td>
<td>MS</td>
</tr>
<tr>
<td>3</td>
<td>8</td>
<td></td>
<td>Patients will be engaged in off-hub activity centres</td>
<td>90%</td>
<td>76.3</td>
<td>81</td>
<td>82</td>
<td>78</td>
<td>MR</td>
</tr>
<tr>
<td>4</td>
<td>8</td>
<td></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>8</td>
<td></td>
<td>Patients will undertake 90 minutes of exercise each week</td>
<td>60%</td>
<td>New system being piloted for 2017/2018.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>8</td>
<td></td>
<td>Patients will have a healthier BMI (bi-annual audit)</td>
<td>25%</td>
<td>12.6</td>
<td>-</td>
<td>13.3</td>
<td>-</td>
<td>LT</td>
</tr>
<tr>
<td>7</td>
<td>5</td>
<td></td>
<td>Sickness absence (National HEAT standard is 4%)</td>
<td>5%</td>
<td>6.96</td>
<td>8.83</td>
<td>8.19</td>
<td>8.35</td>
<td>JW</td>
</tr>
<tr>
<td>8</td>
<td>5</td>
<td></td>
<td>Staff have an approved PDP</td>
<td>100%</td>
<td>82.5</td>
<td>84.9</td>
<td>84.3</td>
<td>73%</td>
<td>JW</td>
</tr>
<tr>
<td>9</td>
<td>1, 3</td>
<td></td>
<td>Patients transferred/discharged using CPA</td>
<td>100%</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>KB</td>
</tr>
<tr>
<td>10</td>
<td>1, 3</td>
<td></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>11</td>
<td>1, 3</td>
<td></td>
<td>Patients will commence psychological therapies &lt;18 weeks from referral date</td>
<td>100%</td>
<td>100</td>
<td>99</td>
<td>100</td>
<td>100</td>
<td>MS</td>
</tr>
<tr>
<td>12</td>
<td>1, 3</td>
<td></td>
<td>Patients will engage in meaningful activity on a daily basis</td>
<td>100%</td>
<td>New indicators to be agreed.</td>
<td></td>
<td></td>
<td></td>
<td>MR</td>
</tr>
<tr>
<td>13</td>
<td>2, 6, 7, 9</td>
<td>Hubs have a monthly community meeting</td>
<td>100%</td>
<td>New indicators to be agreed.</td>
<td></td>
<td></td>
<td></td>
<td>MR</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>2, 6, 7, 9</td>
<td>Patients have their clinical risk assessment reviewed annually.</td>
<td>100%</td>
<td>94</td>
<td>95</td>
<td>97</td>
<td>97</td>
<td>LT</td>
<td></td>
</tr>
<tr>
<td>15</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>

All Clinical Leads
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<tbody>
<tr>
<td>15</td>
<td>2, 6, 7, 9</td>
<td></td>
<td>RMO</td>
<td>90%</td>
<td>96%</td>
<td>100%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>Medical (LT)</td>
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<td>98%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Key Worker/Assoc Worker (MR)</td>
<td>80%</td>
<td>77%</td>
<td>63%</td>
<td>69%</td>
<td>77%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nursing (SM)</td>
<td>100%</td>
<td>96%</td>
<td>98%</td>
<td>100%</td>
<td>96%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>OT (MR)</td>
<td>80%</td>
<td>49%</td>
<td>55%</td>
<td>43%</td>
<td>48%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pharmacy (LT)</td>
<td>60%</td>
<td>70%</td>
<td>78%</td>
<td>77%</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clinical Psychologist (MS)</td>
<td>80%</td>
<td>59%</td>
<td>83%</td>
<td>75%</td>
<td>77%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Psychology (MS)</td>
<td>100%</td>
<td>89%</td>
<td>100%</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Security (DI)</td>
<td>60%</td>
<td>55%</td>
<td>85%</td>
<td>49%</td>
<td>55%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social Work</td>
<td>80%</td>
<td>76%</td>
<td>70%</td>
<td>65%</td>
<td>93%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Skye Activity Centre (MR) (only attend annual review)</td>
<td>tbc</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dietetics (MR) (only attend annual review)</td>
<td>tbc</td>
<td>4%</td>
<td>3%</td>
<td>13%</td>
<td>23%</td>
</tr>
</tbody>
</table>
## APPENDIX 2: KEY PERFORMANCE INDICATORS 2016-17 AND COMPARISON WITH 2015-16 AND 2014-15

<table>
<thead>
<tr>
<th>Item</th>
<th>Principles</th>
<th>Performance Indicator</th>
<th>Target</th>
<th>RAG</th>
<th>16/17</th>
<th>15/16</th>
<th>14/15</th>
<th>LEAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</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>91%</td>
<td>98%</td>
<td>92%</td>
<td>Figure to March each year includes annual and intermediates.</td>
</tr>
<tr>
<td>2</td>
<td>8</td>
<td>Patients will be engaged in psychological treatment</td>
<td>90%</td>
<td>G</td>
<td>96.4%</td>
<td>90.6%</td>
<td>90.8%</td>
<td>Figure to March each year.</td>
</tr>
<tr>
<td>3</td>
<td>8</td>
<td>Patients will be engaged in off-hub activity centres</td>
<td>90%</td>
<td>A</td>
<td>79.3%</td>
<td>81%</td>
<td>73%</td>
<td>Attendance averaged for the year.</td>
</tr>
<tr>
<td>4</td>
<td>8</td>
<td>Patients will be offered an annual physical health review.</td>
<td>90%</td>
<td>G</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>Figure for Apr 2016 - Mar 2017.</td>
</tr>
<tr>
<td>5</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>New system being piloted for 2017/2018.</td>
</tr>
<tr>
<td>6</td>
<td>8</td>
<td>Patients will have a healthier BMI</td>
<td>25%</td>
<td>R!</td>
<td>13.6%</td>
<td>15%</td>
<td>7%</td>
<td>Figure from Dec 2016. Biannual audit.</td>
</tr>
<tr>
<td>7</td>
<td>5</td>
<td>Sickness absence (National HEAT standard is 4%)</td>
<td><strong>5%</strong></td>
<td>RI</td>
<td>8.35%</td>
<td>8.03%</td>
<td>5.96%</td>
<td>Figure for April 2016-March 2017.</td>
</tr>
<tr>
<td>8</td>
<td>5</td>
<td>Staff have an approved PDP</td>
<td>*100%</td>
<td>R</td>
<td>73%</td>
<td>82.7%</td>
<td>86.8%</td>
<td>Figure to March 2017.</td>
</tr>
<tr>
<td>9</td>
<td>1, 3</td>
<td>Patients transferred/discharged using CPA</td>
<td>100%</td>
<td>G</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>Figures for April 2016 - March 2017.</td>
</tr>
<tr>
<td>10</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>Figures for April 2016 - March 2017.</td>
</tr>
<tr>
<td>11</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>100%</td>
<td>100%</td>
<td>&gt;99%</td>
<td>Figure to March 2017.</td>
</tr>
<tr>
<td>12</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>New indicators to be agreed.</td>
</tr>
<tr>
<td>13</td>
<td></td>
<td>Hubs have a monthly community meeting</td>
<td>100%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>New indicators to be agreed.</td>
</tr>
<tr>
<td>14</td>
<td>2, 6, 7, 9</td>
<td>Patients have their clinical risk assessment reviewed annually.</td>
<td>100%</td>
<td>A</td>
<td>97%</td>
<td>97.3%</td>
<td>94%</td>
<td>Figure to March 2017.</td>
</tr>
<tr>
<td>15</td>
<td>2, 6, 7, 9</td>
<td>Attendance by all clinical staff at case reviews</td>
<td>See above</td>
<td>-</td>
<td>59% overall</td>
<td>59% overall</td>
<td>60% overall</td>
<td>Figures for Apr 2016- Mar 2017 – includes annual and intermediates.</td>
</tr>
</tbody>
</table>
THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 29 June 2017
Agenda Reference: Item No: 19
Sponsoring Director: Chief Executive
Author(s): Chief Executive
Title of Report: Chief Executive’s Report
Purpose of Report: For Information

1 BACKGROUND

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

2 GENERAL ISSUES OF NOTE

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

Update on key events in May / June

- Research and Clinical Effectiveness Conference 2017 - 11 May
- Counter Fraud Services Visit on 17 May
- Relational Approaches To Care Event - 23 May
- National Board Workshop Event - 5 June
- Visit from Val De Souza Director of Health and Social Care South Lanarkshire on 9 June
- Visit from Aileen Campbell, Minister for Public Health and Sport on 12 June
- NHS Scotland Event 20 and 21 June

Key areas of work being progressed

- Phase 2 of EASY implemented on 1 June
- Patient Day test of change
- OBC development under way
- 5 Year Property and Asset Management Strategy updated
- Healthy Choices Policy Approved
- IT resilience further strengthened
- Risk Management Strategy developed
- QA/QI strategy development further progressed
- Directors’ Objectives agreed in line with strategic priorities

3 PATIENT SAFETY UPDATE

A brief summary of SPSP activity across the Hospital in the last two months includes:

Locally, steady progress is being made across all five of the agreed national workstreams.

Work is also ongoing around Improving Observation in Practice.
Work is being co-ordinated via a multi-disciplinary steering group which is meeting regularly. Data suggests that the programme having a positive impact on practice.

These are evidenced as follows:

- Psychotropic PRN medication documentation (‘8 rights’) spot check completed in May with median completion of 7.38 against the ‘8 rights’, with 3 hub administering less than 10 PRN medications during the week of the spot check.
- Initial Risk Assessment completion in less than 4 hours has clear improvement, with the last 60 admissions having all items of the 12 required information sets completed. All (45) bar 3 being completed within the 4 hour timescale.
- Post Physical Intervention debrief rolled out site wide, feedback sought from staff during December 2016. Analysis has been discussed at the Patient Safety Group with discussions now being taken forward to progress actions required. This is also being considered as part of a wider group discussion around supporting staff after serious incidents.
- Medicines reconciliation completion on admission since January 2015, 80 sets completed.
- Benchmark data and staff questionnaires distributed around Improving Observation in Practice workstream.

The next series of Leadership Walkrounds commenced 13 June 2017 with revised question set. Programme established until September.

4 HEALTHCARE ASSOCIATED INFECTION (HAI)

This is a summary of the Infection Control activity from 1 April – 30 May March 2017.

Audit Activity:

Hand Hygiene
During this review period, there was an overall increase in the number of hand hygiene audits submitted, with full compliance achieved in May.

April
9 out of a possible 12 were submitted
May
12 out of a possible 12 were submitted

Reminders and follow up were sent to the Senior Charges Nurses, and the Lead Nurses have also been asked to ensure that this is improvement continues.

The poor compliance with the hand hygiene among certain disciplines is being addressed on an individual basis.
Feedback from Skye Centre staff relating to the positioning and the type of product used was incorporated into an SBAR report and was presented to the Infection Control Committee in May. This will be discussed at the SMT in June. Feedback will be provided in due course.

The overall hand hygiene compliance within the hubs varies between 80-100%, with the health centre consistently attaining 100%.

Environmental Audits:

The data will be available for the next report as it is gathered quarterly.

Healthcare Waste Audits:

The data will be available for the next report as it is gathered quarterly.

Cleanliness Champions Program:

No further completions during this time period. The Scottish Infection Prevention and Control Education Program has replaced the Cleanliness Champion program and this will be formally launched 20 June 2017. The Infection Control Committee is currently reviewing the implementation approach for this framework, which sets out 3 levels of infection prevention and control training. Feedback will be provided in due course.

DATIX Incidents (Infection Control):

There were a total of six primary Infection control DATIX submitted during this review period

- 1 relating spitting
- 4 relating to diarrhoea & vomiting (unrelated)

In addition 9 secondary DATIX were submitted

- 8 minor self harm (x3 patients)
- 1 spitting

All DATIX incidents are reviewed by the Infection Control Committee quarterly.

Healthcare Environment Inspection (HEI):

Following the HEI inspection in February 2016, a short life working group undertook a full review of the Uniform and Dress Code Policy. The progression of this policy is sitting with the Human Resources Department.

Blood Borne Virus Screening

A review of the screening process was undertaken by the Advanced Practitioner for Infection Control with a proposal of incorporating testing into the admission process going. This was discussed at the Infection Control Committee and it was agreed that screening for Chlamydia and Gonorrhoea would also be added to the admission screening process. In addition it was agreed that BBV screening would also be taken at 6 months post admission and as part of the annual physical bloods thereafter. This new policy (Sexual Health and Blood Borne Virus Screening Policy) was consulted on and presented to the Clinical Forum who supported the proposed approach. This will be presented to the SMT in June, with feedback provided in due course.

5      PATIENT ADMISSION / DISCHARGES TO 12 JUNE 2017

A detailed report on admissions and discharges is provided to the Clinical Governance Committee on a six monthly basis. The following table outlines the high level position from 20 April 2017 – 12 June 2017.
<table>
<thead>
<tr>
<th></th>
<th>MMI</th>
<th>LD</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Complement</td>
<td>128</td>
<td>12</td>
<td>140</td>
</tr>
<tr>
<td>Staffed Beds (i.e. those actually available)</td>
<td>108</td>
<td>12</td>
<td>120</td>
</tr>
<tr>
<td>Bed Occupancy 12/06/17</td>
<td>100</td>
<td>9</td>
<td>109</td>
</tr>
<tr>
<td>Admissions</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Discharges / Transfers</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Average Bed Occupancy June 2017</td>
<td>-</td>
<td>-</td>
<td>110</td>
</tr>
</tbody>
</table>

91.5% of available beds
78.4% of all beds

6  CIR REVIEWS OUTWITH THREE MONTH COMPLETION DATE

There was one Review outwith the three month completion date as follows:

CIR 16/05  Medication Incident, Mull – report being written up. This was originally an SUI but was escalated to a CIR at SMT request. Due 3 May 2017.

7  RECOMMENDATION

The Board is invited to note the content of the Chief Executive’s report.