THE STATE HOSPITALS BOARD FOR SCOTLAND
BOARD MEETING

THURSDAY 22 AUGUST 2024
at 9.30am
Hybrid Meeting: in Boardroom and on MS Teams

A G E N D A

9.30am			
1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 20 June 2024	For Approval	TSH(M)24/05
4.	**Matters Arising:** **Rolling Actions List: Updates**	For Noting	Paper No. 24/60
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
7.	**Patient/Carer Story:** *'Reflections of a long term carer'* Led by the Director of Nursing and Operations	For Noting	Presentation
10am	**RISK AND RESILIENCE**		
8.	**Corporate Risk Register** Report by the Acting Director of Security, Estates & Resilience	For Decision	Paper No. 24/61
9.	**Finance Report – to 31 July 2024** Report by the Director of Finance & eHealth	For Noting	Paper No. 24/62
10.	**Bed Capacity Report:** **The State Hospital and Forensic Network** Report by the Medical Director	For Noting	Paper No. 24/63
10.20am	**CLINICAL GOVERNANCE**		
11.	**Implementation of Specified Persons Report** Report by the Acting Director of Security, Estates and Resilience	For Decision	Paper No. 24/64
12.	**Quality Strategy 2024-29** Report by the Medical Director	For Decision	Paper No. 24/65
13.	**Quality Assurance and Quality Improvement** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 24/66

14.	**Quality of Care Reviews (Leadership Walkrounds)** Report by the Director of Nursing and Operations	For Noting	Paper No. 24/67
15.	**Approved Medical Practitioner** Report by the Medical Director	For Decision	Paper No. 24/68
16.	**Clinical Governance Committee:** - **Approved Minutes 23 May 2024** - **Report of Meeting 8 August 2024**	For Noting	 CGC(M)24/02 Paper No. 24/69
11.10am	**BREAK**		
11.20am	**STAFF GOVERNANCE**		
17.	**Staff Governance Report** Report by the Director of Workforce	For Noting	Paper No. 24/70
18.	**Whistleblowing:** - **Quarter 1 Report** - **Update** Report(s) by the Director of Workforce	For Noting For Decision	Paper No. 24/71 Paper No. 24/72
19.	**Staff Governance Committee:** - **Approved Minutes 16 May 2024** - **Report of Meeting 15 August 2024**	For Noting	 SGC(M)24/01 Paper No. 24/73
11.40am	**CORPORATE GOVERNANCE**		
20.	**Complaints – Annual Report 2023/24** Report by the Head of Corporate Governance	For Decision	Paper No. 24/74
21.	**Schedule of Board and Committee Meetings 2025** Report by the Head of Corporate Governance	For Decision	Paper No. 24/75
22.	**Performance:** - **Quarter 1 Report** - **ADP 2024/55 – Scottish Government approval letter** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 24/76
23.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 24/77
24.	**Any Other Business**		Verbal
25.	**Date of next meeting:** 9.30am on 24 October 2024		Verbal
26.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
27.	**Close of Session**		Verbal

Estimated end at 12.10pm

THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 24/05**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 20 June 2024.

This meeting took place in the Boardroom at the State Hospital and also by way of MS Teams, and commenced at 12.30pm.

Chair:	Brian Moore
Present:	
Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	Cathy Fallon
Chief Executive	Gary Jenkins
Director of Nursing and Operations	Karen McCaffrey
Vice Chair	David McConnell
Director of Finance and eHealth	Robin McNaught
Non-Executive Director	Pam Radage
Non-Executive Director	Shalinay Raghavan
In attendance:	
Head of Communications	Caroline McCarron
Head of Planning, Performance and Quality	Monica Merson
Head of Corporate Governance/Board Secretary	Margaret Smith [Minutes]
Director of Security, Resilience and Estates	David Walker
Director of Workforce	Stephen Wallace

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone, and noted that apologies for the meeting from Professor Thomson, Medical Director and that Dr Duncan Alcock, Associate Medical Director was in attendance. He also noted that Mr David Hamilton, Mental Health Social Work Manager could not attend today's meeting.

2 CONFLICTS OF INTEREST

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

3 MINUTE OF THE PREVIOUS MEETING

The minute of the previous meeting held on 25 April 2024 was noted to be an accurate record of the meeting subject to minor amendment

The Board:

1. Approved the minute of the meeting held on 25 April 2024.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

There were no matters arising for discussion, from the previous meeting minute. The Board were content with the updates provided by the Rolling Action List (Paper No. 24/37), and that a number of items would be included in today's meeting. Ms Smith added that in relation to the patient running tracks, these were currently in use and available for patient use.

The Board:

1. Noted the updated action list, with the updates provided.

5 CHAIR'S REPORT

Mr Moore provided an update about his activities since the date of the last Board Meeting, starting with a very positive Board Development Session, which had taken place on 2 May 2024. This had been a good opportunity for the Board to come together in person and had covered a range of topics.

NHS Board Chairs had met on 20 May, and Mr McConnell had attended on behalf of the State Hospital (TSH). Mr McConnell confirmed that this session had included presentations on Improving Wellbeing & Workforce Cultures (IWWC), and on the Nursing & Midwifery Taskforce and support for nursing recruitment. Focus had also been on succession planning and support for aspiring Chief Executives, as well as the scope and portfolios of the groups being taken forward by the NHS Board Chairs, noting that Vice-Chairs may have an increased involvement. Board Chairs also met with the Cabinet Secretary for Health and Social Care, and discussion had been focused on NHS reform and improvement and recovery. Mr Gray advised that he had met with the Independent National Whistleblowing Office representatives , and noted his intention to meet with Board Whistleblowing Champions.

Mr Moore noted the letter from the Minister of Social Care, Mental Wellbeing and Sport to NHS Chairs and NHS Chief Executives, confirming the intention to re-constitute this Board, and form a National Forensic Mental Health Board. Following this Mr Moore had met with Ms Todd, and along with Mr Jenkins had taken part in discussion with Scottish Government civil servants on the Forensic Governance Advisory Group.

He also confirmed that he had attended the NHS Scotland Event on 10 June and emphasised the need to encourage and support submission of posters as a means of showcasing the good work that was taking place at TSH. Mr Moore also highlighted the forthcoming Scottish Health Awards and the possibility of submitting entries for the various categories.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins also highlighted the positive nature of the Board Development Session that took place on 2 May.

In relation to the cyber attack experienced by NHS Dumfries & Galloway, which had impacted staff at TSH, he confirmed that the Information Commissioner's Office (ICO) were content with the actions taken by TSH and that nothing further was required presently. The Board could take assurance that it had met its legal obligations, and an update would be provided as part of today's agenda.

Mr Jenkins advised that on 17 June CCTV had gone live in clinical areas within wards and the Skye Centre, as part of the final stages of this complex project.

Over the last two months, there had been site visits to the hospital from the Chief Executive of the Scottish Ambulance Service, the Tactical Command Team from Police Scotland, and the new Sheriff Principal for Lanark.

He asked the Board to note that the report from the Mental Welfare Commission (MWC) had been received following their unannounced visit in February. Further, an announced inspection by the MWC to Mull and Lewis took place on 13 June 2024 with positive feedback being received on the day. Mr Jenkins also advised that there had been a significant number of applicants in the latest round of nurse recruitment, which was very positive.

Mr Jenkins advised that NHS Board Chief Executives meeting in May had an emphasis on NHS Reform and singular approaches for Scotland-wide services, as well as the financial position including funding of all aspects of the Agenda for Change pay agreement, and a nine month evaluation of the National Planning and Delivery Board. Updates had been received on th**e** Infected Blood Inquiry, Covid-19 Inquiries, a Population Health approach to healthcare delivery, as well as early release interface work for the release of prisoners.

He confirmed that Scottish Government had not yet formally approved the Annual Delivery Plan, and therefore it could not yet be published. Finally, he referred to the work progressing in respect of the Forensic Governance Advisory Group, following on from the formal commissioning of a National Forensic Mental Health Board.

The Board:

1. Noted the update from the Chief Executive.

7 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 24/38) from the Director of Security, Resilience and Estates, which provided an overview of the Corporate Risk Register including movement on risk gradings. Mr Walker confirmed that all risks had been reviewed, and highlighted the three risks graded as high: MD 30 – Failure to prevent/mitigate obesity, ND70 – Failure to utilise resources to optimise excellent patient care and experience, FD 90 – Failure to implement a sustainable long-term model. Mr Walker asked the Board to note that there were five Significant Adverse Event Reviews underway, which represented an increase in workflow for the Risk Team, but that work would continue to review the risk management process, and the related risk registers.

Ms Fallon asked about the action plan related to Risk MD30, and how this would be reported. Mr Jenkins reflected that it would be helpful to review reporting around this and the link to the Supporting Healthy Choices framework, as well as patient physical health more widely in terms of the link through the Corporate Management Team, as well as the Board and its Committees.

Mr Moore noted the Board's agreement to the paper being an accurate statement of risk.

The Board:

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

8 RISK AND RESILIENCE ANNUAL REPORT 2023/24

The Board received a paper (Paper No. 24/39) from the Director of Security, Resilience and Estates, to present the Risk and Resilience Annual Report for the year 2023/24. Mr Walker presented the report noting that it had been reviewed by the Audit and Risk Committee earlier in the day.

He provided a high level summary of the content of the report, including the additional resources recruited into the team, and the wide range of workstreams progressed throughout the year. Of particular note was the continued progress in the risk registers, as well as review of resilience plans and the strengthening of partner agency working.

Mr Moore thanked Mr Walker and the team, noting the assurances around resilience planning. Ms Fallon echoed that, and complimented the comprehensiveness of reporting. She also commended the growing strength in multi-agency relationships evidenced in the report. Mr Walker clarified a further point made about national procurement of InPhase (Incident Management System) in that Datix would continue to be used until it was considered beneficial to move to the new system.

The Board:

1. Noted the content of the report.

9 CYBER SECURITY INCIDENT REPORT

The Board received a paper (Paper No. 24/40) from the Finance and eHealth Director, to provide an overview of the cyber risk position, in the context of two recent incidents.

In respect of the cyber-attack made on NHS Dumfries & Galloway in early 2024. Mr McNaught confirmed that this had impacted occupational health records for TSH staff given the Service Level Agreement in place. This was an ongoing criminal case, however, TSH had made appropriate contact with the Information Commissioners Office (UK) who had confirmed that they were satisfied with the actions taken by TSH. Mr McNaught also highlighted the provision of support to staff members who had been affected.

Mr McNaught also provided an update on a recent incident related to a laptop used by a contractor working on site at TSH as part of the Security Project. This was under investigation, but had not presented any specific risk to hospital systems, and prompt action had ensured that contractors would no longer be able to bring devices on site that could be of risk.

Mr Moore asked for clarification on the services available to TSH through NSS and the National Cyber Resilience Unit, and Mr McNaught confirmed that these were national resources available to all NHS Boards, and TSH used these services regularly.

The Board:

1. Noted the content of the report.

10 FINANCE REPORT TO 31 MAY 2024

The Board received a paper (Paper No. 24/41) from the Finance and eHealth Director, to provide the detailed financial position as at 31 May 2024.

Mr McNaught summarised the content of the paper, advising that it indicated the draft financial position, with a small adverse variance being reported, with a year-end break-even position anticipated. He confirmed that budget meetings were being held monthly with each directorate to address plans required to achieve and maintain breakeven. He also advised that at the most recent meeting held with Scottish Government, they had signalled that they were content with the current position and forecast for 2024/25. He also advised that with a number of known pressures, the capital demands for 24/25 were being prioritised against a much constrained year in terms of lack of availability of any additional funds.

Ms Fallon referred to the Nursing and AHPs budget, and the issue around potential loss of earnings impacting recruitment to the outboarding patient team. Ms McCaffrey noted that as this would be

seconded posts rather than redeployment, pay protection would not be relevant. However, one post had since been recruited to nonetheless.

Mr Jenkins underlined the position on the Agenda for Change pay deal for 2023/24, with the three elements outlined in the report. These were unfunded awaiting a response from Scottish Government in this regard, and for TSH this represented £76k in the month 2 position. He noted that Scottish Government had previously committed to the provision of funding for NHS Boards. Mr Moore also noted that a Staff Bulletin had been issued, in respect of the AfC Band 5 nurse review, which described the process for submitting an application.

The Board:

1. Noted the content of the report.

11 BED CAPACITY REPORT

The Board received a paper (Paper No. 24/42) from the Medical Director, which detailed the position for bed capacity within TSH for the period ending 31 May 2024, in the context of the wider Forensic Network.

Dr Alcock provided a summary overview of the key points of the paper, including admissions and transfers to the hospital, as well as internal transfers across services. There continued to be 14 patients within the Intellectual Disability (ID) Service, which was an over occupation but this was not an area of pressure given the excess surge beds. He confirmed that TSH continued to be closed to exceptional circumstances patients, and added that the repair works in the Orchard Clinic within NHS Lothian had commenced.

Mr Moore thanked Dr Alcock, and noted the flow in the system, and that it was important for the Board to have oversight of capacity within TSH as well as awareness of the position across the forensic estate overall.

The Board:

1. Noted the content of report.

12 CLINICAL GOVERNANCE COMMITTEE ANNUAL REPORT 2023/24

The Board received the Clinical Governance Committee Annual Report 2023/24 (Paper No. 24/43) to provide the Board with an update on the wide range of activity overseen by the Committee.

Mr Moore confirmed that the annual reports from each Committee had been reviewed by the Audit and Risk Committee, who had agreed that these provided clear evidence of the scrutiny and improvement work undertaken. There had also been discussion on the consistency of approach in the format and content of reports, and this would continue to benefit from further streamlining.

As Chair of the Committee, Ms Fallon commented on this having been a full year, with a wide range of annual reporting representing the breadth and depth of specialist care services within the hospital. There had been a particular focus on physical health of patients, as well as on their mental wellbeing. Mr Jenkins noted the comprehensive nature and volume of the work of the Committee. There was agreement around the table that reporting demonstrated that the Committee had fulfilled its remit throughout this year.

The Board:

1. Noted that the Audit and Risk Committee had recommended that this report be presented to the Board for approval.

2. Approved the Clinical Governance Committee Annual Report 2023/24.

13 SECTION 22: APPROVED MEDICAL PRACTITIONER

The Board received a paper (Paper No. 24/44) from the Medical Director, to consider approval of Approved Medical Practitioner (AMP) status for a Specialty Doctor. Dr Alcock outlined the background for the Board, in the context of the Mental Health (Care and Treatment) Scotland Act 2003. The Board then provided formal approval for Dr James Morphett on this basis.

The Board:

1. Approved Dr James Morphett as AMP, and agreed that he should be added on TSH list of AMPs.

14 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 24/45) to report on progress made in quality assurance and improvement activities, since the date of the last meeting.

Ms Merson provided an overview of the report, and highlighted the key aspects. This included details of the clinical audit work undertaken, as well as the most recent flash report in respect of hospital wide variance analysis. She also outlined the work progressed by the Quality Forum, including training opportunities in this area. In terms of Realistic Medicine, Ms Merson advised that the Learning into Practice workstream had been re-launched alongside Team Based Quality Reviews. She also noted the embedding of BRAN (Benefits , Risks, Alternatives, Nothing) as part of the Nutrition and Physical Health Pathway Project. On evidence for Quality, she provided the updated position and how the outstanding matter would be brought to conclusion.

Ms Fallon noted the comprehensive nature of the report, and welcomed the progress being made with workstreams detailed on the evaluations matrix. She asked if the outcome of the review process in relation to SIGN in relation to dementia would come back to the Board as part of reporting, and also as part of the clinical governance reporting. It was agreed that the Clinical Governance Committee would take detailed oversight in terms of this, and an update would come back to the Board as part of this report.

Action – Ms Merson

Ms McCaffrey noted the good project work undertaken by the Skye Centre Secretary, and demonstrated by the poster as Appendix 1 – RiO Timetable Recording. Ms Merson emphasised the good stories that TSH had to tell, and that it would be beneficial to share these more widely at national forums.

Mr Moore commented positively on the increased patient attendance at CPAs with 100% attendance; as well as by security staff which had also improved to 100% rate. He referred to the number of clinical audits conducted yearly, at 25 approximately, and asked if there was a means through which the information from these could be amalgamated to help demonstrate any patterns or trends in areas of the hospital, where performance may not have been to the required standard. Ms Merson advised that this was data that the Clinical Quality team routinely interrogated and escalated concerns to the departments involved, and to the senior leadership team. It was agreed that this should be reviewed to show longitudinal trends, and how assurance could be provided in this regard.

Action – Ms Merson

Mr Moore thanked Ms Merson and the Clinical Quality team for their ongoing work in this area.

The Board:

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

15 CLINICAL GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting that took place on 8 February 2024; as well as a summary report (Paper No 24/46) of the key areas of reporting and discussion at the meeting which had taken place on 23 May 2024.

As Chair of the Committee, Ms Fallon highlighted some key areas of reporting at the last meeting in May including the positive nature of the Patients Learning Annual Report, and the positive impact of the Supplementary Staffing Register. She noted that the Daytime Confinement Short Life Working Group was in the process of moving to business as usual governance structures and reporting. She also advised that areas of good practice had been noted in the direct link made between training on the complaints procedure to NHS Values and Behaviours within the Corporate Induction programme.

The Board:

1. Noted the content of the approved minutes CGC(M) 24/01.
2. Noted the update in relation to the meeting held on 23 May 2024.

16 STAFF GOVERNANCE COMMITTEE ANNUAL REPORT 2023/24

The Board received the Staff Governance Committee Annual Report 2023/24 (Paper No. 22/47) which outlined the key developments overseen by the Committee, to demonstrate that the Committee had met its remit and terms of reference. As Chair of the Committee, Ms Radage asked the Board to note the range and scope of activity, and that this report had also been reviewed by the Audit and Risk Committee.

The Board:

1. Noted that the Audit and Risk Committee had recommended that this report be presented to the Board for approval.
2. Approved the Staff Governance Committee Annual Report 2023/24

17 REMUNERATION COMMITTEE ANNUAL REPORT 2023/24

The Board received the Remuneration Committee Annual Report 2023/24 (Paper No. 22/48) which outlined the work overseen by the Committee focused on oversight of Executive and Senior Manager performance and appraisals as well as consultant discretionary points. As Chair of the Committee, Mr McConnell confirmed that this had been reviewed at the Audit and Risk Committee, and provided a sufficient level of assurance for the Board.

The Board:

1. Noted that the Audit and Risk Committee had recommended that this report be presented to the Board for approval.
2. Approved the Remuneration Committee Annual Report 2023/24.

18 WORKFORCE PLAN – ANNUAL REVIEW

The Board received a report from the Director of Workforce (Paper No. 23/49) which provided an

update on the National Workforce Planning expectations for The State Hospital, and progress on the TSH Workforce Plan 2022-2025.

Mr Wallace highlighted the key points, focused on the five pillars of workforce planning and the link to the Annual Delivery Plan 2024/25. This included the strengthening of recruitment including modern apprenticeships, leadership development within the workforce as well as the importance of training. He underlined the variety of activity being taken forward within the wellbeing workstream, as well as improvements made both in attendance management and in compliance on PDPR.

Ms Fallon said that there was a lot to commend over a number of areas; particularly capturing information in exit interviews and also embedding the peer support network. She asked about the evaluation of the Staff and Volunteer Wellbeing Strategy, and the Board noted that this would be through the Staff Governance Committee. Mr Jenkins added that significant work was being taken forward through the Organisational Development lead in terms of the overall strategy, and that a product in this regard would also be brought back to the Board.

Mr Moore asked about the issue of gender balance across the nursing cohort, and it was noted that the Acting Director of Security, Resilience and Estates had been leading a short life working group in this respect, and that an update would be provided at the next Board meeting.

Action – Mr Hardy

Mr Moore thanked Mr Wallace for the report and noted the importance of continued oversight in this regard.

The Board:

1. Noted the content of the report.

19 STAFF GOVERNANCE REPORT

The Board received a report from the Director of Workforce (Paper No. 24/50) summarising workforce performance through a range of metrics. Mr Wallace led the Board through the detail of the report highlighted some key points including sickness absence rates, saying that although nursing sickness absence had increased by a small amount in this period, TSH was performing well in this area if compared more widely across forensic services. He emphasised the importance of shifting focus more positively towards maximising attendance, looking at the support processes in place, and how to improve the quality of interactions at each stage. This should be in a supported, person-centred way.

He was pleased to note the continued positive performance in recruitment and retention of staff. TSH had held an in person event for nursing at the hospital in the Wellbeing Centre, which had drawn a great turnout and resulted in job applications. Given this, HR would take on board the possibility of rolling this out to other services.

Mr Wallace added that work would also be taken forward in relation to PDPR, to help improve the quality of these in conjunction with compliance rates.

Ms Fallon commented positively on the increase in application following the nursing in person event, and also on work placements being a good initiative especially if linked to the TSH Anchors Strategy. Ms McCaffrey advised 32 attended the in person event, and 12 attendees then applied for a nursing role. Ms Radage noted that it was helpful to place nursing sickness rates within the context of other secure hospitals.

Mr Moore summed up for the Board and thanked Mr Wallace for the report.

The Board:

1. Noted the content of the report.

20 WHISTLEBLOWING ANNUAL REPORT 2023/24

The Board received a paper to provide a draft of the Annual Report for 2023/24 (Paper No. 24/27). Mr Wallace noted firstly that there had been no new cases received throughout the course of the year. He advised that he and Ms Raghavan had been mindful of guidance from the Independent National Whistleblowing Officer, that reporting should be based on lessons learned from cases. As there hadn't been any recent cases, the report was based on the activity within TSH to promote the Whistleblowing Standards, particularly around "Speak Up" week. The intention was to re-fresh and re-launch the approach in the run up to this event again this year.

Ms Raghavan thanked Mr Wallace and his team for all of their work, and that it was useful to see the work being undertaken, especially consideration of how best to deliver the confidential contact role within small NHS Boards like TSH. She also noted the challenges in identifying individuals with the right skill sets to conduct investigations, as well as the resource required to do so. Mr Jenkins agreed with this point, and thought that it would be helpful to see progress through the re-fresh being taken forward, with the product being brought back to the Board.

The Board:

1. Noted the update provided, and the review being taken forward.
2. Approved the Annual Report 2023/24,

21 STAFF GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting that took place on 16 February 2024; as well as a summary report (Paper No 24/52) of the key areas of reporting and discussion at the meeting which had taken place on 16 May 2024.

The Board:

1. Noted the content of the approved minutes SGC(M) 24/01.
2. Noted the update in relation to the meeting held on 16 May 2024.

22 AUDIT AND RISK COMMITTEE ANNUAL REPORT 2023/24

The Board received the Audit and Risk Committee Annual Report 2023/24 (Paper No. 22/53) which outlined the work overseen by the Committee during this period.

As Chair of the Committee, Mr McConnell confirmed that the Committee had approved this report as demonstrating that it had fulfilled its remit throughout the year.

Ms Fallon noted the reporting of patient funds, and asked for clarification on how any interest accrued was managed. Mr McNaught provided assurance that any such monies were credited to individual patient accounts proportionately.

The Board:

1. Approved the Audit and Risk Committee Annual Report 2022/23.

23 REPORT ON THE ANNUAL ACCOUNTS 2023/24

The Board received a paper from the Chair of the Audit and Risk Committee (Paper No. 22/54) which detailed the Annual Accounts for the year-end as of 31 March 2024. This paper outlined the 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 (SGHSCD) by 30 June 2024.

Mr McNaught confirmed that the annual accounts had an unqualified audit opinion from the external auditors, KPMG. He led the Board through the details of the content including the Governance Statement and the Statement of Health Board Members' Responsibilities. He also noted the responsibility of the Audit and Risk Committee to report to the Board on the adoption of the accounts, and to give authority as required to the Chief Executive Officer and the Finance and eHealth Director to sign the accounts.

Mr McConnell confirmed that the Audit and Risk Committee had considered the Annual Accounts and the associated recommendations in detail at its meeting earlier this morning. He then confirmed that it was the decision of the Audit and Risk Committee to recommend to the Board that it should adopt the Annual Accounts as attached to this paper and submit them to the SGHSCD by the due date.

On this basis, Mr Moore summarised that the Board was content to adopt the Annual Accounts for the year ended 31 March 2024, and approved the submission to the SGHSCD. He offered thanks Mr McNaught and to the finance team for this work, which represented a very positive position for the Board.

The Board:

1. Adopted the Annual Accounts for the year ended 31 March 2023 and approved submission to the Scottish Government Health and Social Care Directorate.

2. Authorised:

    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 e-Health Director to sign the Statement of Financial Position

24 PATIENT FUNDS ACCOUNTS

The Board received a paper (Paper No. 23/55) from the Finance and eHealth Director, who provided an overview of the report.

Mr McNaught advised that these funds were the balances of money held by TSH on behalf of patients. Due to the nature of these, an annual independent audit has been obtained which had provided an unqualified opinion from Wylie & Bisset. The accounts for March 2024 were a summary of the collective patients' income and spending as managed through the TSH patient account - a simple statement of income and expenditure

He confirmed that the Audit and Risk Committee had reviewed the accounts at its meeting this morning and recommended to the Board that the Chief Executive Officer, and the Finance and eHealth Director, be given approval to sign the summary income and expenditure statement.

The Board:

1. Approved the signing of the summary patient funds accounts by the Chief Executive and Finance and eHealth Director.

25 PERFORMANCE ANNUAL REPORT 2023/24

The Board received a paper (Paper No. 23/56) from the Head of Planning, Performance and Quality to provide a high-level summary of organisational performance for the year to 31 March 2024, as well as providing comparative data to previous reporting years. This was in the context of the national standards that apply to TSH, as well as local targets.

Ms Merson highlighted the key points, noting this context as well as monitoring by Scottish Government through the Annual Delivery Plan and related framework. She highlighted the areas in which target performance rates had not been reached, with the indicative Red/Amber/Green ratings (RAG). This included patients having their care and treatment plans reviewed at six month intervals, and Ms Merson outlined the improvement work carried out in this regard. The target of 150 minutes of patient activity weekly was a stretch target, given the focus on improving patients' physical health and this was currently at an amber rating. Related to this was the target for improving patient BMI, and work was ongoing to review this in the wider context of physical health overall. She also noted that there had been some improvement in attendance at case reviews, albeit attendance by key workers and security liaison remained in the red zone. There would be continued effort to make improvement in this regard.

Ms Merson noted that sickness absence rates had not met the target of 5%, and the Board had received an update today from the Director of Workforce about the ongoing focus in this regard.

Mr Moore thanked Ms Merson and her team for the comprehensive nature of reporting.

The Board:

1. Noted the content of the report.

26 DIGITAL INCLUSION STRATEGY

The Board received a paper (Paper No. 23/57) from the Finance and eHealth Director, to provide an update on digital strategy progress, noting the fact that patients have limited access to digital technology and opportunities.

Mr McNaught outlined the extensive exercise undertaken in 2023, engaging with a broad range of stakeholders to provide a detailed "Options Appraisal" for Digital Inclusion which was approved for being taken forward as a blueprint for implementation. However, since this stage, the financial position worsened nationally with a resultant impact on nationwide capital funding. NHs Boards had been notified that all capital project funding intended for 2024/25 was on hold, with the exception only of a small number of specified national areas of work. Mr McNaught confirmed that this remained the case with no new business cases to be presented. Accordingly, the TSH programme had been required to pause, as it could not be taken forward in full without application for funding for both capital and revenue support. He also advised the there would be continued awareness in respect of any potential new funding routes, should these arise, and for which this project may be eligible. In the meantime, every effort would be made to address any elements of the strategy which may be affordable within existing funding and resources.

The Board:

1. Noted the content of the report.

27 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report from the Director of Security, Resilience and Estates (Paper No. 24/58) to confirm the updated position. Mr Walker noted that completion was scheduled for August 2024, with Revision 58 accepted and Revision 59 currently under development.

The Board were content to note this update.

The Board:

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

28 AUDIT AND RISK COMMITTEE

The Board received the approved minute of the meeting, which had taken place on 21 March 2024; as these had been approved at the Committee meeting which took place earlier in the day.

The Board:

1. Noted the content of the approved minutes ARC(M) 24/02.

29 ANY OTHER BUSINESS

Mr Moore noted that this would be the final formal meeting of the Board for Mr Walker, who would be retiring at the end of the month. He thanked him for his six years of service, especially within risk and resilience. Mr Jenkins paid tribute to Mr Walker's work within the organisation, and his effectiveness in particular in team building and developing services within his remit. He noted the huge contribution throughout the Covid-19 pandemic in his role as Silver Commander. Mr Jenkins underlined the strengthening of relationships with resilience partners, which continued to be of great benefit. Mr Walker thanked colleagues, and noted that way that teams had worked together well during the pressures of the pandemic, to focus on delivering safe care.

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

30 DATE AND TIME OF NEXT MEETING

The next public meeting would take place at 9.30am on Thursday 22 August 2024.

31 PROPOSAL TO MOVE TO PRIVATE SESSION

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

32 CLOSE OF MEETING

The meeting ended at 2.40pm

ADOPTED BY THE BOARD _____

CHAIR _____

DATE _____

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	February 24	Quality assurance and quality improvement Report	Further focus on closing outstanding actions as reported in the evaluation matrix and provide update at next Board meeting	M Merson	November 2024	**April 2024:** Update in report on agenda There has been some progress with closing some of the outstanding actions within the evaluation matrix GAP analysis meeting is being arranged for mid May to discuss the SIGN Stroke guideline with a view to submitting to the Physical Health Steering Group in July/August 2024. **June 2024:** Due to the size and complexity of the SIGN Stroke Guidance as series of GAP, analysis meetings are required. These are in progress with a view to submitting to the PHSG in August 2024. The IOP and Seclusion Gap analysis have been reviewed and are currently with clinical colleagues for consideration. **August Update:** -The IOP and Seclusion Gap were reviewed by Patient Safety Group and signed off, no outstanding actions from seclusion and one from IOP which will be fed through Carers Strategy. -Sign Stroke Guidance to be reviewed this month. -Dementia Gap Analysis was completed at MHPSG, with no actions required. **Board to consider closing this action – further reporting through the Clinical Governance Committee.**

2	February 24	Performance Report Quarter 3	Revise reporting to reflect a longer period	M Merson	June 2024	**April 2024:** Data within this report is being redesigned and wherever possible trend analysis will be incorporated in next report. **June 2024: on agenda** Trend analysis where possible is included in reporting for the annual report **CLOSED**
3	April 24	CEO Update	Update on Cyber Security Incident to be brought to next Board meeting	R McNaught	June 2024	**June 2024:** on meeting agenda Report received to give update on position to Board, confirming no further action required for ICO UK. **CLOSED**
4	April 24	Patient Story	Update on progress on maintenance and use of running track / wander paths within grounds	D Walker	June 2024	**June 2024:** Annual ground maintenance is being taken forward as part of existing budget (including remedial works). Overall upgrade is funding is not available in current capital allocation, and would require funding application to Scottish Government should the opportunity to do so arise. Also confirmed access to track for patients. **CLOSED**
5	April 24	Whistleblowing	Revise annual report engaging with PF and CMT, include advice on sub-contractors and prepare for change in how managed. Revision of approach to be developed.	S Wallace	August 2024	**June 2024 Update:** Report on agenda Reviewed as part of Board Development Session on 2 May, to highlight development routes which are now underway. Noted, and to return to the Board for finalised approach. **August Update: Update on agenda**

6	April 24	A.O.B	Reporting template review around the monitoring report, and how to re-frame report template	M Smith	October 2024	**August Update:** Review underway and suggested approach shared through Non Exec Directors and CMT for feedback, and will return to the Board.
7	June 24	Quality assurance and quality improvement Report	Request to review body of clinical audits per year to review how performance within areas/departments and also for trends and patterns	M Merson	November 24	**August Update:** Clinical Quality conducting review, and report to be fed through Clinical Governance Committee November 2024. Highlight update will then return to Board.
8	June 24	Workforce Plan – Annual Review	Update requested on gender balance workstream	A Hardy	October 24	**August Update:** Work progressing with Joint Staff Side, meeting to discuss as risk focused approach within clinical setting, and then refreshed approach shared, Reporting to the CMT in September 2024 to agree way forward, and then update will return to the Board.

Last updated – 15.08.24 M Smith

Paper No. 24/61

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	August 2024
Agenda Reference:	Item No: 8
Sponsoring Director:	Acting Director of Security, Estates and Resilience
Author(s):	Risk Manager
Title of Report:	Corporate Risk Register
Purpose of Report:	For Decision

1 SITUATION

A corporate risk is a potential or actual event that:

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

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

2 BACKGROUND

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

3 ASSESSMENT

3.1 Current Corporate Risk Register - See appendix 1.

3.2 Out of Date Risks

All risks are in date.

3.3 Update on Proposed Risks for inclusion on Corporate Risk Register

N/A

3.4 Corporate Risk Register Updates

No changes since last meeting.

3.5 High and Very High Risk – Monthly Update

The State Hospital currently has **3** 'High' graded risks:

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

Monthly Update:

July figures represent 86.3% being overweight or obese (102pts in total) and 2.9% refusals.

- There is some availability of GLP-1 agonists for use in weight management and this has commenced within the hospital on a named patient basis.
- Regarding physical activity, Skye Centre inductions will be offered the first week of admission and all new admissions will be offered a minimum of 2 placements per week.
- Skye Centre Activity staff provide beneficial support as part of their remit, to support patient's activities and walks.
- Hub areas open now offering more activity to patients off ward, support from Occupational Therapists and clinical staff allow this to take place when staffing resource permits.
- The Health psychologist is supporting a key role in the developments of the SHC remit, with current regard to the guidance document and action plan being jointly developed. They are also supporting groups and Individuals who are hard to reach and with complex physical health needs.

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

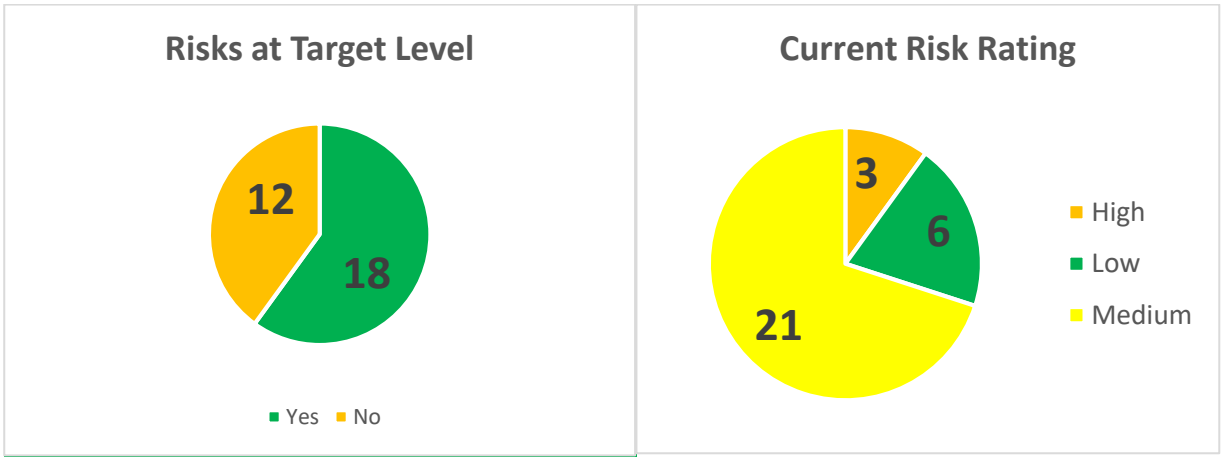
Monthly Update:

- E-Rostering continues to be implemented across hospital, Project Manager has been appointed to bring project to close.
- A proactive recruitment plan has successfully reduced the staffing deficit and adverts are currently live to recruit to the remaining 5.2wte posts.
- Proactive work surrounding absence management has also seen a reduction and return of staff to work. This continued work has had a positive impact on staffing.
- Risk register and risk assessment also completed. Numbers of incidents are reducing overall after a small spike over the festive period, full closure incidents have decreased significantly.
- The risk will be fully refreshed taking into account new data sources including activity levels and RAG Status to ensure an accurate picture of the hospitals situation is available at each review.

Finance Director: FD90: Failure to implement a sustainable long-term model

- Risk FD90 was revised to reflect the national financial pressures as highlighted by SG communications in January and February 2024 – as issued to Chairs, Chief Executives and Directors of Finance – specifically focusing on expected funding shortfalls and significant budget restrictions for 2024/2025.

3.6 Risk Distribution



Currently 18 Corporate Risks have achieved their target grading, with 12 currently not at target level.

MD32 – Absconsion of Patients – Now meets the target level. Upon review it is clear that the current control measures in place are adequate due to the lack of incidents**.**

The below incidents are have made progress towards reducing to target level and will be reviewed at next review period:

CE12 – Failure to Learn from Adverse Events – Cat 1 and 2 Reports will now be presented to CMT to ensure learning is appropriate. Cat 1 and 2 Action Tracker has been stood up to ensure progress on outstanding actions. Action tracker paper now goes to each relevant group for discussion. All reports to committees will be amended to ensure a consistent format in the presentation of risk.

SD52 – Resilience Arrangements not fit for purpose – Almost all of resilience arrangements are now in date providing assurance to The Board. Resilience Officer position has been filled and TSH and will allow for further training and testing to take place within TSH.

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

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

Review Periods:

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

3.7 CRR Development

Progress has been slower than expected as the Risk and Resilience team are working on 5 outstanding Category 1 and 2 Reviews, alongside a change in the teams management structure. The team are looking to optimise their workloads to ensure progress is made on the below development. The majority risks are due for review in August 2024.This will allow time to move forward with the risk refresh project.

The Risk management team are continuing to review and refresh the risk management process and a proposal on a new approach as discussed at The Board Development Session. This was presented to CMT in early January paving the way for a review to take place of the current Corporate Risk Register and ensure the risks are aligned to the Strategic Objectives. Work is ongoing within the Risk and Resilience team.

Current Progress:

- Nursing Directorate review is 66% complete with ND71 and ND73 having been fully reviewed and positive feedback received about new format. ND70 currently being reviewed and will be shared with relevant groups when complete. The risk will be fully refreshed taking into account new data sources including activity levels and RAG Status to ensure an accurate picture of the hospitals situation is available at each review. Estimated completion date at the end of August 2024.
- Exploration of Datix Incident Management System underway in preparation for transfer of Corporate Risk Records. The Risk Manager has made the required changes to the system and a small set of risks have been uploaded to the system for testing which is ongoing. Work has been slower than expected but with the majority of reviews concluding in August 2024 more time will be able to be allocated to this project.
- Security Directorate CRR review has started and meetings will be arranged with Director to approve and finalise any suggested changes. Estimated completion at the end of August 24.

4 RECOMMENDATION

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

MONITORING FORM

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

Paper No. 24/61

High Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	Aug 24	Clinical Governance Committee	Monthly	-
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Major x Likely	Moderate x Likely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	Sept 24	Clinical Governance Committee	Monthly	-
Corporate FD 90	Financial	Failure to implement a sustainable long term model	Major x Almost Certain	Major x Possible	Moderate x Rare	Finance & Performance Director	Finance & Performance Director	Sept 24	Finance and Performance Group	Monthly	-

Medium Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	Sep 24	Corporate Governance Group	Quarterly	-
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Head of Risk and Resilience	Sept 24	Clinical Governance Committee	Quarterly	-
Corporate CE 12	Strategic	Failure to utilise appropriate systems to learn from prior events internally and externally	Major x Possible	Moderate x Possible	Negligible x Unlikely	Chief Executive	Head of Risk and Resilience	Sept 24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate CE15	Reputation	Impact of Covid-19 Inquiry	Extreme x Likely	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	Sept 24	Covid Inquiry SLWG	Quarterly	-
Corporate MD 32	Medical	Absconsion of Patients	Major x Unlikely	Major x Rare	Major x Rare	Medical Director	Associate Medical Director	Nov 24	Clinical Governance Committee	Quarterly	-

Corporate MD 33	Medical	Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)	Moderate x Likely	Moderate x Unlikely	Moderate x Unlikely	Medical Director	Associate Medical Director	Nov 24	Clinical Governance Committee	Quarterly	-
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Likely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	Nov 24	Clinical Governance Committee	Quarterly	-
Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Major x Rare	Major x Rare	Security Director	Security Director	Sep 24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	Sep 24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Unlikely	Moderate x Rare	Security Director	Security Director	Sep 24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 53	Service/Business Disruption	Serious security breaches (eg escape, intruder, serious contraband)	Extreme x Unlikely	Extreme x Rare	Extreme x Rare	Security Director	Security Director	Sep 24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 54	Service/Business Disruption	Implementing Sustainable Development in Response to the Global Climate Emergency	Major x Likely	Major x Unlikely	Moderate x Rare	Security Director	Head of Estates and Facilities	Sep 24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	Sep 24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate ND 71	Health & Safety	Serious Injury or Death as a Result of Violence and Aggression	Extreme x Almost Certain	Moderate x Possible	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	Nov-24	Clinical Governance Committee	Quarterly	-
Corporate FD 91	Service/Business Disruption	IT system failure	Moderate x Likely	Moderate x Unlikely	Moderate x Unlikely	Finance & Performance Director	Head of eHealth	Nov-24	Finance and Performance Group	Quarterly	-
Corporate FD 96	Service/Business Disruption	Cyber Security	Moderate x Likely	Moderate x Unlikely	Moderate x Unlikely	Finance and Performance Director	Head of eHealth	Nov-24	Information Governance Committee	Quarterly	-
Corporate FD 98	Reputation	Failure to comply with Data Protection Arrangements	Moderate x Likely	Moderate x Unlikely	Moderate x Unlikely	Finance and Performance Director	Head of eHealth/ Info Gov Officer	Nov-24	Information Governance Committee	Quarterly	-

Corporate FD 99	Reputation	Compliance with NIS Audit	Major x Likely	Moderate x Possible	Moderate x Rare	Finance and Performance Director	Head of eHealth	Nov-24	Information Governance Committee	Quarterly	-
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Unlikely	Minor x Rare	HR Director	HR Director	Sept-24	HR and Wellbeing Group	Quarterly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x unlikely	Major x unlikely	HR Director	HR Director	Sept-24	HR and Wellbeing Group	Quarterly	-
Corporate HRD 113	Service/Business Interruption	Job Evaluation and impact on services in TSH	Major x Possible	Moderate x Possible	Negligible x Unlikely	HR Director	HR Director	Sept-24	HR and Wellbeing Group	Quarterly	-

Low Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate CE 13	Strategic	Inadequate compliance with Chief Executive Letters and other statutory requirements	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Chief Executive	Board Secretary	Feb-25	Corporate Governance Group	6 monthly	-
Corporate CE 14	ALL	The risk that Coronavirus (Covid-19) could affect The State Hospitals primary aim to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff.	Major x Almost Certain	Minor x Rare	Minor x Rare	Chief Executive	Senior Nurse for Infection Control/ Risk Manager	Dec-24	Corporate Governance Group	6 Monthly	-
Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Rare	Moderate x Rare	Director of Nursing & AHP	Director of Nursing & AHP	Sep-24	Clinical Governance Committee	Quarterly	-
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	Feb-25	Security, Risk and Resilience Oversight Group	6 monthly	-
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	Feb-25	Information Governance Committee	6 Monthly	-

Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Possible	Moderate x Rare	Moderate x Rare	HR Director	Training & Professional Development Manager	Dec-24	Clinical Governance Group	6 Monthly	-

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THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Report:	22 August 2024
Agenda Reference:	Item No: 9
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 31 July 2024
Purpose of Report:	For Noting

1 SITUATION

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

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

2 BACKGROUND

The approved annual operating plan for 2024/25 has been submitted to SG and signed off, with regular meetings anticipated between TSH and SG to monitor progress against targets.

With regard to the capital spend programme, the Perimeter Project is noted to have a delayed end date of October 2024, as reported directly to the Board and notifed to SG finance.

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £45.981m is primarily the Scottish Government Revenue Resource Limit core and non-core allocations, and additional allocations as anticipated (increased capital charges for phase 1 Perimeter project, and MCN). We have not anticipated the ½-hour reduction pressure yet but will note it in table below.

The July accounts show an over spend to date of £0.115m, which is mainly in connection with Ward Nursing pressures, partly offset by a number of staffing vacancies.

PAIAW ("Payment as if at work") funding continues to be held as a reserve for the current year, and will be released monthly to match actual cost. Some pressure also remains re prior years' PAIAW still outstanding – with claimants now being in the hand of CLO (some of whom have now been paid.) This has been accrued, however – while not currently expected – until the process is completed there remains a risk if the final payments exceed the accrual.

3.2 2024/25 Budget

The 2024/25 budget template required by SG has been submitted, including revised savings requirements of £1.3m / approx.3%, with forecast outturn breakeven.

Individual directorate budget reviews established detailed plans for the achievement of a satisfactory level of savings being identified as recurring for the start of the year, to be reported in future budget submissions. These were ratified at the Board meeting in April – highlighting planned savings in 2024/25.

The Capital budget for 2024/25 remains at a recurring level of £269k, with the potential for any additional project funding to be reviewed should any opportunities arise, although this is currently thought unlikely due to overall national pressures. Details are noted in section 5 below.

3.3 Year-to-date position 2024/25 – allocated by Board Function / Directorate

Expenditure Type	Annual Budget £'s	Year to Date Budget £'s	Year to date Actuals £'s	YTD Variance (budget less actuals) for period 4	Budget WTE	Actual WTE (volume)
Pay	39,407,121.24	12,785,176.17	13,069,643.48	(284,467.31)	628.90	636.70
Non Pay	5,051,664.77	1,595,466.89	1,623,848.15	(28,381.26)	0.00	0.00
Purchase Of Healthcare	813,855.00	271,285.00	271,534.20	(249.20)	0.00	0.00
Hch Income	(645,233.66)	(167,896.42)	(205,384.35)	37,487.93	(3.00)	(3.05)
Other Operating Income	(796,181.24)	(224,896.97)	(365,063.17)	140,166.20	0.00	0.00
Savings	(962,072.00)	22,483.56	0.00	22,483.56	0.00	0.00
Capital Charges	3,112,129.13	1,037,376.37	1,037,376.33	0.04	0.00	0.00
Right Of Use Assets	0.00	0.00	2,167.14	(2,167.14)	0.00	0.00
Position in Ledger	**45,981,283.24**	**15,318,994.60**	**15,434,121.78**	**(115,127.18)**	**625.90**	**633.65**

Against the £(115) year-to-date variance, there is an anticipated estimated allocation to come regarding the reduction in shifts from 37.5 to 37 hours – currently £103k. This has been delayed at a national level while calculations are verified between National Boards for consistency.

The above position includes certain specific pressures which have arisen in 2024/25, and which have been raised with SG at the August quarterly finance meeting for consideration. These are –

- Boarding out costs – patients being treated at Wishaw with staff in attendance (to date £247k)
- High risk patient on enhanced care requiring minimum 4 staff daytime shifts and 2 staff night shifts, on an individual basis (since 6th July – staffing required currently costing an estimated £130k per month)
- Escorted transfer of female patient to Wales – cost of TSH staff in attendance through transfer (£1.7k)

In addition, there are further anticipated allocations not yet input to budgets as awaiting confirmations, as follows –

- Digital / Strategic £10k
- OU Students Backfill, phase 2 £50k
- Distinction Awards £36k
- NDC Top Slice £(12)k

Further Capital Charges relate to the increased depreciation on the perimeter project costs – with remaining capitalisation in 24/25 estimated at £0.445m, which has been notified to SG (with a resultant impact to come in 25/26).

Nursing & AHPs
Previous data analysis identified Band 5 vacancies, sickness absence and outboarding due to increased clinical acuity (physical health care) as the major contributors to increased overtime costs. The Directorate continue to actively recruit to nursing vacancies in an attempt to mitigate against costs attributed overtime spend whilst ensuring robust attendance management processes are followed. As noted in previous update reports, interviews for Band 5 vacancies were most recently undertaken in June 2024 with 5.8 WTE posts offered to six candidates. Two candidates, who are already registrants, will undertake induction in August 2024 and the remaining four will undertake induction mid-October. This should alleviate some ward-based nursing pressures. In addition, six staff undertaking their Open University (OU) training will also graduate in October 2024. The Associate Director of Nursing, Lead Nurses and Workforce Lead continue to meet monthly to monitor and pro-actively plan for retirals and upcoming vacancies.

Clinical acuity is unpredictable and can vary month on month. This can have an impact on site resourcing, as a minimum of three staff are required for each outboarding patient. This increases to a minimum of five staff if Soft Restraint Kit is required. As also previously noted, in July we opened an additional ward to care for a patient who's clinical and risk needs determined care could only safely be delivered in a standalone area, separate to other patients. This patient requires a minimum of ten staff per day (four in the AM; four in the PM, and two overnight). The hospital is in the process of requesting additional funding for this bespoke area of care, which will contribute to alleviating some financial pressures experienced within the Nursing Directorate budget.

To ease the additional pressure of scheduled outings (in addition to unscheduled care) we continue to trial a small outboarding team which consists of one registered and unregistered nurse. Since the start of the trial, we have seen a positive impact.

All initial SCN performance reviews now been completed using the dashboard developed by Finance Dept. This has enabled initial discussions around the necessity for SCNs to effectively use their allocated funding through effective use of staffing resource and management of sickness absence, as well as non-pay related spending. These are scheduled on a monthly basis with the first service review due to take place on Monday 12th August 2024.

Security & Facilities & Utilities
Some accruals brought forward are contributing to funding electricity and biomass pressures, and a central reserve has been created for part of the forecast for the remainder of the year.

Food price increases continue to cause pressure in the kitchen and staff restaurant, with a reserve set aside to be released in year, pending scrutiny of purchases.

It is noted that some directorate savings will not materialise until later in the year, however there are vacancies outstanding which are contributing to the underspend.

Medical
A small variance in non-pay costs to date is noted.

Chief Executive
A small variance is noted arising from savings below trajectory to date.

Human Resources
The underspend is arising from non-pay variances, particularly in training, due to timing.

Finance
As approved through CMT in August, eHealth strategic allocation has now been released in order to support the funding of four posts on a permanent basis instead of fixed term – enabling stronger retention and recruitment of quality staff.
Rates are noted to have increased significantly this year, with the budget now released.

Capital Charges
RRL has now been anticipated for phase 1 increase in asset values from perimeter project capitalisation, awaiting expected agreement of projections from SG. A further element (phase two Perimeter) will hit later in the year so while not yet reflected in the budget has been notified to, and confirmed by SG.

Central reserves
These are phased to Month 12 (March 2025) and are being released as required, including the Apprenticeship Levy (charged at year end from balance sheet), PAIAW, Provisions,
On-call, SLAs, Utilities, and consultants' discretionary points.

3.4 Other financial pressures / potential benefits.

Pressures:-
eRostering Project
The project team ceased at the end of June 2024, with accruals in place to fund this. The project itself will incur costs but at a significantly lower level than the previous year's set up costs.

M365
Estimated costs noted to date, awaiting confirmation of charges materialising from NSS.

Energy and inflation increases
The unused prior year accrual has been carried forward to provide against anticipated pressure in 2024/25, with a reserve in place as well. This has been highlighted to SG as a risk area, given uncertainties of winter energy costs to come.

Rates
After the increase in 2023/24, once again a significant increase had been noted for 2024/25.

AFC Reform
(identified and, as noted above, unfunded awaiting SG provision – for which funding is expected)

- Reduction in 37½ working week – underway – by a ½ hour for full time staff (pro-rata part time) in years 24/25, 25/26 and 26/27 - thereafter becoming a 36 hour week.
- Adjustment of a number of posts – yet to be determined – from B5 to B6.
- AFC pay uplift in year.

Benefits:-
Travel
With the budget not fully utilised in the Covid years, this has been reset for 2024/25 – with most meetings (internal and external) now being held via Teams.

Training
These budgets were also underspent in the Covid years – however as part of the AFC Reforms this time should be protected in the main, but with the pressure in meeting higher savings a small element of unessential divisional training budget has been earmarked towards savings.

4 ASSESSMENT – SAVINGS

Savings targets are generally phased evenly over the year (twelfths) – and equate to £1.3m (3%). With adjustment noted as above re nursing for accuracy of tracking (phased July to March).

Directorate Target	9051 Pay NR	9052 Pay R	9053 Non Pay NR	9054 Non Pay R	Total £'k
CE	18	4	36	17	74
Finance	30	10	7	54	101
HR	0	18	0	7	25
Medical	45	0	28	1	74
WN'g	717	90	10	11	828
Security	81	83	45	24	233
Total Savings Target	**891**	**205**	**126**	**113**	**1335**

Directorate Achieved Apr-Jul	9051 Pay NR	9052 Pay R	9053 Non Pay NR	9054 Non Pay R	Total £'k
CE	-10				-10
Finance					0
HR				-10	-10
Medical	-5				-5
WN'g	-312				-312
Security	-35				-35
Total Savings Achieved Apr-Jul	**-362**	**0**	**0**	**-10**	**-372**

Directorate Still to Achieve	9051 Pay NR	9052 Pay R	9053 Non Pay NR	9054 Non Pay R	Total £'k
CE	8	4	36	17	64
Finance	30	10	7	54	101
HR	0	18	0	-3	15
Medical	40	0	28	1	69
WN'g	405	90	10	11	516
Security	46	83	45	24	198
Total Still to Achieve	**529**	**205**	**126**	**103**	**962**

It should be noted that of the Hospital's budget only 15% of costs are non-pay related, certain boards also treat vacancy savings, or a proportion thereof, as recurring savings, we still class as non-recurring. Savings will be agreed and taken in Quarter 1 and monthly thereafter.

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation is £0.269m, with capital projects planned and agreed through the Capital Group. It is recognised that certain future projects likely to require requests on a project-by-project basis to SG for additional funding will require to be placed "on hold" until it is known when such national resource may be available.

Working within the annual allocation, the following have been identified for 2024/25 – prioritising in particular essential security (physical and IT) and estates maintenance works (some of which are underway), while at the same time noting future works which will require to be addressed in 2025/26 and beyond. As is done annually, this was notified through August CMT for awareness across directorates.

IT – firewall	£ 40k
IT – hardware renewals	£ 30k
IT – core network switches	£ 15k
Perimeter – PIDS replacement	£ 65k
Perimeter Project	£ 15k
Vehicle replacement*	£ 32k
Tool marking system	£ 8k
Visitor Management System	£ 5k
Sensory rooms (chairs/bags)	£ 16k
Sub-total	£ 225k
Digital – patient banking	*£ t.b.c.*
Anticipated re Estates	*£ t.b.c.*

** - recurring into 2025/26*

Additional –
Security – X-ray machine replacement – this is likely to require more funding than is available within 2024/25 – and is currently being scoped for prioritisation in 2025/26.

With regard to the Perimeter Security Project allocation, there are elements of delays in the Project – now expected to be completing in 2024/25 – likely August, with retention spend due.

CAPITAL CRL 2024/2025 AS AT JUL 2024	ANNUAL PLAN	YTD PLAN	YTD SPEND	under/ (over)
	£'k	£'k	£'k	£'k
PERIMETER SECURITY				
STANLEY SECURITY SOLUTIONS LTD		7	7	0
THOMSON GRAY LTD		87	87	0
TSH STAFFING APR - MAY '25		58	58	0
PERIMETER SECURITY TOTAL	436	152	152	0
CAPITAL				
IM&T		4	4	0
OTHER		-4	-4	0
CAPITAL	269	0	0	0
Total CRL	705	152	152	0

6 RECOMMENDATION

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

Revenue

The year to date position is an over spend of £0.115m (pending RRL for ½ hr reduction in working week for AFC staff), with ward nursing costs remaining the key pressure.

Forecast for the year remains for a breakeven position to be achieved, with savings target on track.

Capital

Little spend has yet been incurred in year – with the budget however fully committed and a breakeven position forecast for the year.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2024
Agenda Reference:	Item No: 10
Sponsoring Director:	Medical Director
Author(s):	PA to Medical Director
Title of Report:	Bed Capacity Report within TSH and Forensic Network
Purpose of Report:	For Noting

1. SITUATION

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

2. BACKGROUND

a) TSH

The following table outlines the high level position from the 1 June 2024 until 31 July 2024.

Table 1

	Admissions & Acute	Treatment & Recovery	Transitions	ID	Total
Bed complement	24	48	24	12 ID beds (and 12 contingency beds) Total 24	120 (+ 20 additional unstaffed beds)
Beds in use	20	48	20	12 + 3 ID surge	103
Admissions	6 (external) 0 (internal)	0 (external) 4 (internal)	0 (external) 1 (internal)	0 (external) 2 (internal)	6 (external) 7 (internal)
Discharges/Transfers	2 (external) 4 (internal)	1 (external) 1 (internal)	0 (external) 0 (internal)	0 (external) 2 (internal)	3 (external) 7 (internal)
Bed occupancy as at 31/07/2024	83.3%	100%	83.3%	125% (ID beds) 62.5% (all beds)	85.8% (available beds) 73.6% (all beds)

Please note that in total there were 103 patients as of 31st July 2024. Within this number 15 patients are under the care of the Intellectual Disability Service (the service is currently 3 patients in excess of their 12 patient allocation).

Table 2 – Time between admission and referral

Date	6 weeks or less	More than 6 weeks	Total Number
31/07/2024	4	2 1 (gap between referral and assessment) 1 (delay with paperwork at referrer side)	**6**

Four of the six patients were admitted within 6 weeks of referral. The other two had delays – one due a gap between referral and assessment by TSH staff, and the other due to delays in paperwork being provided by the referrer.

There are 16 patients identified for transfer, 6 have been fully accepted, there are none waiting longer than 12 months and there have been 8 excess appeals won (6 x S264, 2 x S265). Full details are available but not included for reasons of patient confidentiality.

There is one patient currently in TSH under the Exceptional Circumstances clause.

b) Bed Occupancy since start of new Clinical Model

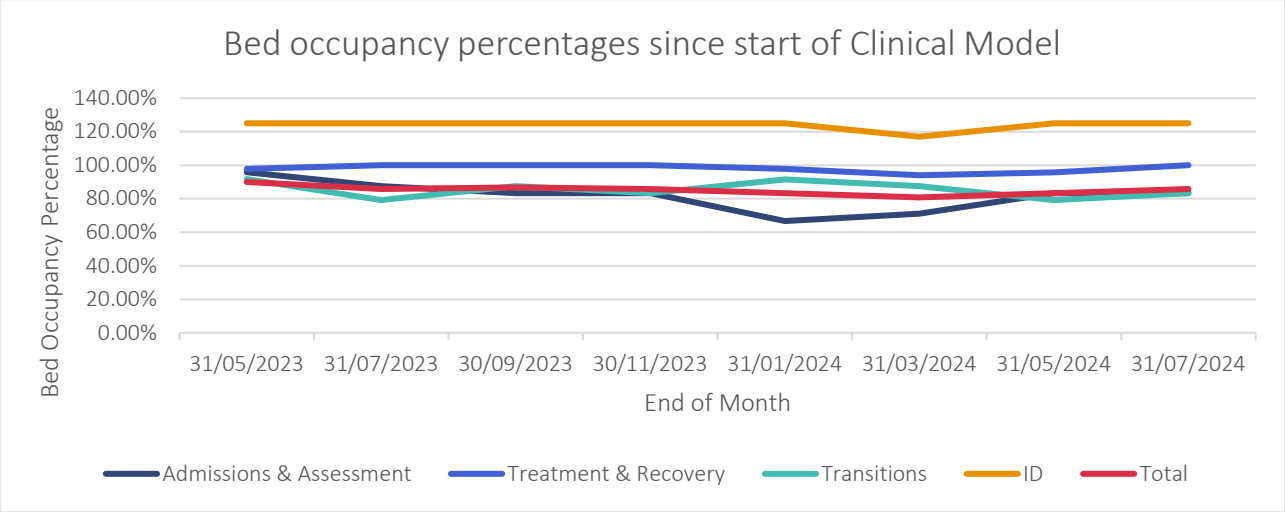


Table 2 Bed Occupancy by Service and in Total

Service	31/05/2023	31/07/2023	30/09/2023	30/11/2023	31/01/2024	31/03/2024	31/05/2024	31/07/2024
Admissions & Assessment	95.80%	87.50%	83.30%	83.30%	66.70%	71%	83.30%	83.30%
Treatment & Recovery	97.90%	100%	100%	100%	97.90%	94%	95.80%	100%
Transitions	91.70%	79.20%	87.50%	83.30%	91.60%	87.50%	79.20%	83.30%
ID	125%	125%	125%	125%	125%	117%	125%	125%
Total	**90%**	**85.8%**	**86.7%**	**85.8%**	**83.3%**	**80.8%**	**83.30%**	**85.8%**

Table 2 shows more patients in admissions & assessment service and fewer in transitions which reflects the greater number of admissions compared to external discharges outlined in table 1.

c) TSH Contingency Plan

Following the new Clinical Model being implemented, SOPs for surge bed contingency planning has been agreed through the Clinical Model Oversight Group. There exists 2 agreed SOPs. One allows for use of surge beds within the Intellectual Disability Service solely at night/when patients have defined time in the rooms. The other for patients who would remain in the surge bed within the Intellectual Disability Service day and night. No patients are currently identified given current bed availability and recent patient flow, it would be possible though to identify patients with clinical teams rapidly should this be required. These arrangements have never been used.

d) Forensic Network Capacity

The Board received copies of the Forensic Network's short-, medium- and long-term plans to improve capacity across the forensic estate. (Appendix 1) These were requested by Scottish Government. We receive a weekly forensic estate update report from the Forensic Network to aid patient flow. The Orchard Clinic has temporarily reduced its capacity for over one year by 7 beds for urgent repairs. The Forensic Network at the request of Scottish Government has submitted updated capacity reports of the whole forensic estate and for women.

3. ASSESSMENT

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

The Orchard Clinic's temporary closure of 7 beds for urgent work is causing further pressure across the forensic estate. This work is due to commence on 5/8/24.

4. RECOMMENDATION

The Board is invited to note the report.

MONITORING FORM

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

W/c 05 August 2024

	High Secure		Medium Secure							Low Secure													
	TSH Male MI	TSH Male LD	Orchard Clinic Male	Orchard Clinic Female	Rohallion Male	Rowanbank Male	Rowanbank Female	National LD Male	National LD Female	Beckford Lodge Male	Bellsdyke Male	Bellsdyke Female	Leverndale Male	Leverndale Female	Leverndale Male LD	Rohallion Male	Blair Unit Male	Blair Unit Female	Stratheden Male	Woodland View Male	Kirklands Hospital Mixed ID	Lynebank Male ID	Strathmartine Male ID
Bed capacity	108	12	30	3	31	56	6	8	4	15	12	6	38	5	10	24	32	2	12 (2 beds in lodge)	8	2	10	8
No. of beds in use	88	15	30	3	29	49	3	8	2	15	9	5	38	4	9	22	34	2	9	7	1	10	8
No. empty beds	7	-3	0	0	2	7	3	0	2	0	3	1	0	1	1	2*	0	0	1 (ward), 2 in lodge	0	1	0	0
No. available beds	7	0	0	0	1	2 (acute)	2	0	2	0	2	0	0	1	0	1*	0	0	0	0	0	0	0
No. on waiting list for access to service	0	0	3	0	1	5	0	2	0	3	0	0	22	0	1	0	3	0	1	1	2	0	0
No. on waiting list currently placed out of area	0	0	0	0	0	2	0	0	0	0	0	0	16	0	1	0	3	0	1	0	2	0	0
No. of patients on transfer list for lower security settings	12	2	3	0	6	7	0	1	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0
No. of patients on transfer list for higher security settings	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
No. of patients on transfer list for community or other services	0	0	0	0	1	5	0	0	0	0	2	1	12	1	2	7	4	0	0	0	0	5	0
No. of delayed discharges	0	0	2	0	0	2	0	0	0	3	1	0	4	0	2	2	4	0	0	0	0	3	0
No. of patients on transfer list fully accepted for transfer	3	2	2	0	5	7	0	1	1	2	0	0	6	0	0	0	3	0	0	0	0	0	0
No. of admissions in the last week	0	0	0	0	2	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0	0	0	0
No. of those admissions that were an emeraency	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
No. of discharges in the last week	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	1	1	0	0	0	0	0
Any foreseen potential issues this week in terms of capacity					Only 1 rehab bed available. No admission beds.		2 beds in use for high secure female				1 patient living in trial flat full-time, 2 patient living in trial living flat part time	1 patient living in trial living flat part time				* 1 bed currently out of use in Esk pending completion of repair works	In addition to the above we have 2 patients in another ward		1 bed booked for transfer CORO		Review of beds being undertaken by the service	No available beds	

Bed Position Weekly Report Guidance
Bed capacity
No. of beds in use
No. empty beds
No. available beds
No. on waiting list for access to service
No. on waiting list currently placed out of area
No. of patients on transfer list for lower security settings
No. of patients on transfer list for higher security settings
No. of patients on transfer list for community or other services
No. of delayed discharges
No. of patients on transfer list fully accepted for transfer
No. of admissions in the last week
No. of those admissions that were an emergency
No. of discharges in the last week
Any foreseen potential issues this week in terms of capacity

The number of beds the service has
The number of beds that are currently being used
The number of beds that are empty in the service (number of beds in use + number of empty beds should add up to bed capacity, if not please explain in foreseen potential issues)
The number of beds that are available for use (this may not be the number of beds that are empty e.g. due to damages, booked beds for patients on the waiting list etc.) Any issues affecting the number of beds
The number of patients on the waiting list for access to the service
The number of patients who are on the waiting list but are currently accessing out of area beds in another
The number of patients on the waiting list for transfer to conditions of lower security
The number of patients on the waiting list for transfer to conditions of higher security
The number of patients on the waiting list for discharge back to community or other services
The number of patients clinically ready for discharge but cannot leave hospital e.g. due to bed availability,
The number of patients who have been referred and fully accepted by service referred to
The number of patients that have been admitted in the last 7 days
The number of patients who were admitted as an emergency rather than a planned admission
The number of patients that have been discharged in the last 7 days
Any foreseen challenges relating to bed use within your service over the coming week. (For example, reasons as to why admissions cant take place despite empty beds; staffing problems; beds closed for repairs; delays

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2024
Agenda Reference:	Item No: 11
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Director of Security, Resilience and Estates
Title of Report:	Annual Report to Scottish Government on the Implementation of Specified Persons Legislation
Purpose of Report:	For Decision

1 SITUATION

The Mental Health (Care & Treatment) (Scotland) Act 2003, Section 286, makes provision for regulations (the regulations) relating to safety & security, use of telephones and correspondence. The Safety & Security Regulations place a duty on The State Hospital to furnish Scottish Government with an annual report on the implementation of the regulations. In the interests of openness and transparency, the annual report to the Scottish Government also includes information on the implementation of the regulations relating to correspondence and telephones.

The draft report for 2023/24 is attached at Appendix 1.

2 BACKGROUND

The regulations are:

- The Mental Health (Safety & Security) (Scotland) Regulations 2005
- The Mental Health (Use of Telephone) (Scotland) Regulations 2005
- The Mental Health (Definition of Specified Persons) (Scotland) Regulations 2005

The regulations allow restrictions to be made relating to “Specified Persons”. The purpose of the specified person designation and related restrictions are to ensure the safety and welfare of the patient and others by allowing the Clinical Team to introduce managed and proportionate controls in defined areas. A system of reviews, reporting and appeals is also in place to safeguard the patient from excessive or disproportionate use of the specified person designation.

The specified person designation relates to:

- Correspondence
- Telephone calls
- Property and visitors
- Searching of patients and their property
- Searching of visitors and their property
- The taking of samples
- Surveillance of patients and visitors

Out-with high security, the specified person designation is applied by the Responsible Medical Officer. The Act states that all patients at The State Hospital are automatically deemed to be Specified Persons due to their detention in The State Hospital.

3 ASSESSMENT

The report attached at Appendix 1 is in the same format as previous years. It meets our obligation for an annual report. The data included in the report is regularly reported in more detail to the Clinical Governance Committee.

4 RECOMMENDATION

The Board is invited to **approve** the report for submission to the Scottish Government.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Meets obligation for annual report to Scottish Government
Workforce Implications	None
Financial Implications	None
Route to the Board Which groups were involved in contributing to the paper and recommendations?	Requested as part of Board Workplan
Risk Assessment (Outline any significant risks and associated mitigation)	None
Assessment of Impact on Stakeholder Experience	None
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not applicable
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One □ There are no privacy implications. X There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Appendix 1

Annual Report to the Scottish Government Health Department on the Implementation of:

- **The Mental Health (Safety and Security)(Scotland) Regulations**
- **The Mental Health (Use of Telephones)(Scotland) Regulations 2005**
- **The Mental Health (Definition of Specified Person: Correspondence)(Scotland) Regulations 2005**

by The State Hospitals Board for Scotland for the period 1 August 2023 to 31 July 2024

1 THE HOSPITAL'S CURRENT POLICY ON SAFETY AND SECURITY

The State Hospital has 140 beds and is currently operating with 120. According to the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Act) all patients at The State Hospital are automatically deemed to be Specified Persons due to their detention in The State Hospital.

The State Hospital does not have a single "Safety and Security" Policy. Due to the intrinsic nature of security within a high security hospital, safety and security are a part of all policies and procedures. Areas in which policy exists that implement or are affected by the above regulations include:

- Patient mail and telephones
- Searching Patients
- Restricted and excluded items
- Restrictions on visitors
- Taking of samples
- Surveillance

Detail on these areas is provided below.

2 PATIENTS' MAIL AND TELEPHONES

Mail

The State Hospital Policy allows mail to or from the patient to be inspected and read by staff if individually prescribed by the Clinical Team. Mail can then be withheld from the patient or from being sent if it satisfies criteria related to safety or distress.

During 2022, the mail policy was reviewed and the categories were changed to High, Medium and Low. No annual figures can be given on these categories, the table below shows how many patients were on each level at 31st July each year the patient numbers in the differing categories and instances of withheld mail were as below:

The tables below show of the number of patients on each category at the end of the year prior to change in categorisation in 2022

Incoming Mail Scrutiny	13-14	14-15	15-16	16-17	17-18	18-19	19-20	20-21
Opened in the presence of staff	39	48	35	31	28	23	22	15
Opened then inspected by staff	27	25	22	22	22	21	20	22
Opened, then inspected and read by staff	61	50	61	60	57	60	71	77

The table below shows the number of patients since the change to the policy in 2022

Incoming Mail Scrutiny	21-22	22-23	23-24
High	2	6	2
Medium	79	78	81
Low	31	19	20

The tables below show of the number of patients on each category at the end of the year prior to change in categorisation in 2022

Outgoing Mail Scrutiny	13-14	14-15	15-16	16-17	17-18	18-19	19-20	20-21
Sealed by patient and handed to staff	25	34	24	22	19	17	16	11
Inspected by staff	33	35	27	24	24	22	19	19
Inspected and read by staff	69	54	67	67	64	65	78	82

The table below shows the number of patients since the change to the policy in 2022

Outgoing Mail Scrutiny	21-22	22-23	23-24
High	1	1	2
Medium	84	82	80
Low	27	20	21

The table below shows the number of mail items withheld over the year.

Withheld Mail	13-14	14-15	15-16	16-17	17-18	18-19	19-20	20-21	21-22	22-23	23-24
Being sent by patient	1	2	0	0	0	2	2	2	0	1	5
Being sent to patient	1	0	0	3	7	0	0	3	7	9	2

Telephones

The State Hospital Policy allows outgoing calls from patients to persons approved by the Clinical Team. Under normal circumstances, patients cannot take incoming calls.

Patients are either directly supervised by a member of staff who listens to the patient during the call, or indirectly supervised by a member of staff in the vicinity of the telephone.

Technology is in place which allows staff to hear both sides of the call and will allow recording of calls if required.

The tables below shows how many patients were on each level at 31st July each year.

The tables below show of the number of patients on each category at the end of the year prior to change in categorisation in 2020
Below are the patient numbers in the differing categories at 31st July each year:-

Telephone Call Supervision	13-14	14-15	15-16	16-17	17-18	18-19	19-20
All Supervised	53	45	59	57	49	52	65
All Unsupervised	53	56	34	30	22	20	18
Some Supervised	21	22	25	26	36	30	30

The table below shows the number of patients since the change to the policy in 2020

Telephone Call Supervision	20-21	21-22	22-23	23-24
High	0	0	1	0
Medium	69	62	63	58
Low	45	50	39	45

Calls to Advocacy, The Mental Welfare Commission, Legal Representatives and other persons listed in the Act are not to be supervised and do not require Clinical Team approval.

3 SEARCHING AND RESTRICTED OR EXCLUDED ITEMS

The State Hospital Policy allows the regular searching of:

- Patients
- Patients' rooms
- Patients' Lockers
- Patients' Visitors

Planned search frequencies are as follows:

Patient	Weekly
Locker	Weekly
Room	Monthly

Patients are also randomly searched when moving between areas, or if leaving an area where risk items are present that have not all been accounted for. An example of this would be when a patient needs to leave the dining room before cutlery has been counted.

In addition to these measures, to which every patient is subject, searches can be individually directed at a patient, his room or his locker based on information or presentation.

Policy also details those items that a patient is allowed in his room or is able to access. Items are excluded or restricted for a number of reasons, particularly the potential to cause harm or communicate with other devices and the internet. There are also overall restrictions on the quantity and volume of items to ensure rooms can be quickly and safely searched.

4 RESTRICTIONS ON VISITORS

The State Hospital Policy restricts patient visitors to those authorised by the patient's Clinical Team and restricts the items that can be brought into the Hospital by visitors. Policy also allows for Restricted Visits, in which 1:1 close supervision of the patient takes place.

The policy relating to Child Protection makes special arrangements to protect children who may visit patients or be present during Leave of Absence. Child contact requires special approval arrangements.

All visitors may be requested to submit to a search following entry through airport style security; all bags and other carried items are X-rayed and then searched if necessary.

5 TAKING OF SAMPLES

The State Hospital Policy allows the taking of oral fluid or urine samples to test for drugs of abuse. The majority of patients opt for an oral fluid test. The frequency of testing has changed during 2020 the patient provides between one sample during the year to 12 samples during the year as determined by the Clinical Team. The numbers of patients subject to each frequency as July 2024 is as follows:

Sampling Frequency	**13-14**	**14-15**	**15-16**	**16-17**	**17-18**	**18-19**	**19-20**	**20-21**	**21-22**	**22-23**	**23-24**
2 Weekly	21	24	23	29	15	15	N/A	N/A	N/A	N/A	N/A
1 Monthly	14	12	13	5	14	7	31	35	35	33	28
3 Monthly	20	13	18	17	17	16	18	19	17	18	26
6 Monthly	29	25	22	19	19	23	N/A	N/A	N/A	N/A	N/A
Annually	43	49	42	43	42	43	63	60	60	52	49

6 SURVEILLANCE

The Hospital operates a full CCTV system across all areas of the hospital.

CCTV was introduced into patient areas and wards in June 2024 as part of a security upgrade, and is now fully functioning across all patient areas.

CCTV also covers the perimeter, grounds and reception building of the Hospital, including areas of reception used by patient visitors.

7 POLICY REVIEW

The Hospital's policies and procedures are reviewed on a regular basis and as required.

Paper No. 24/65

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2024
Agenda Reference:	Item No: 12
Sponsoring Director:	Medical Director
Author(s):	Head of Clinical Quality / Head of Corporate Planning, Performance and Business Support
Title of Report:	Quality Strategy 2024-2029
Purpose of Report:	For Decision

1. SITUATION

The State Hospital commissioned the publication of a Quality Strategy that will provide direction for the next 5 years.

2. BACKGROUND

Previously, the State Hospital had a quality strategy that ran from 2017-2020. It was agreed that the Strategy should be reviewed taking into consideration the national and local picture.

3. ASSESSMENT

The Strategy looks at the national picture across various national workstreams. The Strategy adopts NHSScotland core values of:

- Care and compassion.
- Dignity and respect.
- Openness, honesty and responsibility.
- Quality and teamwork.

With our quality vision aims being to:

- Deliver safe, effective and person-centred care based on available evidence and best practice;
- Achieve demonstrable improvements in outcomes including the patient experience;
- Demonstrate meaningful involvement of patients, carers, volunteers and all other stakeholders* in quality assurance and improvement activities;

- Provide assurance to Scottish Government and stakeholders, around safe systems and continuous improvement to quality of care whilst addressing any health inequalities in our patient population;
- Develop a culture of ongoing learning and continuous improvement.

The Strategy also includes at:

- Our quality ambitions.
- How we will create the conditions.
- How realistic medicine fits into the Strategy
- What our quality management system looks like including our approach to quality planning, control, assurance and improvement
- What success will look like (this will be broad themes in the Strategy with a detailed delivery plan sitting under the strategy). The plan will be monitored through the Clinical Governance Group.
- Where accountabilities and responsibilities will sit within the hospital.

There has been a wide range of consultation on the strategy already in the form of:

- a presentation at the Board session
- attendance at Patient Partnership Group
- meeting with the Forensic Network:
- CGG members taking the Strategy back to their teams
- staff bulletin and intranet
- SCNs liaising with nursing staff and poster and post-it notes provided in staff tea rooms for easier feedback
- communications with Corporate Management Team

All feedback received to date, has been considered within the attached strategy.

Following approval of the Quality Strategy by the Board, the Head of Clinical Quality and Head of Corporate Planning, Performance and Business Support will develop an achievable, but stretching delivery plan base on the 5 key priority areas.

4. RECOMMENDATIONS

Members of the State Hospitals Board for Scotland are asked to approve the Quality Strategy.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP / Corporate Objectives	Provides a vision and direction for Clinical Quality within The State Hospital
Workforce Implications	There are no associated workforce implications by way of this reporting.
Financial Implications	There are no associated financial implications – any issues highlighted are managed through relevant directorate.
Route to Group / Committee -which groups were involved in contributing to the paper and recommendations	Patient Partnership Group, Forensic Network, Corporate Management Team, Clinical Governance Group, Nursing Group, Clinical Governance Committee
Risk Assessment (Outline any significant risks and associated mitigation)	A risk to the organisation if we do not follow evidence base and have a clear quality management system
Assessment of Impact on Stakeholder Experience	This will be captured within the delivery/action plan that will sit under the Strategy
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	All large scale QI projects will be impact assessed.
Data Protection Impact Assessment (DPIA) See IG 16	Tick One **x** There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included


STATE HOSPITAL
EFFECTIVE
EQUITABLE
EFFICIENT
QUALITY
PATIENT CENTRED
SAFE
TIMELY
QUALITY STRATEGY 2024-29

CONTENTS

1 FOREWORD

This Clinical Quality Strategy sets out the Board's unwavering commitment to improving the quality of the care and treatment for patients that is evident in our everyday work and behaviours. This focus on delivering evidence based practice through a process of continuous improvement in turn, builds a shared understanding and an organisation where improvement in quality is embedded in how we work.

The State Hospital can only achieve the high quality care and treatment we provide through the teams of dedicated and hard working staff who are committed to our patients and the wider NHS. They deliver excellent patient care with kindness and compassion.

We know though, that we don't always get it right for our staff, patients and their carers. That's why it's important that we listen, learn and in partnership with these key stakeholders, ask ourselves what can we do better or differently to improve the quality of our services and the experiences of our staff, patients and their carers.

To underpin the Strategy we will promote and support a culture of excellence, innovation, learning and awareness to help staff achieve high quality personal and team standards when delivering care and services. To help embed this way of working throughout the organisation we will systematically invest in proven quality improvement skills and approaches.

In summary, we have a firm commitment to improving quality and how we interact and influence each other and inter-relate with the wider organization. Building strong relationships matters to us and we will continue to strengthen our visibility and engagement with our staff, partners and the Forensic Network.

Lindsay Thomson
Medical Director

Karen McCaffrey
Director of Nursing and Operations

2 EXECUTIVE SUMMARY

The State Hospital is the national high secure forensic mental healthcare provider for Scotland and Northern Ireland. The organisation provides specialist individualised assessment, treatment and care in conditions of high security for male patients with major mental disorders and intellectual disabilities. The patients, because of the risks they present to others, cannot be cared for in any other setting. Working closely with partners in the Forensic Network for Scotland, the organisation is recognised for high standards of care, treatment, research and education.

The vision of the State Hospital is to:

- Excel in the provision of high secure forensic mental health care.
- Achieve positive patient outcomes.
- Ensure the safety of staff, visitors, patients and the general public.
- Strive to be an exemplar employer.

3 THE NATIONAL PICTURE

Scottish Government launched the Mental Health and Wellbeing Strategy in July 2023, the associated Mental Health and Wellbeing Workforce Action Plan 2023-25, and the Mental Health and Wellbeing Strategy Delivery Plan 2023-25 were launched in November 2023. These documents outline priorities for Scottish Government. These include the intention to continue to improve support for those in the forensic mental health system. They identify the challenges and opportunities in reducing stigma and discrimination, delivering support and services, the impact of

trauma and adverse childhood experiences on patients and the workforce. They highlight the benefits of investing in reducing the negative impacts of these on health and wellbeing.

This approach to delivering high quality patient care has been further highlighted in more recent frameworks including:

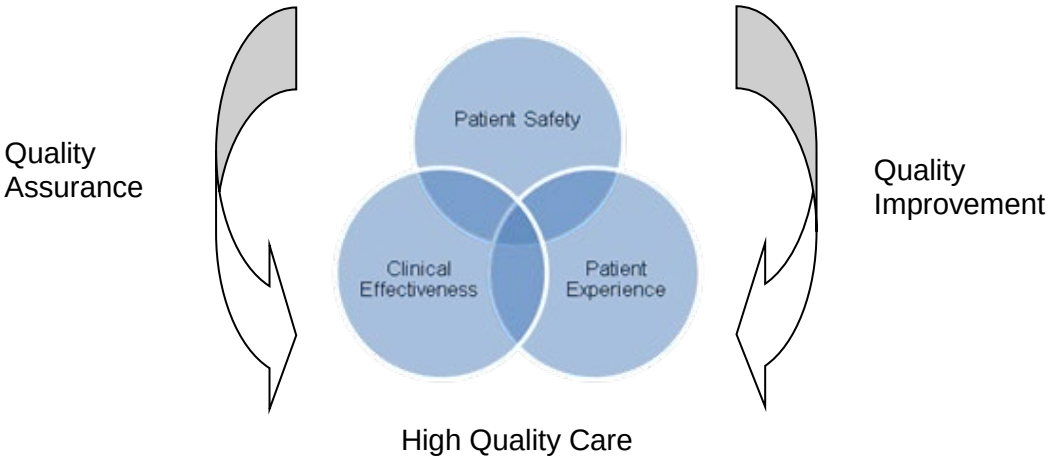
- The Psychological Therapies Specification.
- Excellence in Care.
- Scottish Patient Safety Programme.

Scottish Government are currently developing a National Clinical Framework which is central to reform of services and will set out the clinical direction for NHSScotland. The State Hospital Quality Strategy reflects the existing approach to quality management across NHSScotland. The Quality Management System below brings together the key activities that support improvement in health and care services.

4 THE STATE HOSPITAL PICTURE

Our Quality Vision

The State Hospital's quality vision is to deliver and continuously improve the quality of care through the provision of safe, effective and person-centred care for our patients.



Like all care systems, The State Hospitals Board for Scotland faces significant challenges to improve those experiences for its population. One key component to effectively responding to those challenges is the successful implementation of a quality management system..

The vision for the outcome of this Strategy is:

To improve the experiences of care and health provided to our patients by working together to deliver quality care and support that is person centred and free from harm.

The State Hospital has adopted the core values of NHSScotland which are:

- Care and compassion.
- Dignity and respect.
- Openness, honesty and responsibility.
- Quality and teamwork.

The State Hospital quality vision aims to:

- Deliver safe, effective and person-centred care based on available evidence and best practice.
- Achieve demonstrable improvements in outcomes including in the patient experience.
- Demonstrate meaningful involvement of patients, carers, volunteers and all other stakeholders* in quality assurance and improvement activities.
- Provide assurance to Scottish Government and stakeholders around safe systems and commitment to the continuous improvement in quality of care whilst addressing any health inequalities in our patient population.
- Develop a culture of ongoing learning and continuous improvement.

*Due to the nature of this care setting, it is acknowledged that involvement of the general public, as stakeholders, may not always be appropriate. Stakeholders, in the context of the State Hospital are patients, carers, visitors, volunteers, staff, external supporting/regulatory organisations and other partner organisations, including the Forensic Network and other secure care settings.

As we provide care in a complex and unpredictable environment, so our vision and aims will be regularly reviewed to ensure they evolve to meet new priorities.

The State Hospital will develop a quality action plan and has a Realistic Medicine plan, which together support the delivery of these aims.

The Clinical Governance Committee takes detailed oversight in this area,-enabled by multiple groups and committees that provide assurance through a network of reporting.

Safe	• Patient Safety Group. • Medicines Committee. • Infection Control Committee.
Effective	• Clinical Governance Group. • Research Committee. • Mental Health Practice Steering Group. • Physical Health Steering Group.
Person centred	• Patient Partnership Group. • Person Centred Improvement Steering Group.

The voices of people with lived and living experience of care is important to the development of services to aid understanding of the experience of care. We will, where we can, seek and feed in these valuable insights to support our improvement work.

5 OUR QUALITY AMBITIONS

Looking at the six dimensions of quality in healthcare we want to be sure that improvements are focused to ensure care and support are clearly aligned to:

1) **Safe**: Avoiding harm to patients from the care that is intended to help them.

2) **Effective**: Providing services based on scientific knowledge and the evidence base to all who would benefit and refraining from providing services to those not likely to benefit (avoiding underuse, overuse and misuse respectively).

3) **Patient-centred**: Providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that the patient values guide all clinical decisions.

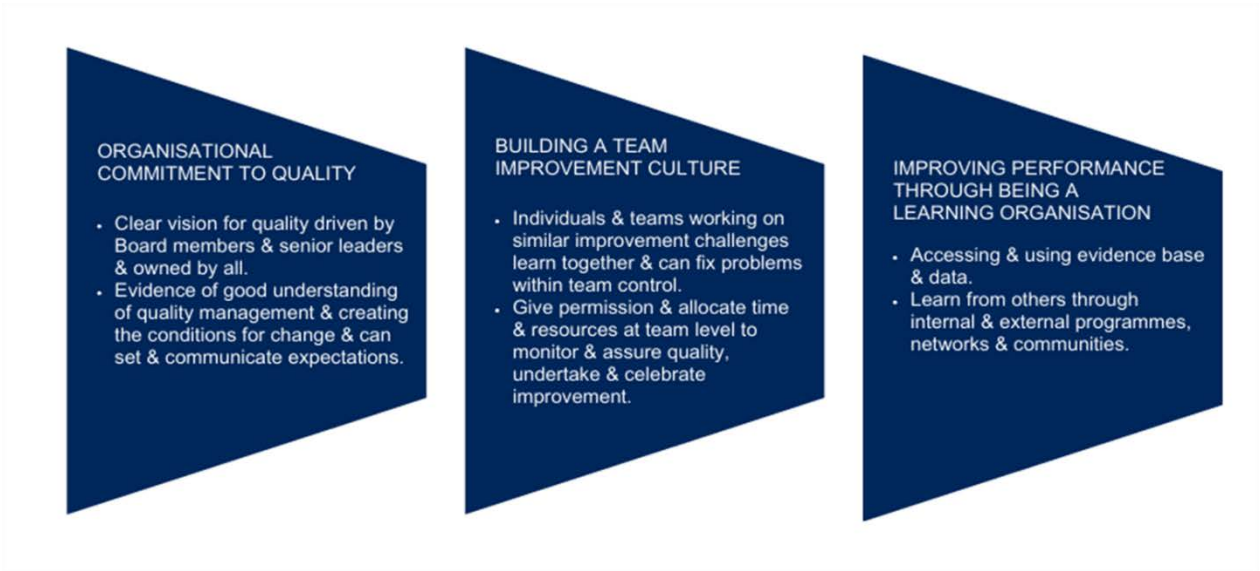
4) **Timely**: Reducing waits and sometimes harmful delays for both those who receive and those who give care.

5) **Efficient**: Avoiding waste, including waste of equipment, supplies, ideas, energy and staff time.

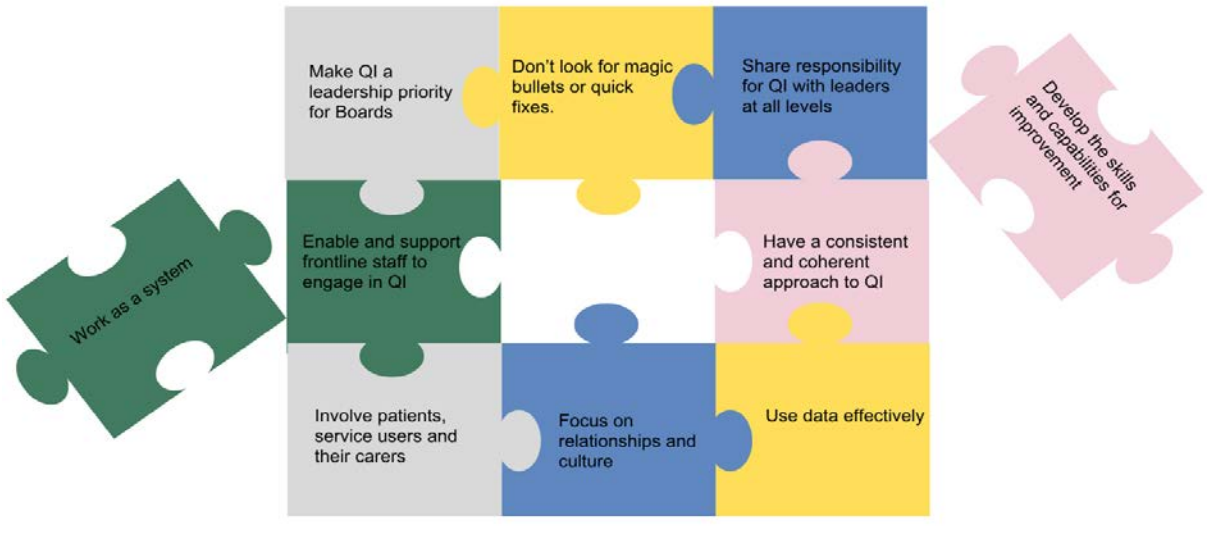
6) **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status.

6 CREATING THE CONDITIONS

Evidence tells us that we need to create positive conditions for change. Healthcare Improvement Scotland and NHS Education for Scotland both support the use of the Quality Management System Framework. This has enabled The State Hospitals Board for Scotland members and the Corporate Management Team to also adopt this framework as part of a coherent approach to quality management across NHSScotland. Our priorities are highlighted below and are included in the Executive Summary.



As a basis for the development of this Strategy, best practice was reviewed. Focusing on The Kings Fund's ten guiding principles, outlined below.



7 REALISTIC MEDICINE

Realistic Medicine is the Scottish Government's approach to delivering Value Based Health and Care (VBH&C) in Scotland. VBH&C is defined as "*the delivery of better outcomes and experiences for the people we care for through the equitable, sustainable, appropriate and transparent use of available resources*". VBH&C is based on the primary principle of person-centred care - care that is not only high in quality but also delivers the outcomes and experiences that really matter to people,

defined by and reported by them. In addition, VBH&C seeks to reduce the waste, harm and unwarranted variation that exist across our health and care system. The equitable distribution of resources is key to delivering VBH&C. It is by practising RM that we will deliver VBH&C.

In December 2022, the Scottish Government published a vision for VBH&C in Scotland: *"By 2030 all health and care professionals will be supported to deliver Value Based Health & Care. This will achieve the outcomes that matter to people and a more sustainable system."*

There are six key commitments within Realistic Medicine, with an annual action plan developed, agreed and delivered.

An action plan will be published annually describing the projects under the six agreed commitments:

1) Continue to promote realistic medicine.
2) Promote the measures of outcomes.
3) Continue to support the development of tools.
4) Continue to build a community of practice.
5) Support delivery of sustainable care.
6) Engage with the public to promote understanding.

8 OUR QUALITY MANAGEMENT SYSTEM

A Quality Management System (QMS) is described by Healthcare Improvement Scotland as "A co-ordinated and consistent approach to managing the quality of what we do across our health and care system, with the ultimate aim of delivering better population health and wellbeing, better care experience, better value and better staff experience." In The State Hospitals Board for Scotland, we will continue to introduce our QMS with the following components: Quality Planning, Quality Assurance and Quality Improvement.

Our Approach to Quality Planning

Planning for quality will be evident from organisational to service level; our vision for quality and the principles within the Quality Strategy will underpin other organisational strategies and delivery plans.

Our approach will be to define at the outset of any service redesign, what excellence will look like, using evidence, data and information, and to use that redesign process to build in the delivery of excellence in relation to improved experiences, outcomes and value.

Corporate functions such as Planning, Quality, Organisational Development, Corporate Services, Information Services and Digital and eHealth will clearly describe how to access support and work together to give easy access to the available resources needed to plan and manage quality.

Our Approach to Quality Control and Assurance

At all levels in the organisation, quality and excellence will be defined clearly in easily understood and highly relevant evidence-based outcomes and metrics.

This will include within operational and strategic plans and be evident across standards for clinical risk and outcomes, patient and staff experience, clinical and care governance, performance management and corporate risk.

Teams, services and departments will have access to meaningful data and will regularly evaluate how they are doing against the standards they, and the organisation, have set. They will have determined what information they require, how they will collect it and how frequently they review it, to be able to assure themselves and others of the quality of their service, and their improvement progress. That commitment to monitoring quality will be visible to them and others, in team discussions, displays of their service outcomes and reporting.

For Clinical Governance and assurance of the quality of care, teams at all levels will follow a standardised approach based on the Measurement and Monitoring of Safety Framework from the Health Foundation.

Where standards are not reached, based on the agreed quality indicators, or services are redesigning, there will be clear links to improvement resources and Measurement for Improvement advice that teams will access easily.

Measurement and Monitoring of Safety

Our Approach to Quality Improvement

There are two levels of change that we will continue to deploy and support i.e. continuous quality improvement and significant transformational change.

Our continuous quality improvement approach is guided by evidence, including what staff have learned about what has worked and what has not from taking part in learning opportunities, programmes and projects.

Any member of staff choosing to improve the way they work will be encouraged to follow the Improvement Journey and use the State Hospital Quality Toolkit, particularly the core tools and approaches including Project Charter, Model for Improvement and Plan Do Study Act cycles of change. QI Essentials is our foundation level training and staff will have regular access to this training.

Continuous improvement is an iterative process that requires measurement to help us to monitor if we are moving towards our goal. Measurement for improvement is presented as data over time and frequently analysed applying a clearly defined set of rules. Measures used for improvement should be defined, specific, sensitive, valid and reliable.

Where it is planned to make more transformational levels of change, for example change that involves several teams, a pathway, or service redesign, people will be signposted to core and pathways tools and approaches including using clinical/care and improvement coaching, stakeholder engagement, pathway mapping and diagnosis and evaluation.

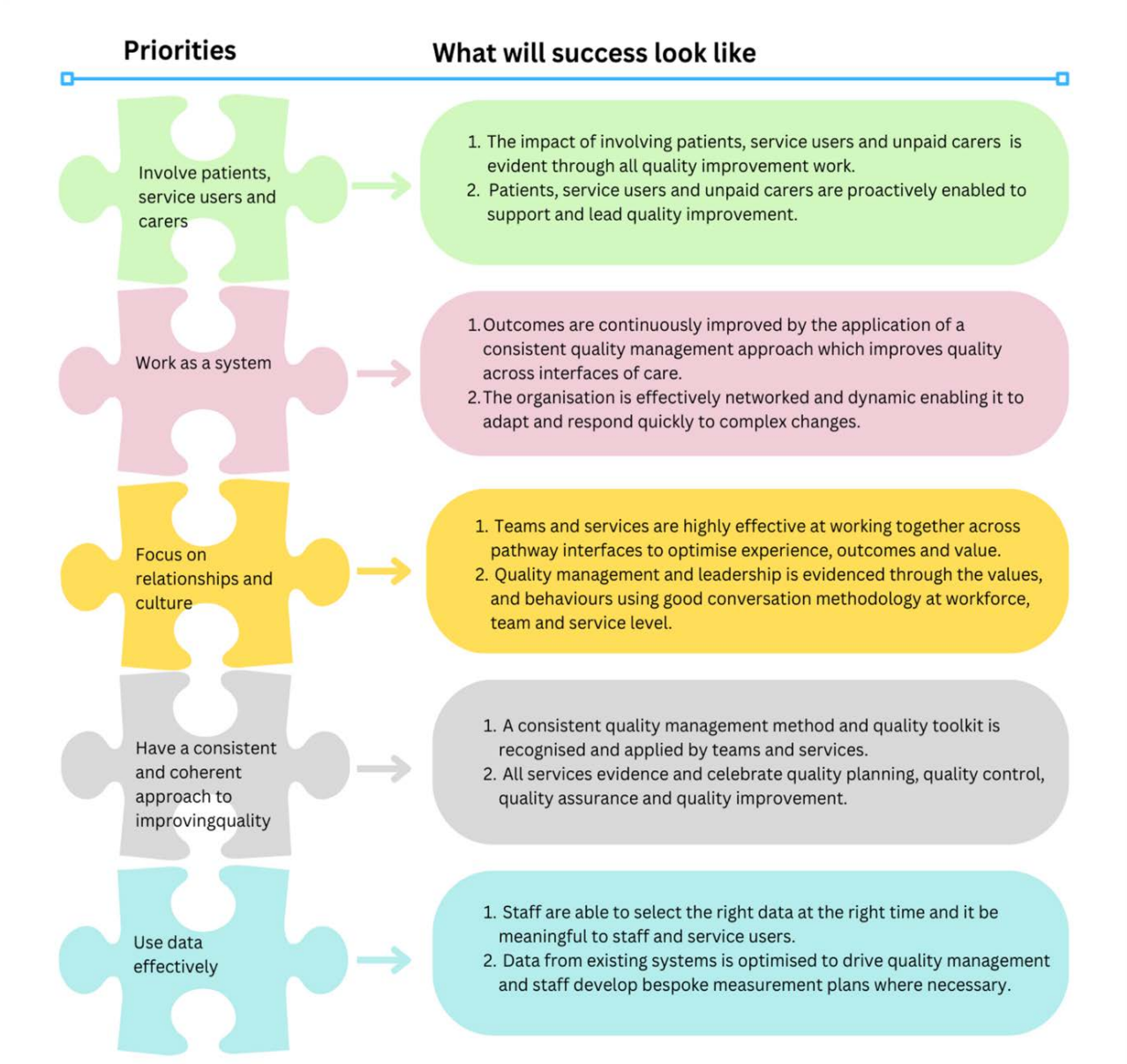
Alongside this, we will continue to develop staff confidence and skills in improving quality through externally funded programmes and projects. We will explore quality internships and other ways of making the most of the skills and talents of people who already have a level of experience in quality improvement. Where helpful and possible we will also seek and, or commission, support from external partners.

At the State Hospital our ambitions for a successful quality management system include:

- Clear clinical and care governance structures are in place reflecting organisational restructuring to support robust quality control and assurance.
- Quality control processes are clearly defined to help staff continuously assess, interpret and respond to variation in the system.
- New and further development of existing dashboards supporting quality assurance and improvement conversations.
- Quality Planning being evident at all levels from organisational to service applying a consistent approach.
- Population, service user, patient and staff and control and assurance data being used to inform quality plans with a focus on improving experiences, outcomes and value.
- Collaboration and networking, particularly at interfaces and interdependencies to achieve best outcomes.

What will success look like

Our five priorities are set out below, linked to ten success statements for the first phase of delivering the Quality Strategy.



9 QUALITY ASSURANCE AND IMPROVEMENT ACCOUNTABILITIES AND RESPONSIBILITIES

It is important that there is clarity about where responsibilities for quality are allocated in terms of overseeing versus delivering, supporting and practicing roles. This section details the systems for quality and identifies operational responsibilities. Appendices 2 and 3 provide further details of the structures to assure and improve the quality of care within the State Hospital.

Operational Delivery

Improvements in the quality of clinical care are best led by multi-disciplinary teams providing front line services. By providing accessible information relating to the quality of care (on a close to real time basis) we can support clinicians to focus their improvement activity in response to 'live' challenges and monitor the impact of changes made.

Whilst the clinical workforce is key to the provision of safe, effective and person-centred patient care, their role and contributions are only enabled with the support of the wider workforce. There is an absolute recognition that safety, quality and person centeredness is everyone's responsibility, and therefore every member of the State Hospital staff has a role to play.

Leaders and managers in all areas have particular responsibility as role models and enablers in the promotion of safety, quality and person centeredness and must demonstrate this through their everyday actions and behaviours.

Internal links and partnership working to support clinical quality are extensive. A number of specialist groups and committees have been set up to share and develop good practice and deliver elements of clinical quality. These committees and specialist groups have a dual reporting line: an operational management route to the Clinical Governance Group, and a governance route to either the Staff Governance Committee, Clinical Governance Committee, or Audit Committee. The specialist groups and committees are outlined in Appendix 2.

Although service leads for quality assurance and improvement are in place, all individuals and teams are responsible for applying quality assurance and improvement into practice. This responsibility is demonstrated through:

- Professional Codes of Practice and Conduct.
- Continuous professional development.
- Performance and appraisal review processes.
- Revalidation/Registration.
- Improvement activity and measurement.
- Audit.
- Evidence Based Practice.
- Personal Reflection.
- Learning from adverse events, complaints and feedback.

Management Responsibility

Individual Directors have lead responsibility for specific elements relating to the Health and Social Care Standards and the Mental Health Strategy, including the development of strategies, policies and plans for their delivery.

Each Director lead is responsible for progress reports to the Board within their area of responsibility, including principle risks to achieving their objectives and their impact on the Board's objectives and plans for the year ahead. There is a recognised executive route and Board route for reporting purposes which is detail in Appendix 3.

The Clinical Governance Group, chaired by the Medical Director, has a standing agenda section devoted to action plans in order to ensure that continuous quality improvement is embedded within the organisation.

10 GOVERNANCE

The Clinical Governance Committee ensures actions arising from clinical quality activities are implemented. The Committee has a comprehensive, rolling plan of work which ensures that all aspects of clinical governance are scrutinised by this group.

The Medical Director has Executive responsibility for Clinical Quality. The Medical Director and Director of Nursing and Operations attend and provide assurance to the Clinical Governance Committee, which monitors this Strategy, through regular reports including an annual Clinical Governance Report to the Board.

The Board receives approved minutes of Committee meetings, as well as a highlight report following each meeting to provide assurance of the detailed oversight being taken. The Committee's annual report is approved by the Board, to give assurance that the Committee is meeting its remit.

Elements of practice relating to staff professional development and support are reported to the Staff Governance Committee. However, arrangements are in place to ensure that issues impacting on patient care and treatment arising from staff governance arrangements are reported and managed through the clinical governance structure. These arrangements are reviewed annually.

The Board is responsible for taking oversight to ensure that adequate resources, including staff time, are committed to deliver the strategic goals for clinical quality.

11 EQUALITY AND DIVERSITY

The State Hospitals Board is committed to valuing and supporting equality and diversity, ensuring patients, carers, volunteers and staff are treated with dignity and respect. Strategic development incorporates consideration of the needs of all Protected Characteristic groups in relation to inclusivity, accessibility, equity of impact and attention to practice which may unintentionally cause prejudice and/or discrimination.

The State Hospitals Board recognises the need to ensure all stakeholders are supported to understand information about how services are delivered. Based on what is proportionate and reasonable, we can provide information/documents in alternative formats and are happy to discuss individual needs in this respect. If information is required in an alternative format, please contact the Person-Centred Improvement Team on 01555 842072

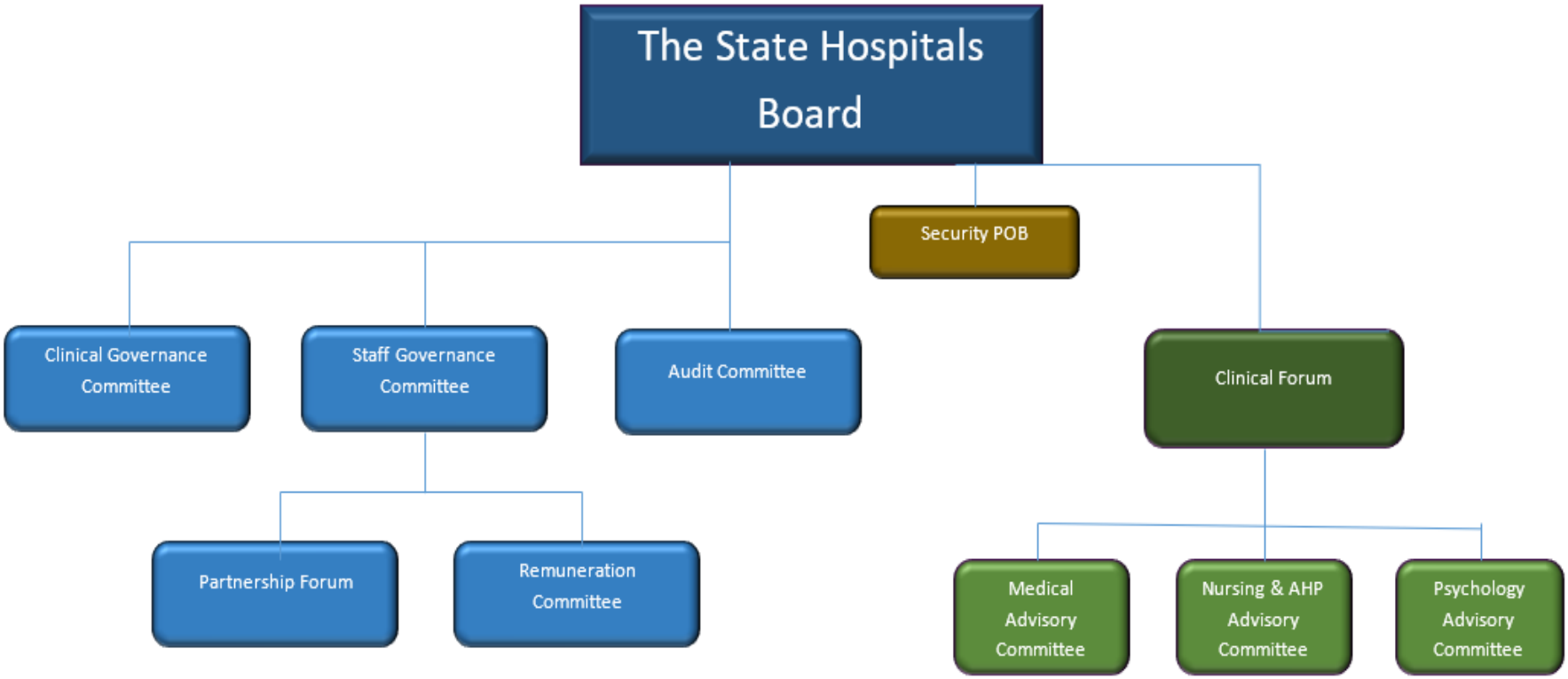
12 REFERENCES

- References Realistic Medicine: https://learn.nes.nhs.scot/18350/realistic-medicine
- Ihub – Quality Management System: https://ihub.scot/improvement-programmes/quality-management-system-portfolio/
- 90-Day Innovation cycle - IHI Innovation System | Institute for Healthcare Improvement
- Triple aim: http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx
- Quality Improvement Made Simple: Quality improvement made simple (health.org.uk)
- The King's fund – 10 key lessons for NHS leaders: Making The Case For Quality Improvement | The King's Fund (kingsfund.org.uk)

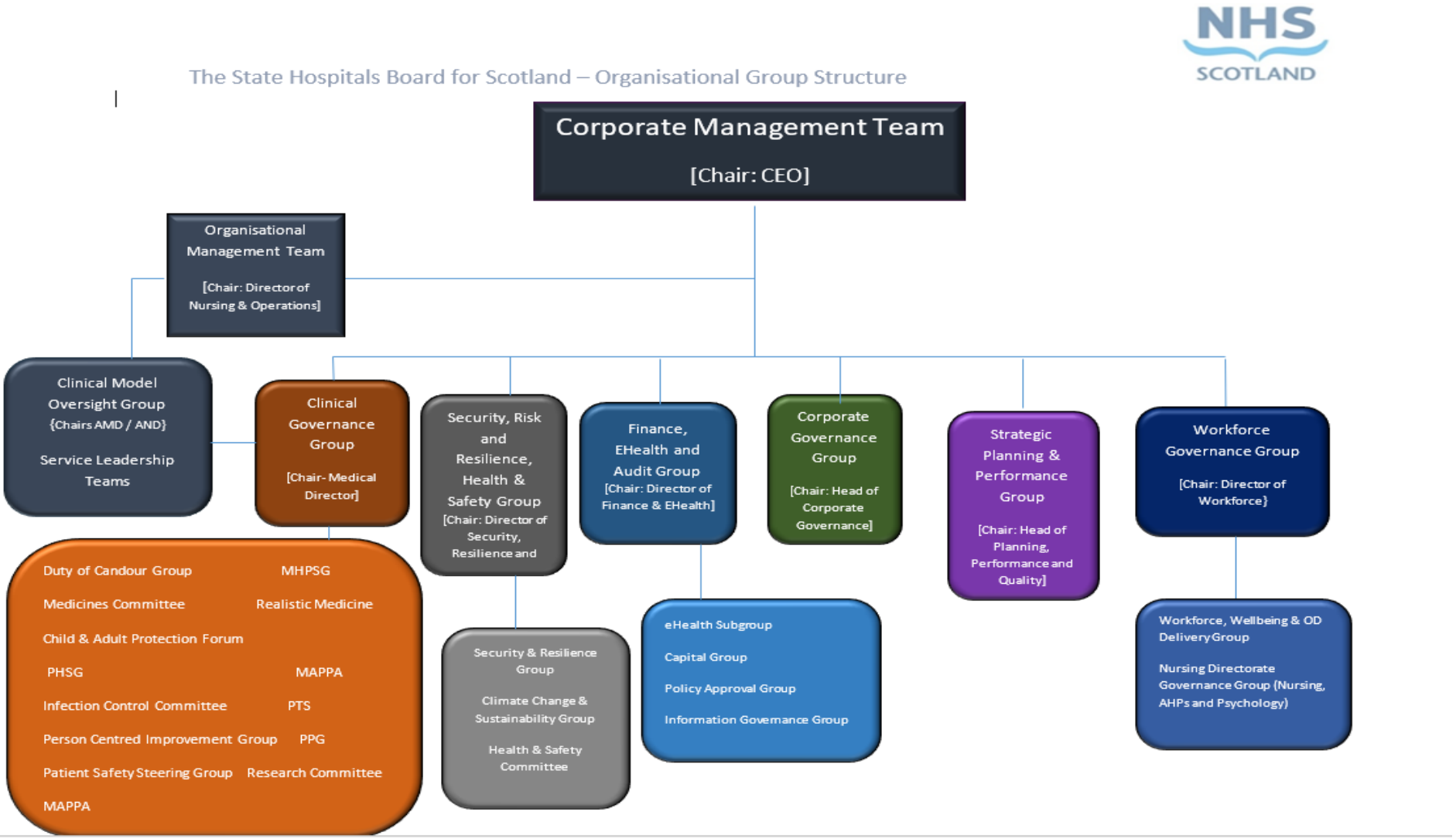
- The Health Foundation Inspiring Improvement – The measurement and monitoring of safety: https://www.health.org.uk/sites/default/files/TheMeasurementAndMonitoringOfSafety_fullversion.pdf
- Psychological Specification - The Specification for Psychological Therapies and Interventions - Delivery of psychological therapies and interventions: national specification - gov.scot (www.gov.scot)

APPENDIX 1: BOARD AND SUB-COMMITTEE/ADVISORY COMMITTEE STRUCTURE

The State Hospitals Board for Scotland – Board and Sub-Committee/Advisory Committee Structure



APPENDIX 2: ORGANISATIONAL GROUP STRUCTURE



THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2024
Agenda Reference:	Item No: 13
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning, Performance and Quality Corporate Planning Support Manager Clinical Quality Facilitators
Title of Report:	Quality Assurance and Quality Improvement
Purpose of Report:	For Noting

1. SITUATION

This report provides an update to The State Hospital Board on the progress made towards quality assurance and improvement activities since the last Board meeting in June 2024. The report highlights activities in relation to QA and QI and outlines how these relate to strategic planning and organisational learning and development. It contributes to the strategic intention of The State Hospital (TSH) to embed quality assurance and improvement as part of how care and services are planned and delivered.

2. BACKGROUND

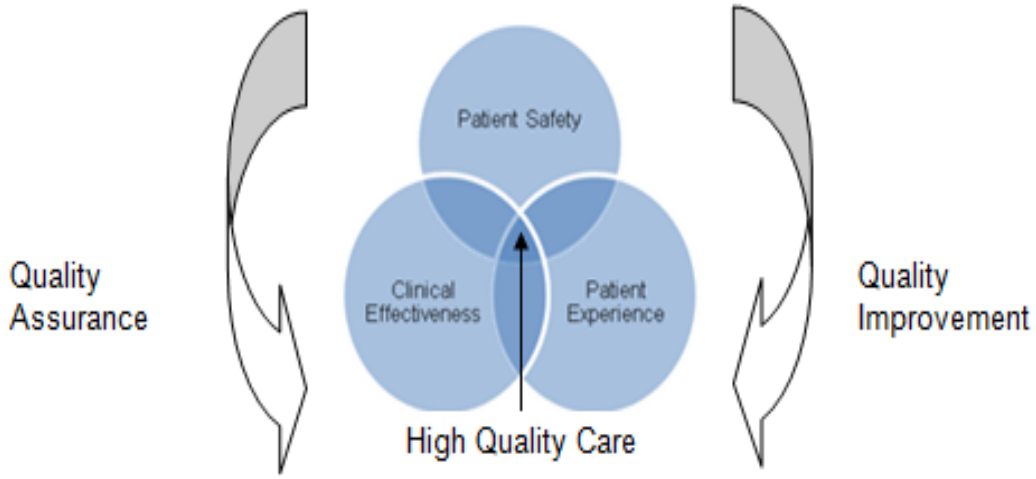
Quality assurance and improvement in TSH links to the Clinical Quality Strategy 2017 – 2020. The Clinical Quality Strategy is currently being revised, with a final draft being presented to TSH Board at its August meeting. Engagement on the draft strategy has taken place and has included patients, staff and Board members. The draft strategy has also been presented at Clinical Governance Group, Clinical Governance Committee and also Corporate Management Team.

The current Clinical Quality Strategy sets out the direction, aims and ambitions for the continuous improvement of clinical care. It outlines the following seven goals to ensure the organisation remains focussed on delivering our quality vision:

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

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

3.



ASSESSMENT

The paper outlines key areas of quality improvement and assurance activity over the reporting period, these include:

- The monthly report from the analysis of variance analysis tools and completion of three clinical audits:
  - Unvalidated progress notes
  - Nurse progress note on each shift
  - RMO record keeping
- An update on the work of the QI Forum including current training in progress for QI.
- An update on the actions associated with the Realistic Medicine portfolio.
- An overview of the evidence for quality including analysis of the national and local guidance and standards recently released and pertinent to TSH

4. RECOMMENDATION

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

MONITORING FORM

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

QUALITY ASSURANCE AND IMPROVEMENT IN TSH JUNE/JULY 2024

ASSURANCE OF QUALITY

Clinical Audit

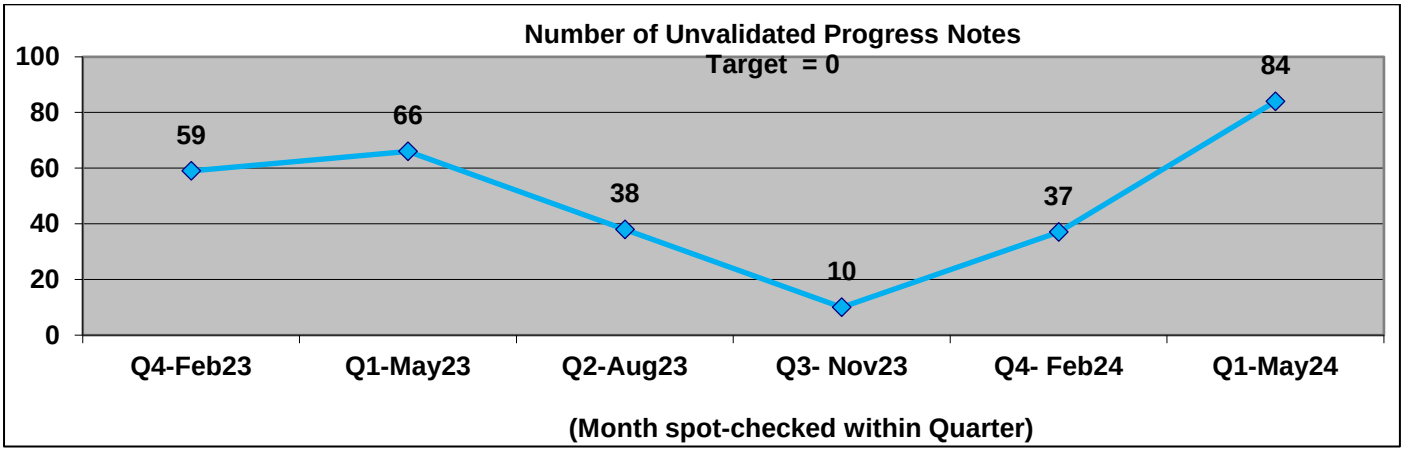
The Clinical Quality Department carries out a range of planned audits. Over the course of a year there are usually 25 – 28 audits carried out. These aim to provide feedback and assurance to a range of stakeholders that clinical policies are being adhered to. All clinical audit reports contain recommendations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

There have been 3 audits completed and actioned during this reporting period.

- Unvalidated progress notes
- Nurse progress note on each shift
- RMO record keeping

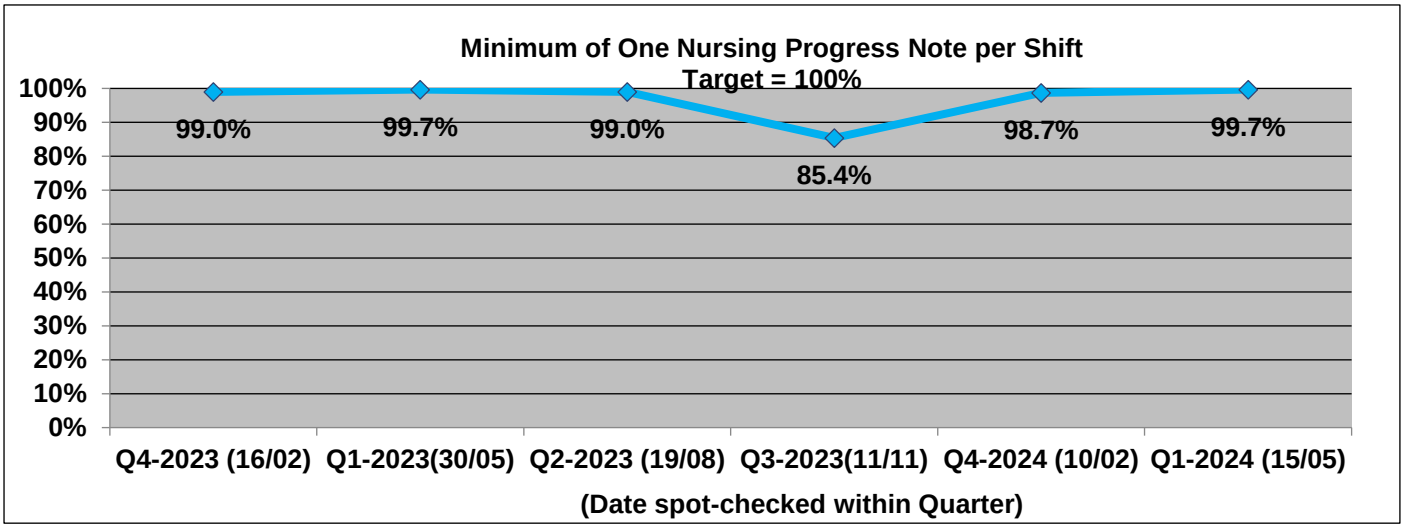
Unvalidated Progress Notes

Although we have seen an increase on the number of unvalidated progress notes, the total number of progress notes entered onto RiO for a one month period is in excess of 10,000. This equates to less than 1% of all entries having not been validated. The appropriate heads of services were notified of the increase to allow improvements to be discussed.



Nurse Progress Notes (one per shift)

As can be seen below, there was an extremely high compliance rate found in this audit. The 0.3% was relating to one patient having one progress note missing on the day shift.



RMO Record Keeping
101 patient records were checked from the month of June. Of the 101, there were 4 patients that had not been seen by an RMO in June. All 4 had been seen in May. This gave a compliance rate of 96%. This is an improvement on the previous month of 95%.

Clinical Quality continues to support the successful implementation of the Clinical Care Policy that went live on 1st May 2024. We are now able to measure the number of patients on an enhanced care plan and the staff associated within these care plans. An audit tool will be agreed in due course.

There are a number of audits due to take place in August that have been commissioned through the Medicines Committee. These are:

- Medication trolley audit
- Medicine fridge audit
- HEPMA checklist audit
- Oxygen cylinder audit

We have also started to test out a large scale project looking at HEPMA to ensure procedures are being followed. This audit will include a patient and ward audit, a check of HEMPA downtime, the time taken to complete the medication round and qualitative feedback from pharmacy. Findings will be discussed at the Medicines Committee with improvement plans put in place where appropriate.

The diabetes audit and the metabolic syndrome audit are both in the final stages and should be ready for presentation at their commissioning groups within the next month.

Variance Analysis Tool (VAT) – Flash Reports

The most recent flash report was circulated in July 2024 and covers the month of June:

HOSPITAL WIDE VARIANCE ANALYSIS FLASH REPORT

Date: June 2024

Overview and areas of good practice

This report refers to all annual and intermediate reviews held across the hospital in June 24.

The monthly VAT report is split as follows:

June 24	Annual	Intermediate	Total	VAT completion	MDT attendance
Admission	0	1	1	86%	Remained at 86%
Arran T & R	2	4	6	99%	63% - decreased from 71% in May 24
Lewis T & R	1	3	4	89%	63% - decreased from 79% in May 24
ID	1	1	2	100%	94% - increased from 85% in May 24
Transition	2	1	3	90%	Remained at 50%

In addition, data on individual Admission CPAs and Discharge CPAs will be reported to the appropriate service.

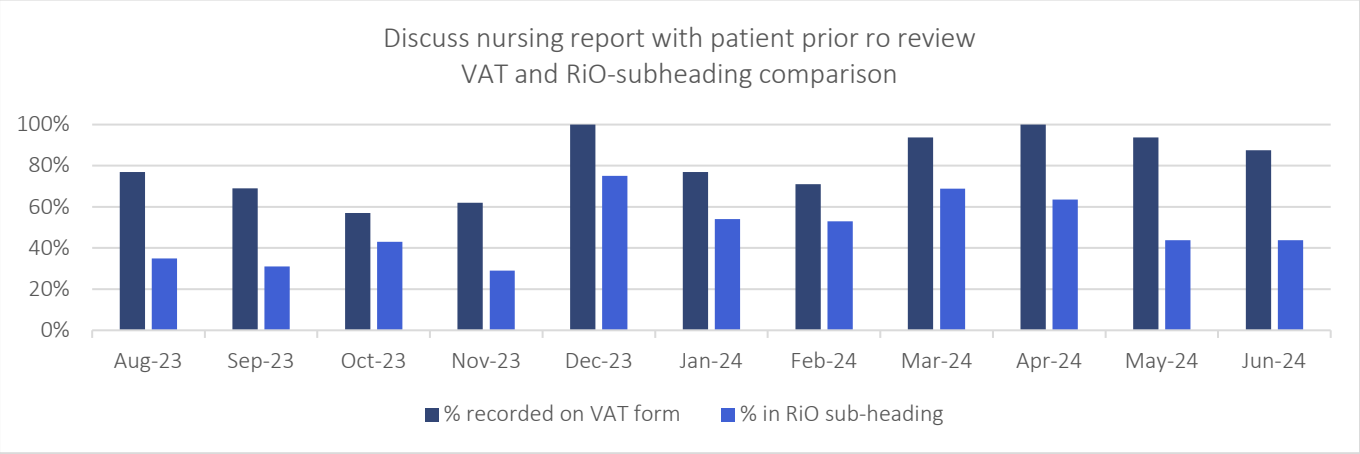
- Nursing - KW/AW attendance remained at 81%.
- Provision of Skye Activity Centre reports remained at 100%.
- Provision of Social Work reports remained at 100%.
- Provision of Security reports remained at 100%.
- Provision of Dietetic reports remained at 100%.
- Provision of Pharmact reports was 100%.
- Despite having staffing issues provision of the Occupational Therapy report remained at 81%.

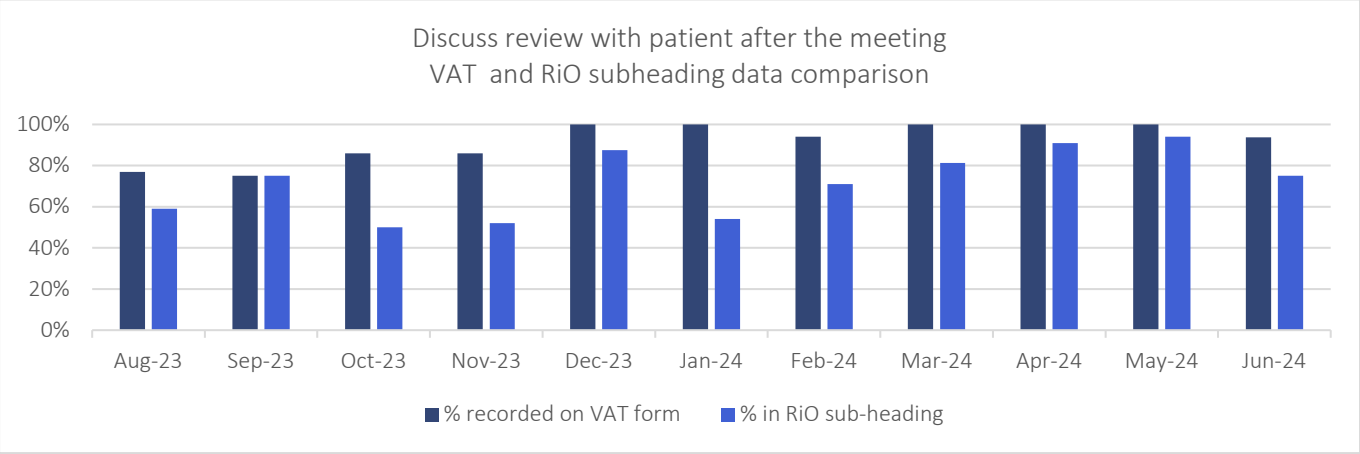
Areas of concern

- Overall VAT completion decreased slightly from 95% to 94%.
- Poor Medical VAT completion was noted in some areas - patient specific data have been forwarded to the Associate Medical Director to address this issue.
- Nursing discussion with patient decreased from 94% to 75%.
- Occupational Therapy currently have staffing issues and we saw a decrease in all OT interventions with the exception of report provision.
- Clinical Psychologist attendance decreased from 94% to 75%.
- Dietetics attendance decreased from 60% to 33%.

Any challenges with the systems that are being addressed

Going forward the VAT data will be collected direct from RiO due to the risks to the organisation in using the current system. It was initally thought that the discussion of the reports with patients would be collected going forward using a sub-heading in the RiO progress notes. The initial test with nursing has shown no sustained improvement (see graphs below) and feedback from other professions at the mock CPA event in June also expressed concern at using this method. Currently working with E-health around an alternative solution.





Ongoing VAT review looking into obtaining assurance data direct from RiO continues.

QUALITY IMPROVEMENT

QI Forum

The QI Forum's purpose is to champion, support and lead quality improvement initiatives across the hospital and raise awareness and understanding of quality improvement (QI) approaches. The QI Forum meets on a six weekly basis and has a focus to raise awareness and build capacity to support and embed QI. Over this quarter there are currently a total of eight QI projects being undertaken throughout the organisation. Outcome posters from completed projects can be found in the Quality Improvement Noticeboards in Reception.

QI Capacity Building

Qi Essential Training Cohort 2 two members of staff have fully completed the QI Essentials two day training. These two projects' overviews were: a) Evaluation of the effectiveness of a 12 week football fan in training course on the aerobic fitness of patients within a high secure forensic in-patients setting (appendix 1). b) Information was obtained via Rio timetables to identify the number of errors occurring in the entry of activity our patients attended. The aim of this project was to focus on duplication of activity entries which effected the Skye Centre activity departments

Qi Essential Training Cohort 3 is scheduled to commence the 28th of August and run over 4 half days into November 2024. Six members of staff submitted their interest in attending and to take the opportunity to learning using some of the tools available to support quality improvement projects.

Scottish Improvement Leaders (ScIL) Programme cohort 46/47: Two members of staff are currently undertaking this programme and provide the Qi Fourm with monthly updates on the course.

Scottish Improvement Leaders (ScIL) Programme Cohort 50: We have been successful in securing spaces on the upcoming Programme scheduled to starting in November 2024. This is currently being advertised locally through the staff bulletin, intranet, Quality Improvement Notice Board in Reception and through the Qi Fourm with several staff showing an interest in applying. Closing date for applications is 30th August.

Realistic Medicine

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

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

Following the submission and approval of the Realistic Medicine Action Plan for 2024/25 in March 2024 to the Scottish Government, the Realistic Medicine Team are currently focusing at three areas of the action plan.

1) Learning into Practice Group continue to meet monthly to develop the establishment of Team Based Quality Reviews whereby Service Leadership Teams will identify and review areas of good practice and areas of concerns to ascertain opportunities for learning.

   Dr Gordon Skilling and Dr Stuart Doig are currently attending staff business meeting to provide an introduction to the benefits of Team Based Quality Reviews. A series seminar has been arranged for 28th August 2024 where the Realistic Medicines Lead will provide a presentation on Human Factors and Systems Thinking which supports Team Based Quality Reviews.

2) Use of BRAN (Benefits, Risks, Alternatives and Nothing) questions as part of the Physical Health & Nutritional Care Plan Process continues to be embedded within Arran Hub. The Nurse Practice Development Team and the Realistic Medicine Programme Manager are supporting keyworkers and patients to have more meaningful conversations and provide patients with informed choices around their nutritional and physical health needs. An implementation plan has been drafted to move the Physical Health & Nutrition Care Plan Process Project into Lewis Hub where BRAN training for staff will be part of this Implementation.

3) Admission Service Leadership Team as part of the Clinical Model have commenced work to implement the activity planning process as set out in the Clinical Guidance. This aims to be a cohesive multidisciplinary decision-making process around the provision of activity within 21 days from patients admission.

The Realistic Medicine Lead will be attending the Board Development Session in October 2024 to provide the Board with an update on the Realistic Medicine.

Evidence for Quality

National and local evidence based guidelines and standards

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

Over a 12-month period, an average of 200 evidenced based guidance documents issued from a variety of recognised bodies and reviewed for relevancy by the Clinical Quality Facilitator. During the period 1 June to 31 July 2024, 17 guidance documents have been reviewed. There were 14 documents which were considered to be either not relevant to TSH or were overridden by Scottish guidance and 3 documents which were recorded for information and awareness purposes.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
Mental Welfare Commission (MWC)	2	2	0
Healthcare Improvement Scotland (HIS)_	1	1	0
National Institute for Health & Care Excellence (NICE)	14	0	0

There are currently 6 additional evaluation matrices, which have been outstanding for a prolonged period, 3 of which have completed the review process and await agreement by their allocated Steering Group. The progress of the first two evaluations (1 from HIS re Observation to Intervention and 1 from the MWC re seclusion) were temporarily paused due to TSH adapting to the COVID-19 pandemic, action on matrix completion began again at the start of July 2020. The responsibility to review these matrices changed ownership from the PMVA Review Group to the Patient Safety Group, which recommenced meetings in September 2020. Both policies were launched on 1st May 2024 and finalising compliance within the policies against the evaluation matrix has completed.

The third evaluation matrix guidance review regarding MS was temporarily been paused due to the need for further consideration regarding relevancy to this setting. It has been agreed that this guidance is for information purposes only as we currently have no patients with this diagnosis.

The fourth evaluation matrix for SIGN national guideline for stroke was delayed due to prioritizing of numerous guideline reviews by the practice nurse and GP. An adapted evaluation matrix (for pre-referral and post discharge) has now been completed.

The fifth evaluation matrix from SIGN in relation to Dementia is nearing completion of the review process with meetings having already taken place. Issues regarding availability of review members to attend a last review session has caused a delay in completion therefore it is anticipated that this process will be concluded by the end of September 2024.

The final evaluation matrix from the Scottish Government regarding substance use will be reviewed by a multi-disciplinary group in early August 2024.

Table 3: Evaluation Matrix Summary

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
HIS	From Observation to Intervention: A proactive, responsive & personalised care & treatment framework for acutely unwell people in mental health care	Patient Safety	This has been reviewed now that the Clinical Care policy has been implemented. 98% compliance has been achieved with one outstanding recommendation. This will be tabled at the next Patient Safety meeting (August) for review and final sign off where the outstanding recommendation will be added to the group's action plan.	Jan 2019	Completed July 2024
MWC	The use of seclusion	Patient Safety	This has been reviewed now that the seclusion policy has been implemented. 98% compliance has been achieved with one recommendation as an accepted variance. This will be tabled at the next Patient Safety meeting (August) for review and final sign off.	Oct 2019	Completed July 2024
NICE	Multiple sclerosis in adults: Management UPDATED	PHSG	Original decision remains that guidance is not relevant to TSH as we have no patients with this diagnosis.	June 2022	Completed July 2024
SIGN	National Clinical Guideline for Stroke	PHSG	This has been reviewed with 100% compliance achieved. The completed gap analysis will be tabled at next PHSG (August) for review and final sign off	April 2023	Completed July 2024
SIGN	Assessment, diagnosis, care and support for people with dementia and their carers	MHPSG	Document collated and review meetings have taken place. Due to ongoing delays with review group availability to finalise decisions re 5 recommendations, Chair of MHPSG taking forward with the aim of the completed gap analysis being tabled at MHPSG in September for review and final sign off	Nov 2023	September 2024
Scottish Government	Responding to substance use amongst inpatients on mental health wards – A practical guide for mental health services	MHPSG	Review group scheduled to meet early August 2024 to review content	April 2024	October 2024

Appendix 1

Intervention to Improve Aerobic Fitness of Patients

Project overview

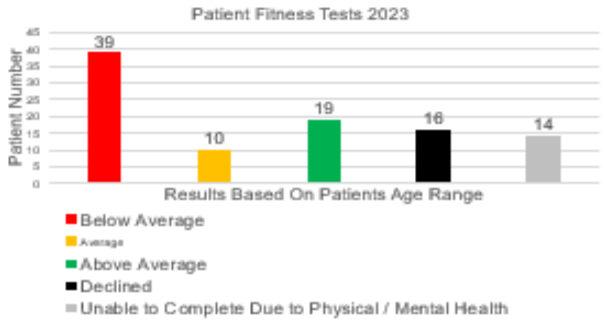
Evaluation of the effectiveness of a 12-week Football Fans in Training (FFIT) course on the aerobic fitness of patients within a high secure forensic inpatient hospital.

Project Aim:

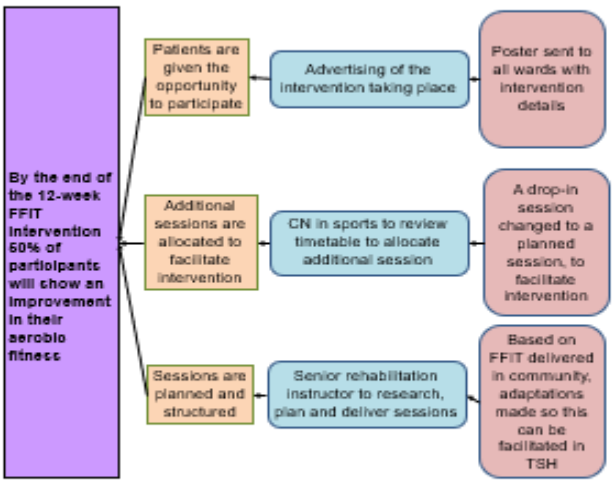
By the end of the 12-week FFIT intervention 50% of participants will show an improvement in their aerobic fitness

Method

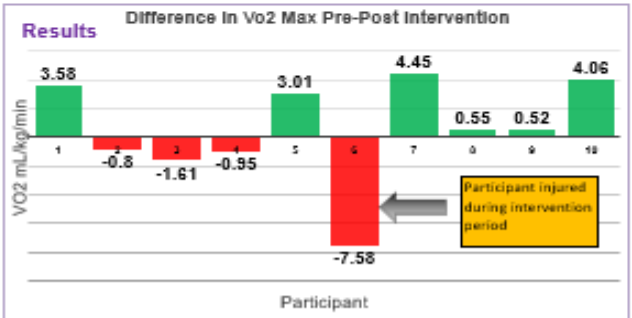
Patients are offered 6 monthly V02 max fitness testing within sports. In 2023, 68 patients completed a fitness test. The average age of participants was 36.32, the average VO2 max was 35.58 mL/kg/min. A VO2 max score of 35.58 mL/kg/min is considered an average score for a man aged 40 – 49.



Process Changes



Results



- 60% of participants showed an increase in VO2 Max from pre to post intervention.
- Average VO2 Max increased from 38.83 mL/kg/min to 39.35 mL/kg/min
- Without data outlier Average VO2 Max increased from 37.81 mL/kg/min to 39.24 mL/kg/min
- 89% attendance rate

Conclusions

- 60% of patients increased their aerobic fitness as a result of taking part in the FFIT Intervention
- Planning and delivery of structured sessions yielded positive results and an 89% attendance rate
- Taking part in FFIT resulted in an average cohort VO2 max increase

Learning points

- Challenging to engage patients in structured high intensity activity for a sustained period of time
- Changing the focus of physical activity from recreational to fitness based takes time and needs to be balanced

Achievements

- Patients see the benefit of high intensity activity in their overall fitness and difference in results
- Staff feel validated in their ongoing aim to improve the aerobic fitness of patients through encouraging physical activity

Next steps

- Consider replicating this intervention in other activities to maximise the benefits for patients across the hospital
- Consider working with MDT to maximise benefits for patients

Scottish Improvement Foundation Skills Programme (SIFS)

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2024
Agenda Reference:	Item No: 14
Sponsoring Director:	Director of Nursing, AHPs and Operations
Author(s):	Associate Director of Nursing
Title of Report:	Quality of Care Reviews (Leadership Walkarounds)
Purpose of Report:	For Noting

1. SITUATION

This paper provides Board members with an update on The State Hospital's participation in the development of a "Once for Scotland" approach to Quality and Safety/Care Assurance visits, formerly referred to as "leadership walkarounds".

2. BACKGROUND

Following queries from a number of Health Boards regarding the variation in approaches to Quality and Safety visits (aka leadership walkarounds) Health Improvement Scotland (HIS), in collaboration with the Scottish Executive Nurse Directors (SEND), commissioned a short-life working group to develop a "Once for Scotland" Quality of Care Review Guidance document to support a more standardised approach to Quality and Safety/ Care Assurance visits across NHS Scotland. This work was undertaken as part of the Excellence in Care programme.

3. ASSESSMENT

The Quality of Care Review short-life working group was established in late 2023 and includes stakeholder representation from a number of Health Boards across NHS Scotland. The Associate Director of Nursing represents The State Hospital at this forum. Over 2024 the group have developed a Quality of Care Review guidance framework that was tested across a number of services, including mental health and prison settings. Following the conclusion of testing a webinar has now been scheduled for the 25th September to formally launch the guidance.

The Quality of Care Review guidance supports a multi-professional approach to care reviews. This approach enables teams to gain a deeper understanding of the standards and quality of care that is being delivered in their area, ultimately informing the sharing of good practice and enabling improvement. Regular updates on the work of the Quality of Care Review short-life working group

have been shared with The State Hospital's Patient Safety Group and webinar details also distributed to group members. Following the formal launch on 25th September 2024 the next steps for The State Hospital will be to (re)establish Quality of Care reviews from October 2024 using the new guidance framework. These reviews will initially be supported by members of the Patient Safety forum and outcomes from the reviews reported through the Patient Safety group. Any actions required will be shared with relevant stakeholders thereafter and a summary of the reviews along with learning themes will be incorporated into the annual Patient Safety report.

4. **RECOMMENDATION**

The Board is asked to **approve** the (re)establishment of Quality of Care reviews from October 2024, with reporting through the patient Safety Group and Clinical Governance Group thereafter.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To take forward Quality of Care< excellence in Care Programme
Workforce Implications	No identified change
Financial Implications	No identified change
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board requested report
Risk Assessment (Outline any significant risks and associated mitigation)	No additional risk identified
Assessment of Impact on Stakeholder Experience	As detailed within Paper
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick (✓) One; ✓ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2024
Agenda Reference:	Item No: 15
Sponsoring Director:	Medical Director
Author(s):	PA to Medical & Associate Medical Directors
Title of Report:	Approved Medical Practitioner
Purpose of Report	For Decision

1 SITUATION

It is necessary for the Board to consider the approval of Approved Medical Practitioner status for one of our Specialty Doctors.

2 BACKGROUND

In order for the Specialty Doctor to perform their full role within the Hospital they require to be approved as an Approved Medical Practitioner (AMP) and placed on the State Hospitals Board for Scotland list of AMPs. An Approved Medical Practitioner (AMP) is a medical practitioner who has been approved under section 22 of the Act by a NHS Board or by the State Hospitals Board for Scotland as having special experience in the diagnosis and treatment of mental disorder.

3 ASSESSMENT

The Specialty Doctor has completed the pre-requisite Section 22 training in line with the Mental Health (Care and Treatment) (Scotland) Act 2003. A copy of the training certificate is included for information.

4 RECOMMENDATION

The Board is invited to agree the following recommendation:

The approval of Dr Mason McGlynn as Approved Medical Practitioner in line with the Mental Health (Care and Treatment) (Scotland) Act 2003 and that he is formally placed on the TSH Board's list of Approved Medical Practitioners.

SoFMH
School of Forensic Mental Health

NHS Education for Scotland

Certificate of Attendance

This is to certify that

Mason McGlynn

Attended a one day online

AMP Initial Training Course

On 1st August 2024

For s22 of the Mental Health (Care and Treatment) (Scotland) Act 2003

and was successful in the following modules:

AMP Part 1, Module 1: General
AMP Part 1, Module 2: Civil Compulsory Powers
AMP Part 1, Module 3: MWCS & MHTS
AMP Part 1, Module 4a: Forensic Psychiatry
AMP Part 1, Module 4b: Forensic Psychiatry
AMP Part 1, Module 5: CAMHS

ID 111374
GMC 7602724

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE

CGC(M) 24/02

Minutes of the meeting of the Clinical Governance Committee held on Thursday 23 May 2024

This meeting was conducted virtually by way of MS Teams, and commenced at 09.30am

Chair:	
Non-Executive Director	Cathy Fallon
Present:	
Non-Executive Director	Stuart Currie
Vice Board Chair	David McConnell
In attendance:	
Associate Nurse Director	Josephine Clark [Item 17]
Consultant Forensic Psychiatrist	Dr Khuram Khan
Skye Centre Senior Charge Nurse	Alexandra MacLean [Item 15]
Director of Nursing and Operations	Karen McCaffrey
Patient Learning Manager	Julie McDonald [Item 8]
Finance & eHealth Director	Robin McNaught
Head of Corporate Planning, Performance & Quality	Monica Merson
Board Chair	Brian Moore
Head of Corporate Governance & Board Secretary	Margaret Smith
Head of Clinical Quality	Sheila Smith
Medical Director	Professor Lindsay Thomson
Lead Pharmacist	Nicola Watkins [Item 6]

1 APOLOGIES AND INTRODUCTORY REMARKS

Ms Fallon welcomed everyone to the meeting and apologies were noted from Ms Shalinay Raghavan, Non-Executive Director. It was also noted that Dr Elizabeth Flynn, Head of Psychology, Allan Hardy, Head of Risk and Resilience, Gary Jenkins, CEO and David Walker, Director of Security, Estates and Resilience were unable to attend.

2 CONFLICTS OF INTEREST

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

3 TO APPROVE THE MINUTES OF PREVIOUS MEETING

The Committee approved the Minutes of the previous meeting held on 8 February 2024

The Committee:

1. Approved the minute of the meeting held on 8 February 2024.

4 MATTERS ARISING

i. Cat 1 23/01: Medication Incident Update

Professor Thomson informed the Committee that the investigation into the incident had stalled due to the unavailability of a staff member considered crucial to the investigation. Consideration was given to concluding the investigation and making reasonable recommendations in their absence, and this will occur if a resume to work date is not forthcoming.

ii. Supporting Healthy Choices Interim Update

Dr Khan provided an update on the implementation of the Supporting Healthy Choices programme, which was part of the overall Physical Health Steering Group work. Dr Khan advised that the action plan for Supporting Healthy Choices had been completed and the process of categorising steps into short, medium or long term was underway. A small pilot project was taking place within the Admission service with the overall aim of preventing patients from gaining weight when admitted to the hospital. Three patients had been identified as being in the pre-admission care programme and a further three patients within the Admissions Service.

These patients would have nutritional and physical care plans implemented. There were plans to help patients optimize their overall physical activity as well as making reasonable choices within the hospital shop and supporting staff to open the Hubs as much as possible to provide activities. An update on the pilot should be available by the end of July.

Dr Khan also informed the Committee that patients continued to have high BMIs and that the hospital had not met the KPI target for physical activity, currently at 62%.

Mr Currie asked for clarity on what the average BMI is in Scotland. Professor Thomson advised that 65% of Scottish adults were in the obese or overweight category. She explained that the decision to make the Admissions Service the priority for the pilot was because the majority of the patients who come to the hospital would go on to develop a weight problem, or an existing weight problem would deteriorate. The State Hospital (TSH) had a duty of care to put measures in place to help patients to make progress in this regard. It was hoped to measure progress in a different way through this project, to clearly see the improvements being made within the Admission Service.

Mr McConnell remarked on the link between some antipsychotic medications and weight gain and asked if this was taken into consideration, and Professor Thomson underlined the difficulty of this albeit that antipsychotic medication less likely to cause weight gain would be used where possible. She advised that previous projects carried out had shown that patients who did not receive such medications also gained weight within the TSH environment. In response to a question from Mr Moore on wider involvement by the medics with staff, Dr Khan confirmed that there had been wider engagement, and that there was widespread awareness of this issue. Dr Khan added that BMI was an important guide to who is at risk of Metabolic Syndrome adding that the hospital was good at mitigating the risks of the different elements of this. By way of comparison, he advised that within Broadmoor Hospital currently the percentage of patients with Diabetes was 25%, whereas at TSH it was 10%.

Ms Fallon thanked Dr Khan for the update adding that it was helpful to see the steps taken to support patients to optimise their physical health, and it was agreed that a further update would come to the next meeting.

Action: K Khan

The Committee:

1. Noted the updates.
2. Agreed that a further update would come to the next meeting.

5 PROGRESS ON ROLLING ACTIONS LIST

The Committee received the Rolling Actions list noting progress since the last meeting.

Ms McCaffrey advised that in relation to Item 2: *IC Annual Report –Skye Centre & Islay Water Leaks and Damage,* a company had attended to assess the water damage to the Skye Centre. Once received their inspection report would be submitted to the Infection Control Committee and an update to this Committee would follow. Ms Fallon expressed disappointment that this issue was first brought to the Committee's attention over a year ago, and is still not resolved.

The Committee:

1. Noted the updates from the Rolling Actions List.

6 MEDICINES COMMITTEE / PHARMACY REPORT

Members received and noted the Medicine Committee / Pharmacy Report presented by Ms Nicola Watkins, Lead Pharmacist. Ms Watkins provided a brief overview of the report, highlighting the work undertaken within the last 12 months. All targets set out the previous year had been met, with the exception of HEPMA (electronic prescribing) full benefits realisation. Ms Watkins explained that in terms of this, discussions were taking place weekly with NHS Lothian in regards full data access. The next large piece of work identified for next year, once the safe use of medicines policy and e-learning had been completely rolled out, would be to establish guidelines for the use of Lithium.

Mr McConnell thanked Ms Watkins for the report and asked for clarity surrounding the HEPMA full benefits realisation, in terms of the support available, and what benefit would be obtained from the new reporting system. Ms Watkins assured the Committee that the team was well supported within TSH and by NHS Lothian's HEPMA team. The benefit of the new system would allow for quick and easy access to medication related queries, which at present was a manual process. Discussions were taking place with NHS Lothian in relation to Information Governance for data sharing, and there should be access to all the main reports required within the next two months.

Professor Thomson thanked the Pharmacy Department, noting it was well managed and provided confidence that all aspects were carried out safely. Professor Thomson added that the report provided reassurance, in relation to the scale of medication prescribed, dispensed and administered, that the number of incidents was relatively small.

Ms Fallon also thanked Ms Watkins on behalf of the Committee, and echoed Professor Thomson's comments.

Ms Fallon noted a potential discrepancy between figures contained on Page 7 of the report and the figures contained within the Incident Report (Agenda Item 11) and asked for clarity on this. Ms Watkins agreed to check this and report back the correct figure.

Action: N Watkins

The Committee:

1. Noted the Medicines Committee / Pharmacy Report.
2. Requested clarity on data contained within the report.

7 CLINICAL GOVERNANCE COMMITTEE ANNUAL REPORT 2023/24

Members received and noted the Clinical Governance Committee Annual Report and stock take presented by Ms Sheila Smith. Ms S Smith explained that the report was a summary of all items

brought before the Committee over the last 12 months and that before the submission of the report all information was passed by the original authors to ensure they were happy with the summarised version of their information.

Ms Fallon thanked Ms S Smith and stated that report showed the amount of hard work carried out by staff groups and by the Committee throughout the year.

The Committee:

1. Approved the Clinical Governance Annual Report 2023/24.

8 PATIENT LEARNING REPORT 2023

Members received and noted the Patient Learning Report for 2023 presented by Ms Julie McDonald who provided an overview of the report and highlighted an increase in patient engagement by 10% compared to the previous year. Ms McDonald provided a breakdown on the various learning achievements and courses patients have undertaken and advised that currently there is a consultation process underway to look at introducing KPI's for Patient Learning, which once agreed would be included in future reports.

Mr McConnell thanked Ms McDonald for the report and asked for clarity surrounding the data within Table A that appeared to show a drop in uptake. Ms McDonald explained that this may relate to the number of programmes still ongoing, with some not due to reach completion until December. Ms Fallon thanked Ms McDonald and asked if she could provide the Committee with an update of the number of patients who had commenced on programmes this year.

Action: J McDonald

Professor Thomson thanked Ms McDonald for a very positive report adding that the service made a great difference to patients' lives. Professor Thomson assured the Committee that work was underway via a Skye Centre review to improve the availability of sessions for patient learning as these had decreased. Professor Thomson also commended the fact that learning needs were tailored to patient groups with consideration given to the Intellectual Disability population.

Mr Moore thanked Ms McDonald for an excellent report remarking on the variety of learning programmes and the achievement of formal qualifications. He asked what the key ambitions were moving forward post COVID. Ms McDonald advised that the aim was to get the learning service back to pre COVID numbers and to look at ways to reduce the likelihood of disruption to services due to staffing pressures. Ms McDonald added that focus remained on basic literacy and numeracy skills so that when patients move on they are able to carry out everyday tasks. At the same time, introducing qualifications that patients preferred to achieve encouraged them to want to learn.

The Committee:

1. Noted the Patient Learning Report 2023.
2. Requested further data on patients commencing learning programmes.

9 INFECTION CONTROL ANNUAL REPORT 2023/24

Members received and noted the Infection Control Annual Report 2023/24. Ms McCaffrey opened by advising the Committee Karen Burnett, Infection Control Nurse was moving on and noted her thanks to Ms Burnett for her work within the hospital over the years in relation to infection control and in particular her guidance throughout the COVID pandemic.

Ms McCaffrey provided an overview of the report noting that it was now set out based on the

standards set, on a business as usual model. Ms McCaffrey highlighted key areas within the report and outlined steps taken in relation to any areas that needed addressed. She noted less COVID activity within the report, as with previous reports, with reassurance that any small outbreaks were managed effectively.

Mr Currie referred to a fall in the uptake of vaccinations and asked if patients were aware of the potential risks of not taking these. He also asked if there was a potential for vaccinations to interfere with psychotropic medication.

Ms McCaffrey assured the Committee that the patients were fully supported and aware of the benefits of vaccinations; however, they had the right to refuse. Ms Merson advised that a new Scottish Government initiative whereby the COVID and Flu vaccination rates would be monitored nationally as part of the annual delivery plan reporting, would demonstrate TSH performance against other NHS boards. On questioning, Professor Thomson provided assurance that vaccinations did not interfere with psychotropic medication.

Mr McConnell noted that the BBV Admission Assessments and the Annual Care Risk Assessment audit results had decreased, in comparison to the overall strong BBV systems in place. Ms McCaffrey provided assurance that there were no significant impacts as a result.

Ms Fallon thanked Ms McCaffrey for a comprehensive report adding that it reassured the Committee that spikes in data were handled quickly. Ms Fallon added thanks on behalf of the Committee, to Ms Burnett for her contribution over the years.

The Committee:

1. Noted the Infection Control Annual Report for 2023/24.

10 CORPORATE RISK REGISTER - CLINICAL RISKS

Members received and noted the Corporate Risk Register - Clinical Risks update. Professor Thomson gave a brief summary of the information contained within the report and advised there were no out of date risks.

- **ND 73, Lack Of Soft Restraint Kit Training and Staffing**, there have been no incidents therefore this now meets the criteria ‘Rare’
- **ND71, Corporate Risk**, reduced from ‘High’ to ‘Medium’

The Committee were content to agree the changes as outlined, including the reduction in Risk ND71 from a high to medium risk grading.

The Committee:

1. Approved the Corporate Risk Register – Clinical Risks.

11 INCIDENTS AND PATIENT RESTRICTIONS REPORT Q4

Members received and noted the Incidents and Patient Restrictions Report Q4. Professor Thomson asked the Committee to note that although the report was for the last quarter, the report contained information for the full year 2023/24.

Professor Thomson highlighted an increase in Personal Attack Alarms (PAA) Activations and Physical Restraints and provided the rationale for this. She explained that the percentages quoted in Table one, column two, were worked out by the average number of patients throughout the year and showed an increase in the use of Handcuffs and in PAA Activations. By way of reassurance, Professor Thomson added that the assault tracker would trigger a review of a patient’s care if

appropriate. She also highlighted a decrease in staff resourcing incidents by a third, although the hospital continued to be clinically busy.

In relation to the increase PAA activations, Mr McConnell asked if this was due to the new PAA system and staff being unfamiliar with devices or if it was in relation to patient acuity. He also sought clarity surrounding the 122% figure in Table one in relation to PAA calls. Professor Thomson confirmed that the increase was not due to the new PAA system and the majority of the activations were staff requiring assistance. In relation to the figure in Table 1, Professor Thomson added that a footnote would be included in respect of the data going forward to provide additional clarity as this figure was correct.

Mr Moore asked for clarity regarding Staff Harassment, and in particular, how external phone calls were directed to staff. Professor Thomson explained the process for dealing with external calls, through the switchboard system.

Ms Fallon thanked Professor Thomson for the report.

The Committee:

1. Noted the Incidents and Patient Restrictions Report Q4.

12 PATIENT MOVEMENT STATISTICAL REPORT

Members received and noted the Patient Movement Statistical Report presented by Professor Thomson who provided an overview of the content. At the time of writing the report 97 beds were noted as occupied, which had increased to 100 beds occupied at today's date. Professor Thomson clarified that due to a technicality of the timing of the report it showed eight patients had won their excessive security appeals with only seven showing as being fully accepted. Professor Thomson suggested to the Chair that given that this reporting came to the Committee and to the Board, revision of the format of the report may be helpful to allow for a more consistent framework.

Action: L Thomson / M Smith

In response to a question from Mr Moore about exceptional circumstance admissions, Professor Thomson confirmed that TSH was not presently accepting such admissions placing this within the context of clinical activity within TSH. She added that clinical decision-making on admissions remained focused on patient requirements, and whether or not patients required high security care.

Ms Fallon thanked Professor Thomson for the report and for the suggestion to work on the format of the report.

The Committee:

1. Noted the Patient Movement Statistical Report.
2. Agreed that the report formatting should be reviewed.

13 NURSING RESOURCE REPORT

Members received and noted the Nursing Resource Report presented by Ms McCaffrey who highlighted the impact of nursing staffing levels on the provision of clinical care and actions taken to address this during the period. Ms McCaffrey summarised the report informing the Committee that although the risk was currently at high on the risk register, there is a process underway to review the risk, in particular some of the metrics used to quantify this. This review was in the draft stages and would be brought back to the Committee.

Ms McCaffrey added that it was encouraging to see the growth in the use of Supplementary Staff

Register (SSR) and this was something that would be promoted to staff during the retirement process. She also highlighted the focused efforts of staff in terms of resourcing which had contributed to the decrease in ward closures. In relation to the Health and Care Staffing Act, effective 1 April 2024, Ms McCaffrey advised that feedback received from Scottish Government in respect of the Q3 report had been very positive.

Mr McConnell commented on the changes in the recording of modified working and ward closures and Ms McCaffrey advised that this had been re-framed to take into account the improvements made, and to better demonstrate any current impact on patients' activities. Mr Currie noted the improvements made in this area, and the way reporting linked to wider workstreams. He was also encouraged by the steps taken to proactively recruit staff, as well as the positive feedback in relation to the Health and Care Staffing Act.

Ms Fallon thanked Ms McCaffrey for the report stating that it showed movement in the right direction and noted an error in the table on Page 2, which was showing the wrong figures. Ms McCaffrey acknowledged this and advised she would share the amended figures with the Committee. Ms Fallon also asked for clarity on staff variance and overtime payments. Ms McCaffrey clarified that this was not a direct link, with other factors also having an impact e.g. clinical activity especially for out boarding patient when required.

Action: K McCaffrey

The Committee:

1. Noted the Nursing Resource Report.
2. Requested clarification of the data on page 2 of the report.

14 DAY TIME CONFINEMENT UPDATE

Members received and noted the Day Time Confinement (DTC) update provided by Ms McCaffrey who advised that the four work streams looking at various aspects surrounding DTC had mostly completed their work. She noted considerable efforts had been made to reduce instances of DTC, however, the boarding out of patients continued to impact resourcing. The group were considering the move to business as usual governance routes.

Mr Moore asked what areas the proposed Short Life Working Group for unscheduled care focus on next. Professor Thomson advised that this would be looking at improving the route into A&E departments in the context of the safety and resource issues behind that. Professor Thomson added assurance that the Clinical Governance Group would take oversight on monitoring, along with the Activity Oversight Group. The aim would be to step up attendance at the Skye Centre, as well as increasing meaningful activities in the Hubs.

Ms Fallon thanked Ms McCaffrey for the update and commented that it was helpful and encouraging to note the move towards business as usual.

The Committee:

1. Noted the Daytime Confinement Update.

15 LEARNING FROM FEEDBACK REPORT Q4

Members received and noted the Learning from Feedback Report Q4 presented by Ms Alexandra MacLean, Skye Centre Senior Charge Nurse. She highlighted the positive feedback received regarding the festive events, food and other events that took place within the Skye Atrium and Sports Departments. Also of note was that staff from the ID service and the Catering Manager had been looking into solutions surrounding issues some patients had experienced in relation to their food presentation. Feedback was also received regarding the use of the wander paths, with

patients asking when these would be in use again. The Estates team have this on their work plan to be addressed. Ms MacLean also noted patient feedback relating to the amount of resourcing child visits require, impacting on other visits. She advised that a review of this had allowed multiple visiting slots to be offered when required, to increase capacity. This change had been received well by patients and carers.

Mr Currie thanked Ms MacLean for the report noting that it built confidence to see feedback being taken on board. He asked how we feedback any changes made to patients and carers. Ms MacLean advised that patients who attend the PPG group take responsibility as ward representatives to feedback outcomes to their peers. There were also ward based community groups held which informed patients of outcomes. In relation to patients who do not engage well with these groups, staff within the PCIT and Skye Centre had a good knowledge and understanding of these patients and would also provide feedback on a one to one basis.

Ms Fallon thanked Ms MacLean for the report and for raising the issue of the child visits and the steps taken to resolve this. Ms Fallon added that the report was very helpful to the Committee in providing up to date information that may not come through in other reports or information.

The Committee:

1. Noted the Learning from Feedback Report Q4.

16 LEARNING FROM COMPLAINTS REPORT Q4

Members received and noted the Learning from Complaints Q4 Report presented by Ms Margaret Smith. Ms M Smith provided a summary of the report relating to the number of complaints received and closed within this period as well as any learning taken. She noted an increase in complaints received and provided background into the reasons for this. She advised that there was currently an ongoing internal reflective review, which meant that full responses to these complaints would follow once the review was concluded.

Ms Smith highlighted an area where action had been taken in response to complaints made. This was in relation to pool tables within two Hubs which had been condemned, leaving a gap in availability of this within these Hubs. New pool tables had now been installed within two Hubs, and replacements for the other two Hubs had been ordered to avoid the same situation arising again.

Ms Smith informed the Committee that an internal audit carried out by RSM into the Complaints Service was recently concluded, with the draft report recommending substantial assurance could be taken. This would be submitted to the Audit and Risk Committee, and would come to this Committee for information in due course. Ms Fallon thanked Ms Smith for the report and commended the Complaints Department on the outcome of the internal audit adding that the report, alongside the Learning from Feedback Report was helpful and highlighted the importance of group activities.

Mr Currie also thanked Ms Smith adding that it was helpful to provide context surrounding the complaints detailed within the report and remarked on the diligence displayed within the Complaints Department. Mr Currie asked, in relation to complaints surrounding staff attitudes and behaviours, if this was part of the induction process. Ms Smith confirmed that she had discussed this with the Organisational Development Manager, suggesting that within the Corporate Induction the complaints presentation should be aligned to the section on NHS Values and Behaviours as this was a good fit. The Committee agreed that this was a helpful way forward.

The Committee:

1. Noted the Learning from Complaints Report Q4.

17 DISCUSSION ITEM: NEW CLINCAL CARE POLICY

Ms Clark provided the Committee with a presentation on the New Clinical Care Policy. She led the Committee through a series of slides, providing background into the policy and what it involved. She also detailed the background to the change and why the policy was being introduced and confirmed that the policy had become effective as of 1 May 2024. Ms Clark added that as laid out within the new policy, TSH would proactively inform the Mental Welfare Commission (MWC) if any patients were on enhanced care for a period greater than three months.

Professor Thomson thanked Ms Clark for bringing the topic to the Committee adding that this clinical care policy was a more modern approach to working and involved a major change in the way of thinking. She added that the change had been implemented well, with time being taken to ensure this. Professor Thomson agreed that the new care plan provided an opportunity to look again at staffing levels for patients on enhanced care and that the approach was a more individually tailored way of caring for patients.

Mr Moore welcomed the new policy adding that it was a more individualised approach to care. He reiterated the points mentioned by Ms Clark that the MWC would be kept informed and that in time the policy may be shared with other organisations. Ms Merson commented that a review of patients on enhanced care at 28 days was a helpful trigger and would prove helpful in monitoring impacts going forward.

Ms Fallon thanked Ms Clark for the comprehensive information surrounding the policy. She commended the team for bringing this piece of work forward and the proactive involvement of the MWC. She asked for clarification if Carers were included as part of the feedback process, and Ms Clark confirmed that they were.

The Committee:

1. Noted the New Clinical Care Policy.

18 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

The Committee noted the following areas of good practice:

- Daily medicines report for the non-administration of medication and the e-learning module on the Safe Use of Medicines.
- A member of staff had maintained contact with a patient who had moved on to enable them to continue with their degree.
- Good practice in relation to the linking complaints training to NHS Values and Behaviours within Corporate Induction.

19 COMMITTEE WORKPLAN 2024/25

Members received the Committee Work plan for 2024/25. Ms Fallon noted the only point to raise was the issue of whether the Corporate Parenting Strategy should be added, and this would be reviewed

Action – Secretariat / Ms McCaffrey

The Committee:

1. Noted the Clinical Governance Committee Workplan.

20 ANY ISSUES ARISING TO BE SHARED WITH OTHER COMMITTEES

It was noted that the Audit and Risk Committee had highlighted the internal audit plan for the current year, in terms of the timing of the audit on Patient Health.

Ms Fallon suggested that it would be helpful for the Committee to keep oversight of the impact of redeployment on learning activity and the initiative in support of patient outings.

21 AGREEMENT OF ITEM FOR DISCUSSION AT NEXT MEETING

Professor Thomson suggested that an update on the Clinical Model evaluation was presented at the next meeting.

22 ANY OTHER BUSINESS

No other business was presented by the Committee members.

22 DATE OF NEXT MEETING

The next meeting would be held on Thursday 8 August 2024 at 0930 hours via Microsoft Teams.

The meeting concluded at approx. 1230 hours

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2024
Agenda Reference:	Item No: 16
Report Author:	Head of Corporate Governance
Title of Report:	Clinical Governance Committee – Highlight Report
Purpose of Report:	For Noting

This report provides the Board with an update on the key points arising from the Clinical Governance Committee meeting that took place on 8 August 2024.

1	Corporate Risk Register / Risk Reporting	The Committee reviewed the clinical risks within the Corporate Risk Register, and agreed that reporting represented an accurate statement of risk.
2	Quality Strategy	The draft strategy was presented to the Committee, who commended this workstream and the product. This had been reviewed previously in detail within a Board Development Session, and members were content to approve this for submission to the Board, with some minor amendments suggested. This would be a valuable document, and there was focus on how to engage staff more widely across the organisation.
3	Annual Reports: -Duty of Candour -Mental Health Practice Steering Group -Research Committee -Rehabilitation Therapies	The Committee noted annual reports in these key areas, each of which summarised activity. The helpfulness of reporting from Rehabilitation Therapies across specialisms was acknowledged, and good practice in 'Activity Boxes' for patients on enhanced care, who may otherwise be hard to reach.
4	Scottish Patient Safety Programme	The Committee received an update on the delivery of the programme, focused within TSH on the mental health strand, including the current programme of work and future aims and ambitions. The Committee requested an update on the delivery of Quality and Safety Visits, and it was confirmed that reporting would be brought to the Board at its meeting this month.
5	Psychological Therapies – 6 Month Report	Reporting included updates on the delivery of core activity over the past 6 months including talking and group therapies. The launch of the National Specification for Delivery of Psychological Therapies was noted and that for TSH, the first step in moving towards adherence to this Specification is to

		establish a Psychological Therapies Governance Group.
6	Bed Capacity Report	Reporting provided data across patient admissions and transfers, as well as through services within TSH, within the context of the wider forensic estate. It was noted that 11 wards were currently in use, to deliver services.
7	Incident Reporting and Patient restrictions	The Committee received quarterly reporting on the types and numbers of incidents, including RIDDOR reporting and serious adverse events, and patient restrictions during this period. It was noted that services within the ID service had been tailored to meet patient acuity, and that a further update would come to the Committee in this respect.
8	Nurse Resourcing	The Committee noted the improving position in recruitment within nursing, and the pressures due to sickness absence. The positive work taken forward with an Open Day being held to promote TSH as an employer of choice, was noted.
9	Infection Prevention and Control Update	The Director of Nursing and Operations provided an update, with no areas of concern, and noted that the position of lead for IPC had been filled, with a start date in August.
11	-Learning from Complaints -Learning from feedback	The Committee received reporting to summarise the activity within the Patient Centred Improvement Team, in respect of patient feedback, as well as reporting in respect of complaints activity across the quarter. There was focus on how to consider how learning and actions could be considered, as well as agreement that reporting for complaints and feedback would be collated into a singular report going forward. It was also noted that internal audit had given a rating of substantial assurance in respect of complaints management.
13	Clinical Model Evaluation	The Medical Director presented a summary of service delivery, to provide a basis of evaluation of the clinical model, implemented in July 2023. There was consideration from members in terms of gaining assurance that the model was delivery what had been intended, particularly in maximizing resources for the benefit pf patients. The Committee also noted the need to measure staff feedback and noted the role of Organisational Development in coordinating in this area.
14	Areas of good practice/concerns	The Committee noted good practice in the Rehabilitation Therapies report, in respect of ‘Activity Boxes’.

RECOMMENDATION

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

MONITORING FORM

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

Paper No: 24/70

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2024
Agenda Reference:	Item No: 17
Sponsoring Director:	Director of Workforce
Author(s):	Head of HR / Head of OD & Learning
Title of Report:	Staff Governance Report
Purpose of Report:	For Noting

1 SITUATION

This report provides a summary of ongoing activity in relation to key staff governance factors.

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

2 BACKGROUND

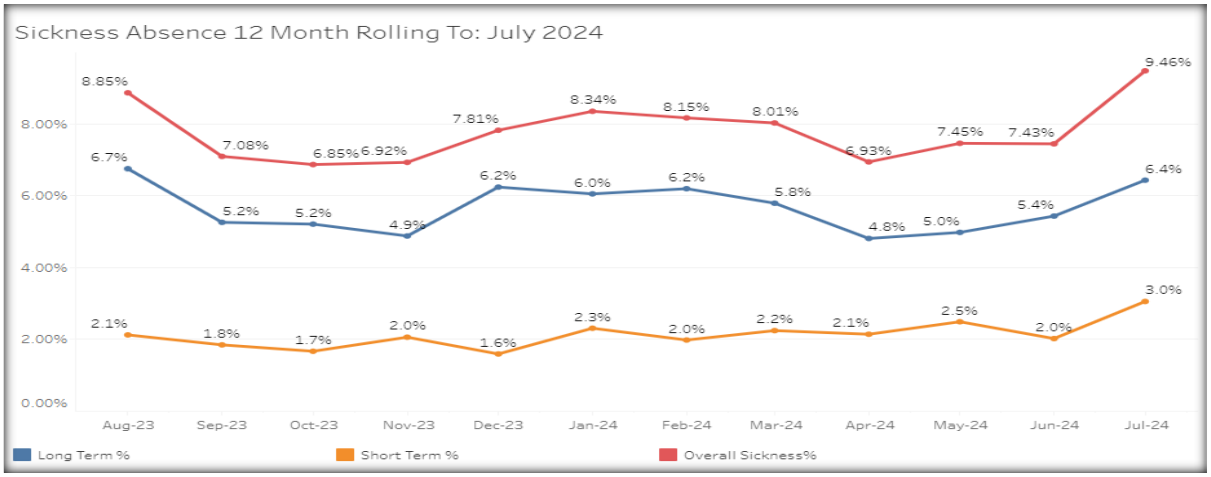
The Workforce Directorate consist of HR, Learning, Training & Development and Occupational Health Services.

The Teams work closely together to support Managers and Staff within TSH on a number of key areas and this report details the key performance metrics for each area.

3 ASSESSMENT

HR Update

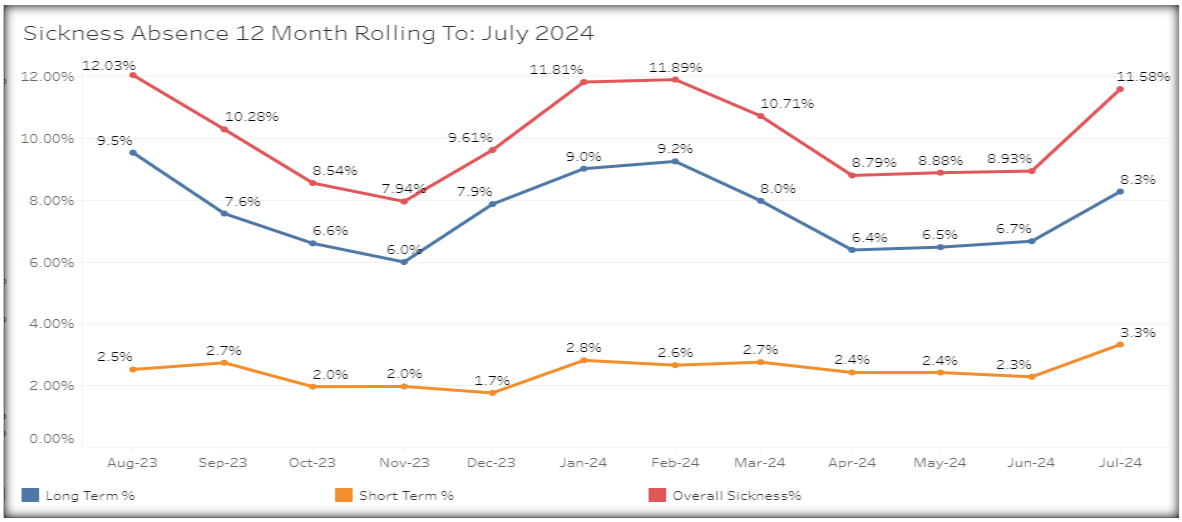
i) Absence



Our position of 9.46% sickness absence in July 2024, comprised of 6.4% long term and 3% short term, highlights: -

- An increase in both long and short term absence, the key reasons for the increase being cough cold/flu related absence as well as increased instances of COVID absence which is now recorded as sick leave.
- Our monthly position remains higher than the 12 month rolling average (7.12%).

Nursing focus



The Nursing Hub remains a key area of concern in terms of overall absence, for July 2024, there was an increase in both long and short term absences, total of 11.58% absence. This is a similar rate to the same time in 2023 (11.36%).

Absence Reasons

- Key reasons for short-term absence were Anxiety/stress/depression/other psychiatric illnesses, Cold/Cough/Flu, Gastro-intestinal problems and Covid-Related Illness.
- Key reasons for long-term absence, were anxiety/stress/depression, injury / fracture and Other Musculoskeletal Problems

Attendance Management Activity (Aug 23 to July 24)

Staff actively monitored from effective date of monitoring demonstrating a commitment to managing absence in accordance with the Once for Scotland policy:

Active Monitoring	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	April 24	May 24	June 24	July 24	Total
Stage One	25	32	19	17	13	11	19	17	24	16	3	11	149
Stage Two	3	2	4	1	1	1	1	2	5	4	0	0	25
Stage Three	0	0	0	0	0	1	0	0	0	0	0	0	1
Grand Total	28	34	23	18	14	13	20	19	28	20	3	11	175

- *72 staff currently have an active monitoring period in place.*
    - *Active Stage 1 monitoring – 59*
    - *Active Stage 2 monitoring – 12*
    - *Active Stage 3 monitoring - 1*

Attendance Management Training / Support

- The HR team continue to support line managers and offer guidance around policy compliance and best practice.
- 49 managers have attended local training to date, the topics covered include application of the Attendance Policy, absence reporting, holding meaningful absence meetings, return to work discussions, occupational health referrals and employee assistance.
- At the recent event on the 7th August 2024, 11 out of 13 managers who were invited, attended. This is a much higher uptake than previously, following the approach which was agreed at CMT where this forms part of the mandatory training for managers.
- More line managers, supervisors and team leaders will be invited to training over the course of the next 12 month, the next training session is 13 September 2024.
- Attendance at Occupational Health continues to be monitored and encouraged. In July 2024 there was a vast increase in attendance compared to previous months with only 4 DNAs from a total of 21 appointments.
- Employees who DNA will no longer be offered a second appointment from 1 July. This was agreed to align with practice across NHS Scotland and has been communicated through all users email and weekly bulletin.

ii) Recruitment & Retention

- 4 separate posts were advertised in July.
- There are 6 individuals with confirmed starts dates and a further 7 with conditional offers pending pre-employment checks.
- Time to Hire for July was 102 days in comparison to the KPI of 75 days however this was due to an isolated incident with a newly qualified member of staff achieving their qualification and registration out with the control of The State Hospital.

Employability

- Further foundations have been laid in recent months to enable the organisation to support Employability as an Anchor organisation and a number of guidance documents have been produced and agreed through the Workforce Governance structure:
    - Guidance on the recruitment of Apprentices
    - Guidance on the Employment of Young People
    - Work Placement Guidance

Leavers

- There were 5 leavers in month of July, 19 year to date which is a turnover of 2.85%.
- Exit interviews continue to be offered to all staff on leaving the organisation at the time of resignation letter received to HR.
- 7 exit interviews have been completed from the 19 actual leavers YTD which is a 37% uptake. Line managers are cc'd into the exit interview invitation email and should encourage participation.

iii) Employee Relations

In line with Once for Scotland Policy approach, this table evidences our ongoing commitment to supporting and encouraging early resolution, with matters dealt with informally and at the earliest opportunity, which is very positive.

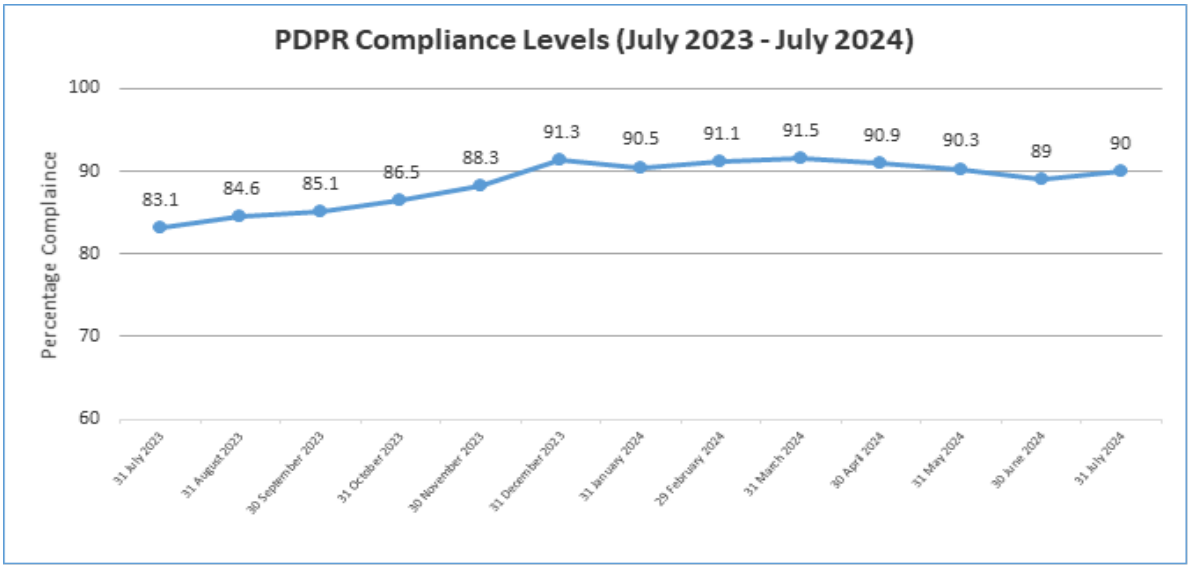
ER Cases – commenced												
	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	March 24	April 24	May 2024	June 2024	July 2024
Capability- informal	0	2	0	1	1	0	0	0	0	1	0	0
Capability - formal	0	0	0	0	0	0	0	0	0	0	0	0
Conduct - informal	0	1	0	2	1	1	1	2	0	1	0	1
Conduct - formal	1	1	2	1	0	0	2	0	2	0	0	0
Bullying & Harassment - informal	0	0	0	0	0	1	1	0	1	0	0	0
Bullying & Harassment - formal	0	0	0	0	0	0	0	0	0	0	0	0
Grievance- informal	0	0	1	0	1	0	0	0	0	0	0	0
Grievance - formal	0	0	0	0	0	0	0	0	0	0	0	0
Whistleblowing	0	0	0	0	0	0	0	0	0	0	0	0
Total	1	4	3	4	3	1	2	2	3	2	0	

Learning, Training & Organisational Development

PDPR Compliance

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

As at 31 July 2024:



Progress reports continue to be provided to all departmental managers on a monthly basis, and compliance levels are monitored and reviewed quarterly by the Organisational Management Team. Compliance will also be monitored at the Quarterly Performance Reviews with the Chief Executive.

4 RECOMMENDATION

Board Members are invited to note this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Links to the Staff Governance Plan, Attendance Management Policy, Mandatory / Statutory Policy.
Workforce Implications	Failure to achieve relevant targets will impact ability to efficiently resource organisation.
Financial Implications	Failure to achieve 5% sickness absence target results in additional spend to ensure continued safe staffing levels
Route to Board Which groups were involved in contributing to the paper and recommendations.	Corporate Management Team, Staff Governance Committee, Workforce Governance Group, Partnership Forum
Risk Assessment (Outline any significant risks and associated mitigation)	Fully outlined and considered in the report
Assessment of Impact on Stakeholder Experience	Failure to achieve the set targets will impact on stakeholder experience
Equality Impact Assessment	Not required for this report as monitoring summary report.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	There are no identified impacts.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Paper No 24/71

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2024
Agenda Reference:	Item No: 18
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Whistleblowing Report. Quarter 1 Update – 2024/25
Purpose of Report:	For Noting

1 SITUATION

The SPSO (Scottish Public Services Ombudsman) developed a model procedure for handling whistleblowing concerns raised by staff and others delivering NHS services and this was formally published on 1 April 2021.

As part of the Standard, a quarterly update on the number of whistleblowing cases is provided to the Staff Governance Committee.

2 BACKGROUND

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

3 ASSESSMENT

The Quarter 1 update is from 1 March 2024 to 31 July 2024. No formal Whistleblowing cases were raised during this quarter either direct to The State Hospital or indirect via the INWO.

In the performance year 2024/25, the State Hospitals Board for Scotland had no cases raised under Whistleblowing to date.

4 RECOMMENDATION

Members of the Board are asked to note the nil return for Quarter 1 of 2024/25.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Provides an update to the Board
Workforce Implications	To provide a further mechanism to allow staff to feel able to raise any concerns without fear of retribution.
Financial Implications	N/A
Route To Board Which groups were involved in contributing to the paper and recommendations.	Staff Goverance
Risk Assessment (Outline any significant risks and associated mitigation)	Risk to the organisation of not offering staff the safe and secure environment to raise any Whistleblowing concens.
Assessment of Impact on Stakeholder Experience	Ensuring that staff feel secure to raise any Whistleblowing concerns.
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	As detailed previously – providing a safe and secure environment to raise any issues.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One **X There are no privacy implications.** □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Paper No 24/72

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2024
Agenda Reference:	Item No: 18
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Whistleblowing/Speak Up Week Update
Purpose of Report:	For Decision

1 SITUATION

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

2 BACKGROUND

This report outlines our approach to how we implement the National Standards, honest reflection on whether this supports the culture required, along with outlining the key considerations and approach to developing the 'Speak Up Culture' and a open, transparent process to handling whistleblowing concerns.

3 ASSESSMENT

Broad agreement was reached that we would relaunch our revised approach to Whistleblowing to coincide with Speak Up week, which is 30th September to 4th October 2024.

To support this request, a working group has met to coordinate our approach to Speak Up week and the group are in the process of developing a calendar of activity. This will include:

- Regular communication on Speak Up, Whistleblowing, the role of the Whistleblowing Champion through our normal communication Channels. 1st Article appeared in Vision recently.
- A message from our Whistleblowing Champion, both written and recorded, along with drop in sessions in our Wellbeing Centre.
- Pledges from Our Board in how they can support Speak Up Week
- Management Seminars on how to respond to and address Speak Up concerns.
- Toolbox Talks on how the Whistleblowing standards will operate

The week of Speak Up Week will be based on the key themes provided by INWO: Leadership and Whistleblowing, Building Trust, Psychological Safety, Access to the Process, along with Understanding the experiences of those involved in the process.

We will also have a manned desk at reception with promotional materials and supported by Senior Managers and Staff Side Colleagues available to discuss Speak Up and Whistleblowing.

This programme of activity is aimed at building awareness, knowledge and supporting the development of a 'Speak Up' Culture.

In terms of Whistleblowing Standards, I would highlight the following suggested changes to support our approach to national standards:-

Executive Lead for Whistleblowing	To Be confirmed	
Administrative Support for Process	Corporate Services Team	Work ongoing to review structure to support this work
Confidential Contacts	Hybrid: CC's within the service, but also available through other boards	CC Role being advertised internally Discussion with neighbouring and national boards on sharing of CCs (including collaborative training and network)
1st Level Investigation	By line Manager	To be covered by Toolbox Talk
2nd Level Investigation	By trained Senior Manager, but may be referred to other board if required to maintain independence and impartiality	Outstanding

4 RECOMMENDATION

Members of the Board are asked to approve and support: (a) the approach outlined to support the development of a 'Speak Up Culture' and (b) the changes to improve our model procedure for handling whistleblowing concerns (ie how we maintain the whistleblowing standards).

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Provides an update to the Board
Workforce Implications	To provide a further mechanism to allow staff to feel able to raise any concerns without fear of retribution.
Financial Implications	N/A
Route To Board Which groups were involved in contributing to the paper and recommendations.	
Risk Assessment (Outline any significant risks and associated mitigation)	Risk to the organisation of not offering staff the safe and secure environment to raise any Whistleblowing concens.
Assessment of Impact on Stakeholder Experience	Ensuring that staff feel secure to raise any Whistleblowing concerns.
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	As detailed previously – providing a safe and secure environment to raise any issues.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One **X There are no privacy implications.** □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE COMMITTEE **SGC(M) 24/02**

Minutes of the meeting of the Staff Governance Committee held on Thursday 16 May 2024

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

Chair:	
Non-Executive Director	Pam Radage
Present:	
Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	Cathy Fallon
In attendance:	
POA Representative	Alan Blackwood
Associate Director of Nursing	Josie Clark
Non-Executive Director, Public Health Scotland	Carron McDiarmid
Corporate Planning, Performance & Quality	Monica Merson
RCN Representative	Richard Nelson
Head of HR	Laura Nisbet
Head of Corporate Governance	Margaret Smith
Director of Workforce	Stephen Wallace

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Ms Radage welcomed everyone to the meeting. Apologies were noted from Gary Jenkins, Chief Executive, Brian Moore, Board Chair and Karen McCaffrey, Director of Nursing and Operations.

2 CONFLICTS OF INTEREST

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

3 MINUTES OF THE PREVIOUS MEETING

The Committee received the minute of the previous meeting held on 15 February 2024.

The Committee:

1. Approved the minute of the meeting held on 15 February 2024.

4 MATTERS ARISING AND ROLLING ACTIONS LIST UPDATE

The Committee received the Rolling Actions List and noted progress on the action points from the last meeting.

Ms Radage highlighted Item 3: Once for Scotland Policies, and in terms of trying to understand the

impact of these on the State Hospital (TSH) asked if there was anything else to be considered. Mr Wallace advised that work in this respect had been progressing for a number of months and there were no significant differences or concerns raised. In terms of the Phase 2 polices there was no huge difference or implications for TSH, however, he would be happy to circulate the key differences if this would be helpful to the Committee. Ms Nesbit agreed adding that this had been discussed during the launch and no significant differences were identified. Post implementation had involved looking at the uptake and usage of the policies through staff applying for certain types of leave, in respect of special leave, and in terms of usage of the HR Connect page. In terms of further reassurance, usage had remained constant throughout and there were no issues of concern.

Ms Fallon asked if there was an update under the Workforce Report on the work commissioned on the gender mix balance or any update on the Pathfinding Project with NES for clinical supervision. Ms Clark replied that work regarding the gender mix balance was ongoing and this was a large piece of work with many strands connected to it. In terms of clinical supervision, a detailed update would be provided within the 6-monthly Nurse Resource Report regarding the number of people within the hospital trained as restorative supervisors. The pilot has been presented at a number of national forums, which was going well and the plan was to keep growing. Ms Clark offered an update sooner if the Committee would find this helpful. Ms Fallon thanked Ms Clark, adding that this was a really good initiative and an update within the 6 monthly update would be acceptable.

In relation to the changes to policies and in terms of feedback, Mr Connor commented this was worked through in partnership with HR to identify changes. The Parental Leave policy was returning to the Workforce Governance Group next week for discussion as there had been some divergence of views, it was expected that this could then be resolved. Ms Radage thanked Mr Connor for the update noting the amount of change, particularly in relation to family friendly policies, and the need to closely monitor this.

Item 4: Evaluation of Staff and Volunteer Health & Wellbeing Strategy, Ms Radage informed the members that this was going to be picked up as part of the overall Organisational Development (OD) work, and would be discussed later in the meeting.

Item 13: iMatter, Ms Radage noted the cycle for the current year was commencing and this was included in the OD Strategy so this would come back to the Committee.

Finally, she noted that Item 14: Nurse Practice Development Update would come to the Committee in August.

The Committee:

1. Noted the updates.

5 SCOTTISH GOVERNMENT STAFF GOVERNANCE MONTIORING RETURN

The Committee received and noted the Staff Governance Monitoring Return. Mr Wallace explained the purpose of which was to highlight areas of good practice and areas that should be included within the Workplan and provided detail and comparison on the iMatter return. He noted many positives in terms of what was already in place such as the visibility of leadership, communication and the wellness framework. A few areas to note were culture and the OD Strategy and changes in diversity and inclusion that would form a big part of how the organisation moves forward.

Ms Fallon noted there were good areas to feed into the action plan for next year, however queried the reference to the 'Meet the Board' video in Appendix 1, which, although a good idea, had not been created. Ms Radage echoed this.

Mr Wallace replied that this would be picked up with the Communications Team noting they were keen to capture this type of activity. Ms Radage added that this has been discussed previously

and all agreed on improving the visibility of Board members. Non-Executive Directors were now attending PPG regularly and were included in Corporate Inductions for new staff.

Ms Radage added that this should be followed up as an action as it has been suggested previously but not moved forward. In terms of the report, Ms Radage added that it was a useful and positive report presenting a good summary of activity.

Action: S Wallace / Communications

The Committee:

1. Noted the Scottish Government Staff Governance Monitoring Return.
2. Requested an update about creating a 'Meet the Board' video.

6 CORPORATE RISK REGISTER – STAFF GOVERNANCE RISKS

The Committee received and noted the Corporate Risk Register - Staff Governance quarterly update which detailed the current positon on risks that sit under the Workforce Directorate. In relation to the four identified risks, Mr Wallace advised that:

- HRD111 – Deliberate Leak of Information – no change;
- HRD122 – Compliance with Mandatory Level 2 PMVA Training - no change however, compliance was sitting at over 90%;
- HRD110 - Failure to Implement & Develop the Workforce Plan - no change but appropriate mitigation and work in place;
- HRD113 - Job Evaluation and impact on services – acknowledged this had caused concern over the past few months, but the risk had now been reduced to medium. In terms of process and timelines, this was a much better position. Worthy of note is the pending Band 5/6 review nationally, which could impact on this.

Ms Fallon commented on the very positive content of the report in terms of the media links and that it was welcome to see that TSH was looking to stretch targets on job evaluations.

Ms Radage agreed and added that this showed the power of including information and discussion on risks early; and added that what had been really helpful as a consequence, was the amount of training that has gone into, for example, job evaluations. She noted that this was a very good step going forward and thanked Mr Wallace for the work undertaken to mitigate these risks.

The Committee:

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

7 STAFF GOVERNANCE ANNUAL REPORT 2023/24

Members received and noted the Staff Governance Annual Report 2023/24, which highlighted performance over the last year. Ms Radage commented that the report was a useful summary of what has been happening and asked Mr Wallace for his thoughts on the report.

Mr Wallace agreed adding that the report was impressive in terms of what has been done, and TSH was covering the key areas. In terms of activity, he noted a huge number of positives around wellbeing and compliance with PDPs, which was positive. In addition, more could be done tying in to key governance strands especially on attendance management. In terms of culture, the work being done around the OD strategy and how to improve communication and engagement would bring improvement.

Mr Currie added the report was a good read and anyone not involved in the Committee would be

able to understand the work that had been done in terms of Staff Governance, noting the content was recognisable and reflected the discussions that had taken place at Committee meetings throughout the year. Mr Currie also noted the strength of working relationships and expressed confidence that challenges would be dealt with. He further noted that within small Boards staff tend to be involved in many strands and you can see how everything is interconnected. He acknowledged the amount of work going in the background, expressing his appreciation of this and adding that, importantly, where there are challenges the Committee is able to discuss them and resolve them as best they can.

Ms Radage thanked Mr Currie for his comments adding that was a good summary of the report.

Ms Fallon agreed, adding there were a few minor points to raise:

- Page 6 last bullet point – reads as if it is a D&G report and wondered if rephrasing 'we' to 'they' would make it read as a TSH report;
- Under TOR s.4.3.4 – "proposed policy amendment funding - provides assurance to the Board" Ms Fallon felt this would benefit from rephrasing;
- S.5 under Authority – suggested this would also benefit from re-phrasing.

Mr Wallace agreed to review these points.

Ms Radage added that seeing everything in one place in terms of activity was really helpful. She felt that there was stronger links across work streams. Further, that development of the OD strategy and framework would support the Committee. Ms Radage thanked everyone for their efforts in getting us to this place.

The Committee:

1. Approved the Staff Governance Annual Report 2023/24 subject to the above amendments.

8 FITNESS TO PRACTICE ANNUAL REPORT 2023/24

Members received and noted the Fitness to Practice Annual Report Workforce Report presented by Mr Wallace who highlighted the position around registrations for NMC, GMC and HCPC registrations advising that none had lapsed within the year. There was one extension in relation to an NMC registration due to sickness absence, and no lapses within those providing services under service level agreements in terms of Pharmacy and Social Work.

Ms Radage noted there have been no significant issues in the past but it was good to see this outcome.

Ms Fallon commented that it was helpful for the Committee and noted the impacts of failure to maintain appropriate registration in wider terms, not just the employee's pay. She added that in terms the 'each' category the report highlighted where a member of the NMC cohort lapsed in registration, but not for members of the GMC or HSPC. She suggested that all lapses should be included to maintain consistency across the reports.

Ms Radage noted the comments and thanked Mr Wallace for the report.

The Committee:

1. Noted the Fitness to Practice Annual Report 2023/24.

9 WORKFORCE (HR, LEARNING & WELLBEING, & OD) REPORT

The Committee received and noted the Workforce (HR, Learning & Wellbeing, & OD) Report.

Ms Nisbet informed the Committee that the report provide an update on key activities throughout March however, April's report was now available and could provide a further update. She highlighted attendance management performance, noting this was a priority for the organisation. This showed a continued reduction in overall sickness absence, notably within long-term absence across the organisation – this had reduced from 7.9% in March to 7.2% in April, and reported improvements with engagement and attendance at Occupational Health. She also noted performance in relation to recruitment timescales, and that there was now a formal position regarding young workers, with guidance on the recruitment of people between the ages of 16-18 into appropriate non-clinical roles. She also highlighted that there was no longer a waiting list for job evaluations and PDPR compliance was sitting at over 90%, but remained a focus across the organisation.

Ms Radage thanked Ms Nisbet for the update, noting the large amount of information within the report adding that the April updates had been helpful and opened up to any questions.

Ms Fallon also thanked Ms Nisbet for the report adding that it was helpful not just for this Committee but also for the Clinical Governance Committee (CGC). She acknowledged the amount of work that had been done and noted the positives in relation to long-term absence. Ms Fallon enquired if leavers were being double counted, noting four roles were on the Supplementary Staffing Register, but assumed these has already been counted when staff officially retired and asked if this could be looked at. In addition five members of staff left because roles 'did not meet expectations' and wondered what, if anything more proactive could be done about this. Additionally, Ms Fallon noted the Skye Centre had been non-compliant with PDPRs for seven months.

Ms Clark advised that she now oversees the Skye Centre, and more PDPR conversations had taken place and was hopeful there would be an improvement in the next report. It was noted that the meetings had taken place but required to be signed off online, to register this. Ms Radage noted that a number of departments have not been compliant for some time so it was good to hear that this was progressing.

Mr Blackwood asked if the 'unsatisfactory' element of leavers' feedback was enough detail provided to this forum or was more context needed around this, acknowledging there had been previous discussions regarding delving more deeply exposing individuals. Ms Fallon asked about the number of Return to Work Interviews (RTW) outstanding (31) which had also been raised at the Staff Forums and echoed Mr Blackwood's concern that 'unsatisfactory' does not give the Committee enough information. Ms Radage agreed, noting that despite making the process easier and anonymous, take up was still low and wondered how this would compare with face-to-face interviews in terms of take up.

Ms Nisbet added that a face-to-face exit interview was offered if preferred, and this could be highlighted more strongly. Where 'not meeting expectations' was indicated in feedback, individual responses are shared with the appropriate Director. HR would look at what additional information could be added to reporting in that regard.

Action: L Nisbet

Mr Wallace agreed it would be useful to look at what further detail could be provided from the exit interviews to highlight emerging themes, whilst still ensuring anonymity. Mr Wallace also agreed we needed to look at ways to improve RTW compliance.

Ms Fallon asked if there had been discussion of potential difficulties in carrying out RTW interviews especially in terms of staff availability when they return to work. Mr Wallace replied that the biggest challenge in terms of availability was from shift working. Ideally, the earlier the RTW interview was done following absence the more meaningful they are. Mr Wallace added that he is keen to look into this further to see how it can be improved and report back to the Committee.

Action: S Wallace

Mr Radage added that would be helpful noting there is a multi-pronged attack to sickness absence and having data is one of the key things that would be helpful to allow the Committee to have a better understand of this.

Mr Blackwood agreed that it could be challenging to complete these interviews due to staff availability, and Mr Connor noted that this issue was being picked up at a local level, and the results could depend on the timing of reporting. Ms Nisbet noted the importance of staff being able to meet with their line manager when they return to work, so that they could be supported appropriately. She would consider if further data could be reported to support line managers. She also noted that PDPR performance was reviewed at directorate performance meetings with the CEO, on a quarterly basis.

Mr Nelson enquired about ER casework timescales noting the cases were more than six months old and asked about support for staff. Ms Nisbet noted the importance of supporting staff through these processes adding that all cases were monitored closely.

Ms Radage noted good attendance at the Time to Talk day on 1 February and was pleased to see targeted attendance of Housekeeping staff. From the detail within the report, Ms Radage highlighted the chart showing the reason for absence, trigger points and compliance, which was a good visual reminder of the significant scale of issues around anxiety, stress and depression.

Ms Radage also asked about reporting of Covid absence, and it was confirmed that special leave for Covid ceased on 1 April 2024.

Ms Radage asked about the potential of making projections for sickness absence. Mr Wallace replied that rather than a projection, the key was an overall trajectory to try to get to a target point, and being proactive.

Mr Currie commented on the helpfulness of linking cause and effect, especially when it came to investing resources. For example, it was difficult to measure the benefit brought by wellbeing activity and if it was bringing the desired effect. Mr Currie added that over the next 12 months and beyond, NHS Boards were going to be faced with making decisions around resources, which would be challenging. Ms Radage added that this was an interesting point and noted the value of having wellbeing and the OH service in place. Ms Radage also acknowledged the amount of effort and work that has gone into managing sickness absence, which had been significant.

The Committee:

1. Noted the Workforce (HR, Learning & Wellbeing and OD) Report.

10 SICKNESS ABSENCE TASK AND FINISH GROUP

The Committee received and noted the Sickness Absence Task and Finish Group Report presented by Mr Wallace who recapped that the Committee commissioned the Task and Finish Group in August 2023 to look at sickness absence, which was currently sitting at 7.29% and showing a continued overall downward trend and in terms of long-term absences. The key objectives have now been concluded as outlined in section 3; however, the 5% absence target has not been achieved. The plan was to now focus on making sure there was an embedded process within the business as usual framework.

Ms Fallon thanked Mr Wallace for a helpful report adding she was happy to support the cessation of the group, as it was important to embed this into processes. Ms Fallon added that the benchmarking detail from the medium secure units was interesting and provided a truer picture, which would be helpful for the Committee to receive this on a regular basis.

Ms Merson also commented on a really helpful paper adding that in terms of maximising attendance and management through performance frameworks they could include directorate performance meetings as a way of reviewing directorate performance and looking at trends as an

additional layer of support and review.

Ms Radage noted the very helpful discussion and unanimous support for the cessation of the Task & Finish group and was supportive of the way forward. Adding the group was very helpful in highlighting escalating absences and agreed comparison figures were immensely helpful.

The Committee:

1. Agreed to the cessation of the Sickness Absence Task and Finish Group and returning to a business as usual position.

11 WHISTLEBLOWING REPORT Q4

The Committee received and noted the Whistleblowing Report, which provided members with an update on activity during Quarter 4 covering the period 1 January to 31 March 2024. Mr Wallace highlighted there were no whistleblowing cases raised during the quarter, and no cases raised during the year 2023/24. At the recent Board Development day there was a keenness to relaunch how we look at Whistleblowing and Speak Up and how we try to reinforce the independence of the process and assure staff that they can speak up without fear of repercussion. Preparations are ongoing for Speak Up week in September, which would be a good time to relaunch the service and reinforce the role of the Whistleblowing Champion and what that involves.

Action: S Wallace

Ms Radage noted the position for the Committee, in that no incidents were reported in the last quarter and the importance of raising awareness in this area.

The Committee:

1. Noted the Whistleblowing Report for Q4
2. Noted there were no Whistleblowing cases throughout 2023/24
3. Noted the planned review / relaunch of the service.

12 HEALTH and CARE STAFFING / eROSTERING UPDATE

Members received and noted the Implementation for Health and Care Staffing Act / eRostering update, which detailed the role of the Board and identified specific actions that required to be progressed to ensure readiness for enactment of the legislation, meanwhile ensuring the Committee remained sighted on the requirements of the legislation. The Quarter 3 report was submitted on 25 March 2024 showing no areas of concern. Boards were required to produce an Annual Report next year, but meantime a number of monitoring compliance meetings would take place to ensure compliance. In terms of eRostering, this was fully in place with a few rosters requiring review and further support. The small project team in place will disband at the end of June and the plan was to ensure there is a robust process in place that will allow us to continue to use the system effectively to meet our legislate requirements. A further update would be brought back to the Committee.

Action: S Wallace

Ms Radage thanked Mr Wallace for a very helpful update and opened up for questions.

Mr Connor asked about the assessment and observational study and the costs involved and manpower required and the impact on Day Time Confinement (DTC). Ms Clark responded advising that funding had been received from HIS, which was projected in advance, so there was no correlation between this staff cohort and DTC.

Ms Radage noted that the project had been successfully implemented and would be interested to

see any lessons learned, also noting her thanks to the team for their respective parts in this.

The Committee:

1. Noted the Implementation for Health and Care Staffing Act and eRostering Update.
2. Requested an update at the conclusion of the project team.

13 PARTNERSHIP FORUM APPROVED MINUTES

Members received and noted the approved Partnership Forum minutes dated 23 January 2024, 27 February and 26 March 2024. Some minor inaccuracies were noted for amendment.

The Committee:

1. Noted the approved minutes of the Partnership Forum meetings.

14 AREAS OF GOOD PRACTICE / AREAS OF IMPROVEMENT

- Mr Wallace commented on the amount of work undertaken following the cyber-attack on NHSD&G and the way this was managed in terms of communication with staff and holding a series of drop in sessions to provide reassurance. Ms Radage agreed that it was a strong, comprehensive, timely and robust response to a difficult situation.

- Ms Fallon highlighted the good job the Task & Finish Group did on sickness absence and were now in a position to embed in the work that has been done which is a good role model for other task and finish groups. Ms Radage agreed that this was a good example of something that was responded to quickly and effectively.

- Ms Radage suggested the OD Strategy, which has taken an inclusive and engaging approach.

15 ANY ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTIEES

Ms Radage shared feedback from other Boards in terms of learning from things they are doing. She said it was useful to understand what was happening in a broader context around things like hardship, looking at foodbanks and other initiatives that other Boards are thinking about.

Ms Radage asked if there was anything to highlight from the CGC. Ms Fallon replied there was not, but that she would feedback the updates relating to job evaluations and the downward trend in long-term sickness absence to the CGC for awareness.

16 ANY OTHER BUSINESS

No other business was presented by the Committee members.

17 DATE OF NEXT MEETING

The next meeting would be held on Thursday 15 August 2024 at 0930 hours via Microsoft Teams.

The meeting concluded at 1110 hours

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2024
Agenda Reference:	Item No: 19
Report Author:	Head of Corporate Governance
Title of Report:	Staff Governance Committee – Highlight Report
Purpose of Report:	For Noting

This report provides an update on the key points arising from the Staff Governance Committee meeting that took place on 15 August 2024.

1	Occupational Health 12 Month Report	The Committee received a 12 month report from NHS Dumfries & Galloway Occupational Health Department, who deliver these services vis a Service Level Agreement to the State Hospital (TSH). Discussion included the range of services offered, and the need to evidence the benefit gained for staff within the context of performance indicators and cost effectiveness. It was agreed that the team would be asked to refresh reporting to meet these requirements, and help to focus service delivery going forward. The cyber attack experienced by NHS Dumfries & Galloway was noted, and that TSH was not required to take any further action – with a presentation on lessons learned to the Corporate Management scheduled.
2	Corporate Risk Register Quarterly Update	The Committee received the quarterly report detailing the corporate risks assigned to the Workforce Directorate. This was agreed as an accurate statement of risk, and that work would continue with the Risk Team in respect of the reporting format.
3	Workforce Report	Reporting provided the Committee with updates across the full range of activity across the directorate including Human Resources, Organisational Development, Learning and Wellbeing. This included metrics across workforce data. The factors contributing to the increase in sickness absence in July was noted, and the need for improvement. It was noted that completion of Return to Work interviews required attention to bring improvement, as well as the support provided to staff during long terms absences. In respect of Employee Relation Cases, there was concern about the time taken both to initiate and to complete the process involved. The work on 'Exit' interviews was commended as being helpful.

4	Workforce Governance Group	The Committee noted the progress made in this area of governance, and that this is a continually developing area. There was discussion on how to ensure close management of all vacancies, and the need to consider new ways of working and the need for efficiency and innovation across the organisation. It was noted that this will continue to be developed.
5	Workforce Planning and Reporting	The Committee received an update on the current workstreams being progressed, and the way that these were being coordinated to bring cohesion and a planned way forward including key milestones. This included the Organisational Development Strategy, as well as evaluation of wellbeing initiatives, and staff engagement mechanisms. This will support the development of the Workforce Plan 2025/28.
6	Health and Care Staffing – Quarter 1	The Committee reviewed the content of reporting which will provide the Quarter 1 submission to Health Improvement Scotland, and this was approved. The positive progress made was noted.
7	Nurse Practice Development – 6 Month Report	The Committee commended the work being progressed in this area, including the implementation of the new Clinical Care Policy, and the improvement in Clinical Supervision, as well as the development of the First Year Support Programme.
8	Whistleblowing	Reporting for Quarter 1 of 2024/5 confirmed that there had been no new cases for consideration. The Committee noted the work progressing on refreshing the support to whistleblowing within TSH, and the preparation made to date for Speak Up Week.
9	Complaints Management Audit	The Committee noted that although oversight of complaints management sits within the Clinical Governance Committee, it was helpful for this report to be shared, and for an update to be provided on the supports made available to staff from the Complaints Team.
10	Areas of good practice / Concerns	The Committee agreed that the First Year Support Programme led by Nurse Practice development was an area of good practice. The also noted the success of the on-site Open Day for recruitment within nursing.

RECOMMENDATION

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

MONITORING FORM

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

Paper No. 24/74

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2024
Agenda Reference:	Item No: 20
Sponsoring Director:	Chief Executive
Author(s):	Complaints Officer/Head of Corporate Governance
Title of Report:	Complaints Annual Report 2023/24
Purpose of Report:	For Decision

1 SITUATION

NHS Boards are required to produce annual reporting relating for both complaints and feedback, to comply with the Patient Rights (Scotland) Act 2011 and associated regulations and directions. This report will provide the Board with a summary of activity within complaints handling activity for the year 1 April 2023 to 31 March 2024.

The NHS model Complaints Handling Procedure (CHP) is designed to encourage NHS Boards to listen to, and learn from, complaints in order to help to improve services for patients. This supports a person centred approach to complaints handling across NHS Scotland, ensuring people using NHS services have confidence in the complaints services provided.

This is a standard approach across NHS Scotland, which complies with the guidelines set by the Scottish Public Services Ombudsman (SPSO) and meets the requirements of the Patient Rights (Scotland) Act 2011.

The two-stage model enables complaints to be handled by way of early resolution (Stage 1) within five working days; or for issues that are more complex, by Investigation (Stage 2) within 20 working days.The local resolution stage continues to encourage speedy resolution of issues and is welcomed by patients and carers, as well as staff.

2 BACKGROUND

In the State Hospital, the Head of Corporate Governance acts as Complaints Manager for the organisation, and is currently supported by a Complaints Officer. The Corporate Services Team is currently reviewing its structure, and this will ensure that learning from complaints continues to be at the heart of service delivery.

During 2023/24, a number of initiatives were developed and implemented to improve the delivery of complaints handling within the State Hospital. Whilst the Complaints Officer role has always

provided the main point of contact for complaints, there is now more focus on direct patient contact.

As a high secure hospital, the State Hospital is unique within NHSScotland meaning that this environment could present additional challenges in respect of accessibility for patients. During the past year, the service has set up a dedicated phone contact service which is available to all patients in ward areas. The Complaints Officer attends the Skye Centre Atrium very regularly meaning that patients attending placements within the centre and/or the shop or café have the opportunity of direct contact. These direct contacts have been particularly helpful in making sure that all patients know how to make a complaints, as well how the process works. It is clear that having a familiar and approachable figure within the hospital, focused particularly on early resolution, is a valuable and well-used resource.

The Complaints Officer also attends the Patient Partnership Group every month where there will be a dedicated agenda item for complaints experiences, meaning that patients can discuss this in a safe and supported way.

During 202/24, the Complaints Officer continued to work closely with the Person Centred Improvement Team (PCIT) who have responsibility for patient engagement. PCIT also managed patient feedback during 2023/24, and with the change in structures in each team, this portfolio will now move to the Corporate Services Team.

The Complaints Service liaises very closely with the Patient Advocacy Service (PAS) to provide a joined up service for patients to help to ensure that patients are empowered to engage in the complaints process. The Complaints Officer meets regularly with PAS colleagues to discuss any trends or themes which may arise, and this is a valuable additional conduit for feedback for feedback.

A further initiative during this year was to initiate and support an informal network with colleagues from other high secure hospital in NHS England, to compare experience and learning, and this continues to develop.

Finally, complaints management was included within the internal audit plan for 2023/24, and this produced a very positive outcome with a number of areas of good practice identified. The audit produced a rating of substantial assurance.

3 ASSESSMENT

Encouraging and Handling Complaints

The model CHP introduced a standard approach to managing complaints across NHS Scotland, which complies with the Scottish Public Services Ombudsman (SPSO) and meets the requirements of the Patient Rights (Scotland) Act 2011. The two-stage model enables complaints to be handled;

- Locally, allowing for ***Early Resolution*** (**Stage 1)** within 5 working days;
- Or for issues that are more complex, by ***Investigation*** (**Stage 2**) within 20 working days.

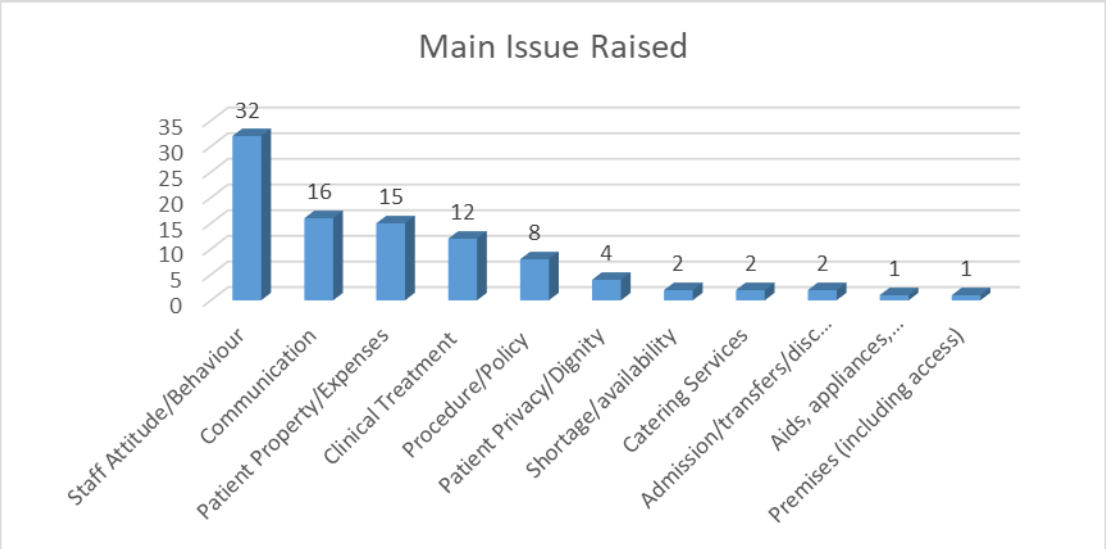
Complaints Received

The hospital received **95** new complaints this year showing an increase of 7% on the previous year. The table below shows the number of complaints received, the average number of patients, and the number of complainants over the last three years.

Number of Complaints Received	**2021/22**	**2022/23**	**2023/24**
Total Number Received	65	87	95
Average number of Patients throughout the year	114	110	103
Number of Complainants	33	41	40

Due to the nature of the environment as a long-term health care setting, it is expected that patients will make more than one complaint during their time with us. During the year 16 stakeholders made more than one complaint this year, compared to 20 in 2022/23 and 15 in 2021/22.

The chart below shows the main issues raised in each complaint.



Involving the Complainant in Early Resolution

The 5-day early resolution stage continues to be a positive step in resolving issues quickly, and is welcomed by staff and patients.

The independent Patients' Advocacy Service (PAS) continue to provide a valuable service in supporting patients who wish to make a complaint but do not wish to do so direct or require support. PAS are based on site and regularly support patients to resolve issues through early resolution.

They also provide support and guidance to patients who wish to escalate their complaint. PAS work closely with the Complaints Team and PCIT to highlight themes and identify opportunities to share best practice in relation to learning emerging from complaints and feedback.

This year **44** patient complaints were supported by PAS, this represents **46%** of all complaints received.

The Complaints Team works closely with PAS, meeting regularly, to share best practice in complaints handling and to discuss learning emerging from complaints. These relationships further strengthen the advocacy route through which patients can raise concerns.

We remain mindful of how challenging it can be for patients in a long-term health care setting to speak up. Particularly where it relates to the staff providing their care and with whom they are in daily contact, and how this can deter patients from raising issues with us.

To encourage and support patients to provide feedback and to make complaints, patients can choose if they would like to meet with staff locally themselves, meet with staff locally supported by PAS, or have no direct involvement with staff in the early resolution process and receive a written or verbal response directly from the Complaints Team or through PAS.

These options continue to work well and there has been more uptake from patients when presented with these options. Patients are also encouraged to identify what outcome they are seeking when making a complaint, which is of benefit when discussing concerns with patients and in managing their expectations.

Complaints Closed

A total of **82** complaints were closed this year. Of these, 59 complaints (72%) were resolved at Stage 1.

The table below shows the number of complaints closed at each stage this year and, for comparison purposes, the previous two years. Complaints received but subsequently withdrawn (two this year) are not reported nationally and therefore not included in this report.

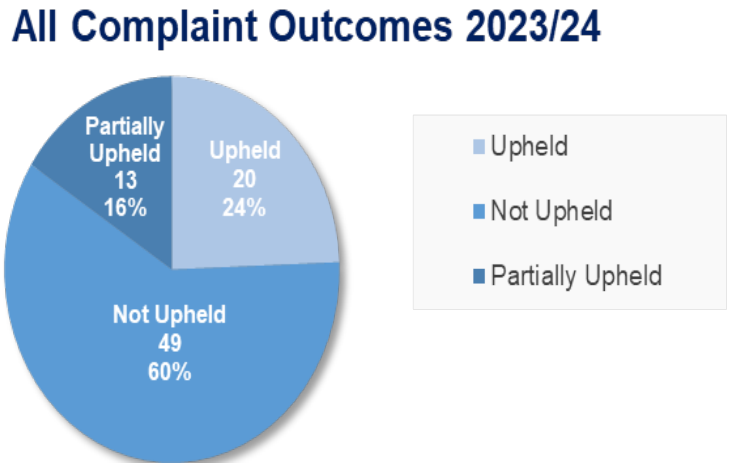
Complaints Closed	2021/22	2022/23	2023/24	% of all closed
At Stage 1 (Early Resolution)	42	65	59	**72%**
At Stage 2 (Investigation)	6	13	12	**15%**
After Escalation to Stage 2 (Investigation)	6	7	11	**13%**
Total	**54**	**85**	**82**	**100%**

Complaint Outcomes

Complaints closed are categorised as either being upheld, not upheld or partially upheld. Outcomes continue to be sense checked through the Complaints Manager, and random audits are carried out on complaints files. This helps to review both the quality of responses provided as well as recognising that the culture of an organisation may impact on the way that it responds to complaints. The need for transparency and openness, as well as an ability to acknowledge and apologise for those times when service delivery has fallen short of the accepted standard, is essential. At the same time, this will only be successful when staff feel supported through the process and can take learning from it.

The chart below provide performance data relating to the outcomes of complaints closed during 2023/24.

- 49 were Not Upheld
- 20 were Upheld
- 13 were Partially Upheld



Average Response Times

TSH continues to adhere to the CHP targets timescales for resolving complaints within five working days at Stage 1. At Stage 2, this was not possible with the average days to respond being 31.

The table below shows the average number of days taken to respond to complaints this year and for comparison purposes, the previous two years.

Average Number of Days	2021/22	2022/23	2023/4
To resolve at Stage 1	3.5	**5**	**4**
To respond to a complaint at Stage 2	17	**31**	**26**
To respond to a complaint after escalation to Stage 2	16	**18**	**19**

Responding within Timescales

The tables below show our performance in responding to complaints at each stage within the CHP target response times. Whilst extensions to the response times should be an exception, the Complaints Team works to ensure that the response fully addresses all of the issues raised. Therefore, in some instances an extension has been required to allow a more comprehensive response to be provided.

The SPSO has confirmed that there is no prescriptive approach about who should authorise an extension – only that decisions should be proportionate and made at a senior level. The Complaints Manager takes this responsibility within TSH.

Responses within Timescales

Complaints Closed within the target timescales	2021/22	2022/23	2023/24
Closed at Stage 1 within 5 working day target	38	46	**48**
as % of the total number closed at Stage 1	90%	71%	**81%**
Closed at Stage 2 within 20 working day target	11	12	**13**
as % of the total number closed at Stage 2	92%	60%	**57%**

Extensions to Timescales

Complaints that required an extension to the timescales	2021/22	2022/23	2023/24
Closed at Stage 1 after 5 working day target	4	19	**11**
as % of the total number of Stage 1 closed	10%	29%	**19%**
Closed at Stage 2 after 20 working day target	1	8	**10**
as % of the total number of Stage 2 closed	8%	40%	**43%**

This year has seen an increase in complaints requiring an extension at Stage 2. This can be attributed in some instance to staff shortages, but also due to an increase in the complexity of the issues raised. Whilst being mindful of meeting timescales it is important that a full investigation is

completed before a final response is issued. Where delays occur complainants are kept informed of this and the reasons for the delay.

Focus on Quality

An internal quality assurance process has been established to ensure compliance with the requirements of the CHP. As detailed within this report, performance timescales and recording of outcomes are quality checked by the Complaints Manager.

Stage 2 investigation responses are also checked by the Complaints Manager to ensure the quality of the response and that it answers all of the concerns raised. The Director(s) responsible for the service(s) involved are asked to review and approve the content, before a proposed draft is provided to the Chief Executive for finalisation. This process is aimed at ensuring directorate accountability, as well as bringing focus on learning opportunities and identifying trends in respect of the issues raised.

Alternative Dispute Resolution

The Board supports the use of alternative dispute resolution to conclude cases that are unable to be resolved locally. No complaints this year required support from the Scottish Mediation Service.

Scottish Public Services Ombudsman

As the final stage of the CHP, complainants who remain unhappy with the response to their complaint at Stage 2 can ask the SPSO for an independent external review.

During this year, two complaints were escalated to the SPSO. The SPSO confirmed following an initial review that they were satisfied with the investigation of both complaints within TSH, and that they did not intend to make any further detailed enquiries and/or action.

Culture, Staff Awareness, Training and Development

Our Vision is "To excel in the provision of high secure forensic mental health services, to develop and support the work of the Forensic Network, and to strive at being an exemplar employer."

Our Values and Aims; are the core values of NHS Scotland:

- Care and compassion
- Dignity and respect
- Openness, honesty and responsibility
- Quality and teamwork

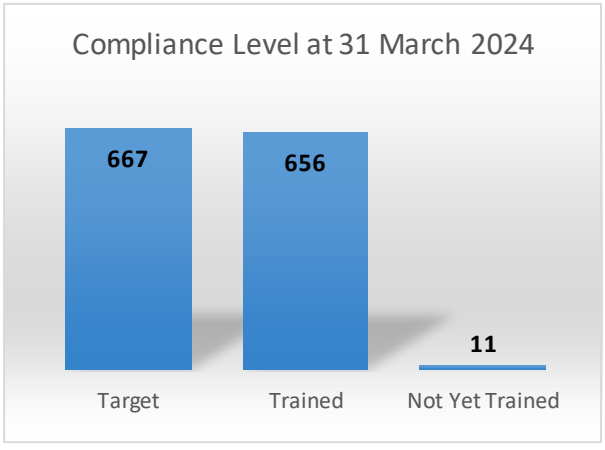
Our primary twin aims are the:

- Provision of high quality, person centred, safe and effective care and treatment.
- Maintenance of a safe and secure environment that protects patients, staff and the public.

Staff Awareness and Training

Complaints and Feedback

All staff are required to complete the national e-learning Feedback and Complaints training modules. The table below shows that 656 (98%) members of staff had completed the e-learning modules at the end of March this year.



In addition to the online modules, a complaints awareness session formed part of the induction programme for all new staff and student nurses.

Supporting staff to respond to complaints investigations, with refreshed training in this area for newly promoted staff, remains a key area of focus for the Complaints Team.

Details of complaints received relating to medical staff form part of their annual appraisal process, enabling staff to discuss these fully with the appraiser.

Full support is also provided to managers resolving issues locally and senior managers investigating complaints at Stage 2.

Learning from Complaints and Feedback

When any aspect of a complaint is upheld or partially upheld, we look to identify if improvements can be made with preventing a reoccurrence.

The majority of complaints were resolved at Stage 1 during this year. Most of these were resolved on an individual basis locally with the staff who provide the service, and did not involve implementing improvements or changes to policies, services or ways or working across the hospital. However, an apology is always offered to the complainant where appropriate and a reminder issued to staff to reflect on behaviours or adherence to policies / procedures.

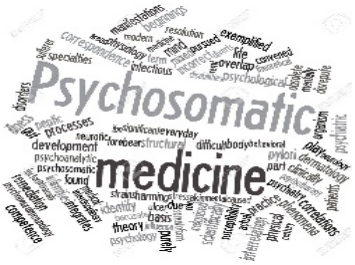
When any aspect of a complaint is upheld or partially upheld, care is taken to look to identify if there are any improvements, changes or actions that will prevent the same thing happening again.

Themes Emerging

27% of issues related to **Staff Attitude/Behaviour/Conduct.** Although 86% of issues were not upheld, in order to further explore the reasons for this issue frequently being raised the Complaints Team are working with senior nursing colleagues and the PPG to see how this can be addressed. Three complaints resulted in staff being reminded of the need to adhere to procedure and the importance of clear and professional communication.

17% of issues related to **Patient Property & Expenses**. Issues relating to patient property accounted for 93% of these complaints, 36% of which were upheld. These complaints prompted a review of the Patient Property procedures and the claim process for lost or damaged items. One issue in relation to patient expenses resulted in a change in process by the finance department in relation to patients' funds.

17% of issues related to **Communication.**
Oral Communication accounted for 86% of the communication issues raised. Over half of the complaints relating to communication were either partially upheld or upheld. All were attributable to staff not communicating effectively, and this provided an opportunity for additonal staff training.



15% of issues related to **Clinical Treatment**.
A wide range of issues were considered from involvement in a care plan, grounds access, therapies, medication and changes to clinical services, most of the issues raised were specific to the particular patient. The majority (75%) were found to be not upheld.

Actions taken or improvements made as a result of Complaints

Some complaints do result in changes in practice and examples of these are produced in the table below.

Issues Raised	Outcome	Output
Patient unable to purchase preferred item from the shop.	A change in purchasing practice during to Covid-19, meant patient was unable to purchase item.	The purchasing practice was reverted back to original operating procedure allowing patients to purchase requested items.
Wrong or missing items for evening meals not being able to be rectified as Kitchens were closed	Identified that Catering Staff finishing time is just as the evening meal is being delivered.	A review of finishing time for catering staff to ensure any issues with meals can be rectified at the time.
Patient unable to locate personal property.	Highlighted deficiencies in recording of property and system for recording not fit for purpose.	Responsible Directors asked to review the process.

All complaints received are reported to the Clinical Governance Committee each quarter who monitor the issues raised, findings, outcomes and any learning identified.

Complaints Experience Feedback

Although making a complaint may be the result of a difficult experience, it is the aim of the Complaints Team to ensure that all complainants have a positive experience when contacting the service.

To ensure we can capture learning from this, a feedback form is available to help to seek the views from everyone who uses the service. Historically this process has a poor response rate which may reflect the long-term health care setting where we may receive multiple complaints from the same person. It therefore remains a challenge encouraging complainants to complete the feedback forms on each occasion. During 2023/24, only two feedback forms were received. A review of the form template, and how the information is captured is underway to improve the volume and quality of the feedback provided.

Responses were mainly positive indicating that users found it easy to make a complaint, and that staff had been helpful, and that users understood the final decision and correspondence was easy to read.

Accountability and Governance

The Chief Executive is accountable for the delivery of the CHP within TSH, including supporting a culture of transparency and openness in complaint investigation. This supports the organisation's ability to listen and respond to concerns raised, as well as to take learning from complaints.

The Board has oversight of complaints and receives annual reporting. This follows quarterly reporting to the Clinical Governance Committee, which takes oversight of the issues raised, findings, outcomes and any learning identified. Quarterly reporting is also routed through the Organisational Management Team (OMT) which is comprised of service leads.

There is continued focus on delivering the aims of the CHP in terms of each of the Key Performance Indicators, as well as a focus on quality and making a contribution to service improvement. In addition to other established patient engagement work streams the CHP is another route through which stakeholder voices can be heard, and the organisation can measure its performance on the delivery of its key aims.

4 RECOMMENDATION

The Board is invited to:

1. Note assurance on delivery of the CHP within TSH, especially the focus on quality improvement and learning from complaints.
2. Note evolving practice in this area, and the focus on learning which has contributed to service development
3. Approve the content of reporting for inclusion in the TSH Complaints and Feedback Report 2023/24.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP / Corporate Objectives	The CHP introduced a standard approach to managing complaints across NHS Scotland which complies with the Scottish Public Services Ombudsman (SPSO) and meets all the requirements of the Patient Rights (Scotland) Act 2011. Reporting measures performance and delivery within TSH.
Workforce Implications	There are no associated workforce implications, and training and support for staff is reported on within the report.
Financial Implications	There are no associated financial implications.
Route to Board	Requested by Board through workplan as part of annual reporting requirements. Provides basis for annual Complaints & Feedback Report for Scottish Government.
Risk Assessment (Outline any significant risks and associated mitigation)	There are reputational risks associated with not meeting the MCHP target response times, as well as the risk of systemic failure to respond to concerns raised.
Assessment of Impact on Stakeholder Experience	Reporting captures stakeholder views and how these are responded to by the organisation for service improvements.
Equality Impact Assessment	Not required.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	Not applicable
Data Protection Impact Assessment (DPIA) See IG 16	Tick One **x** There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

Paper No. 24/75

The State Hospitals Board For Scotland

ANNUAL SCHEDULE OF MEETINGS - 2025

BOARD AND SUB-BOARD

MEETING	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
BOARD*		Thursday 27.02.25 9.30am		Thursday 24.04.25 9.30am		Thursday 19.06.25 12.30pm		Thursday 28.08.25 9.30am		Thursday 23.10.25 9.30am		Thursday 18.12.25 9.30am
AUDIT & RISK COMMITTEE	Thursday 30.01.25 9.30am		Thursday 27.03.25 9.30am			Thursday 19.06.25 9.30am				Thursday 02.10.25 9.30am		
CLINICAL GOVERNANCE COMMITTEE		Thursday 13.02.25 9.30am			Thursday 08.05.25 9.30am			Thursday 14.08.25 9.30am			Thursday 13.11.25 9.30am	
STAFF GOVERNANCE COMMITTEE		Thursday 20.02.25 9.30am			Thursday 15.05.25 9.30am			Thursday 21.08.25 9.30am			Thursday 20.11.25 9.30am	
REMUNERATION COMMITTEE*		Thursday 06.02.25 9.30am				Thursday 26.06.25 2pm					Thursday 06.11.25 9.30am	

*The Board and Remuneration Committee may also meet as and when required

2025 PUBLIC HOLIDAYS

New Year:	Wednesday 1 January & Thursday 2 January
Easter:	Friday 18 April & Monday 20 April
Autumn Holiday:	Friday 26 September & Monday 29 September
Christmas:	Thursday 25 December & Friday 26 December

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2024
Agenda Reference:	Item No: 22
Sponsoring Director:	Chief Executive
Author(s):	Head of Corporate Planning and Business Support Corporate Planning, Performance and Quality Project Support Mgr
Title of Report:	Performance Report
Purpose of Report:	For Noting

1. SITUATION

This report presents a high-level summary of organisational performance through the reporting of Key Performance Indicators (KPI's) for Q1: April to June 2024. Trend data is also provided to enable comparison with previous performance. The national standards directly relevant to the State Hospital are Psychological Therapies Waiting Times and Sickness Absence. Additional local Key Performance Indicators (KPIs) are reported to the Board and are included in this report.

Board planning and performance are monitored by Scottish Government through the Annual Delivery Plan (ADP) for 2024-25 which was approved by the Scottish Government in June 2024. The approval letter is attached as appendix 1.

2. BACKGROUND

Members receive quarterly updates on KPI performance as well as an annual overview of performance and a year-on-year comparison at the Board meeting each June.

The calculation for a quarterly figure is an average of all 3 month's totals.

3. ASSESSMENT

The following sections contain the KPI data for Q1 and highlight any areas for improvement in the next quarter through a deep dive analysis for KPI's that have missed their targets.

There are 8 KPI's which have reached and / or exceeded their target this quarter and there are 4 KPI's which are off target this quarter, these are:

Reached and / or exceeded their target	Off target
- Patients will be engaged in psychological treatment. - Patients will be engaged in off-hub activity centers. - Patients will undertake an annual health review.	- Patients have their care and treatment plans reviewed at 6 monthly intervals. - Patients will have a healthier BMI. - Sickness absence rate - Patients have their clinical risk assessment review annual

- Patients will undertake 150 minutes of moderate exercise each week - Staff have an approved PDR - Patients transferred / discharged using CPA. - Patients requiring primary care services will have access within 48 hours. - Patients will commence psychology therapies <18 weeks from referral date.	

Performance Indicator	Target	RAG Q2 23/24	RAG Q3 23/24	RAG Q4 23/24	RAG Q1 24/25	Actual	Comment
Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	R	R	R	85.1.%	This indicator remains in the red zone.
Patients will be engaged in psychological treatment	85%	G	R	G	G	90.56%	This indicator remains in the green zone.
Patients will be engaged in off-hub activity centers *(This includes drop-in sessions which took place in hubs, grounds and Skye Centre)*	90%	G	G	G	G	95.67%	This indicator remains in the green zone.
Patients will undertake an annual physical health overview by the practice nurse	100%	G	G	G	G	100%	This indicator remains in the green zone.
Patients will undertake 150 minutes of moderate exercise each week	70%	A	R	R	G	66.67	This indicator moves from the red to the green zone.
Patients will have a healthier BMI	25%	R	R	R	R	11.33%	This indicator remains in the red zone.
Sickness absence rate	5%	R	R	R	R	6.45%	This indicator remains in the red zone
Staff have an approved PDR	80%	G	G	G	G	90%	This indicator remains in the green zone
Patients transferred / discharged using CPA	100%	G	G	G	G	100%	This indicator remains in the green zone.
Patients requiring primary care services will have access within 48 hours	100%	G	G	G	G	100%	This indicator remains in the green zone.
Patients will commence psychological therapies <18 weeks from referral date	100%	G	G	G	G	99.62%	This indicator remains in the green zone.
Patients have their clinical risk assessment reviewed annually.	100%	A	G	A	R	89.3%	This indicator remains in the red zone.

Definitions for red, amber and green zone:

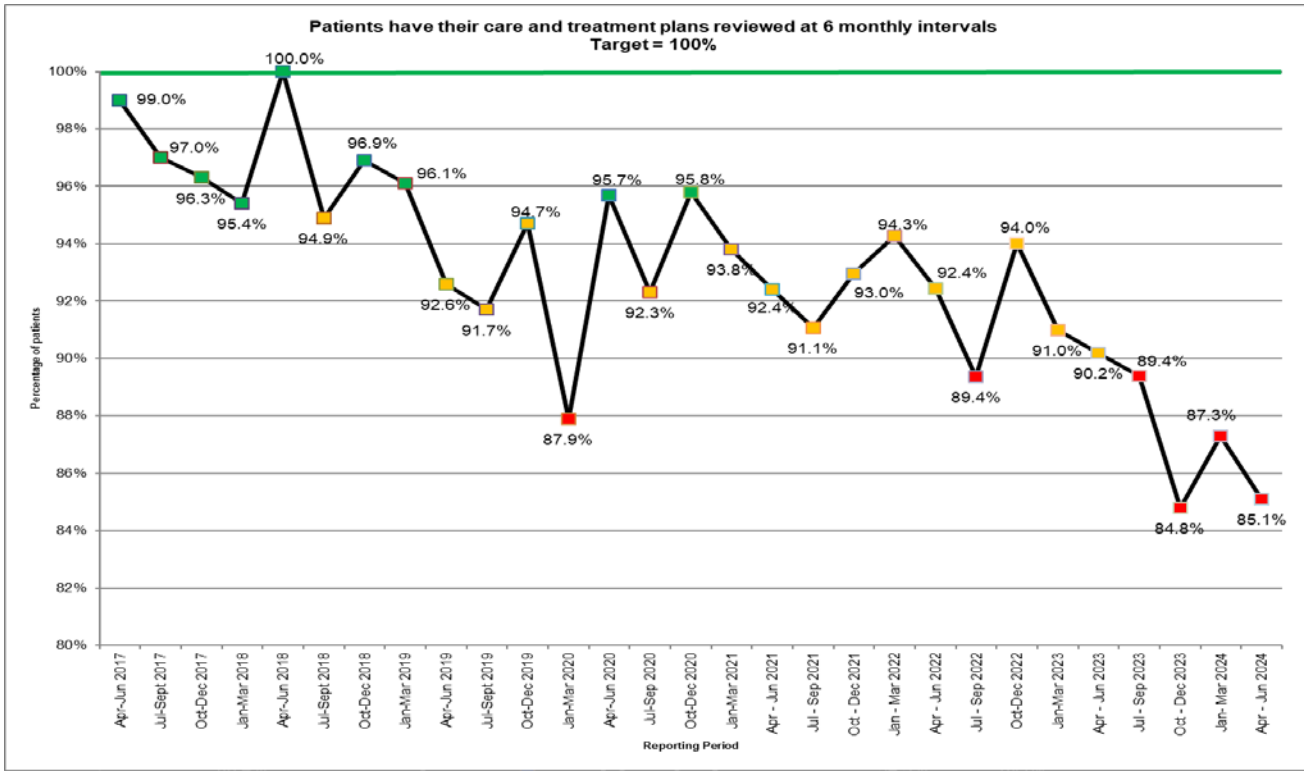
- For all but item 6 and 7 green is 5% or less away from target, amber is between 5.1% and 10% away from target and Red will mean we are over 10% away from target.

- For item 6: ‘Patients have a healthier BMI’ green will be 3% or less away from target, amber will be between 3.1% and 5% away from target and red will be over 5% away from target.
- For 7 ‘Sickness absence’ green is less than 0.5% from target, amber will be between 0.51% and 1% away from target and red will be over 1% and away from target.

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

Target: 100%
Data for current quarter: 85.1%
Performance Zone: Red

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



This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In April 2024 the compliance was 82%, May was 88.5% and in June 2024 compliance was 85% giving a quarterly compliance of 85.10%. This is a decrease from last quarter’s figure of 2.2%. This indicator remains to the red zone and has remain in the red zone since Q2 in 2023/24.

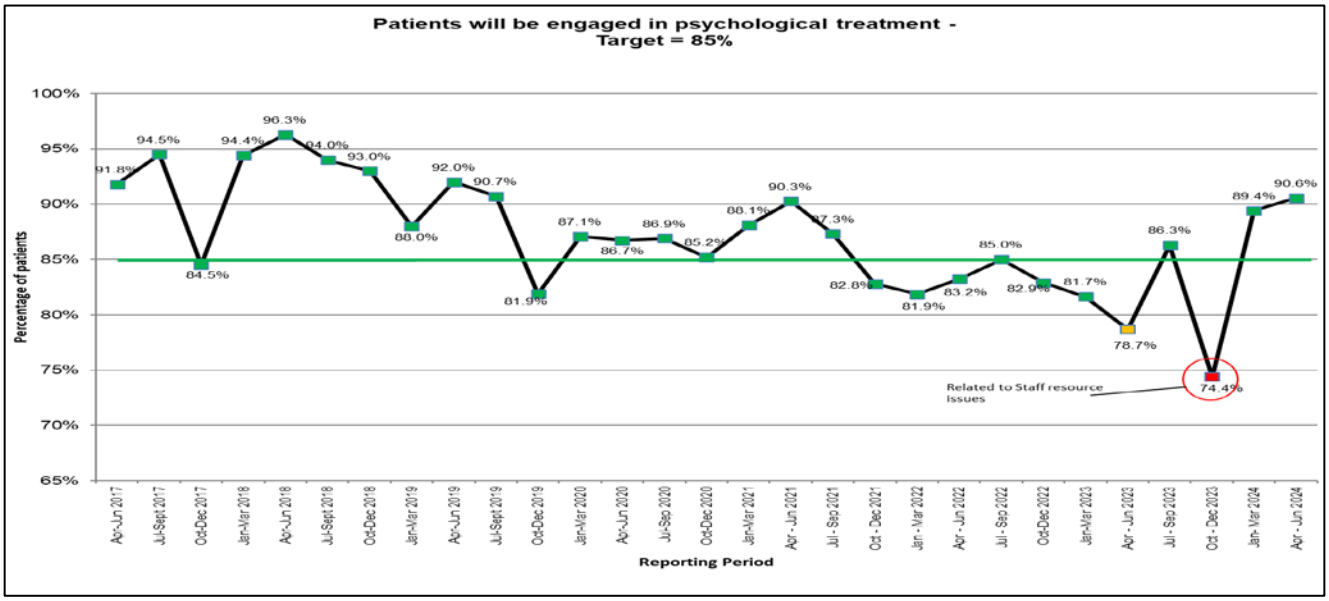
Work has commenced with the Medical Secretaries to develop a map of the current CPA process. There have been five areas identified which could cause potential holdups within the CPA process and a meeting has been arranged to discuss the next stage of the process considering the work currently being done by the Mental Health Practice Steering Group to move the CPA documentation onto RiO.

In the interim, Health Records staff will continue to send reminder emails to RMOs and medical secretarial staff to advise that a patient’s review or renewal of detention is due. Data is also being reviewed with an aim to provide clearer insights into any trends or patterns in delays in completion and / or uploading. The renewal of detention ties in with the annual CPA document being completed.

No 2: Patients will be engaged in Psychological Treatment

Target: 85%
Data for current quarter: 90.56%
Performance Zone: Green

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

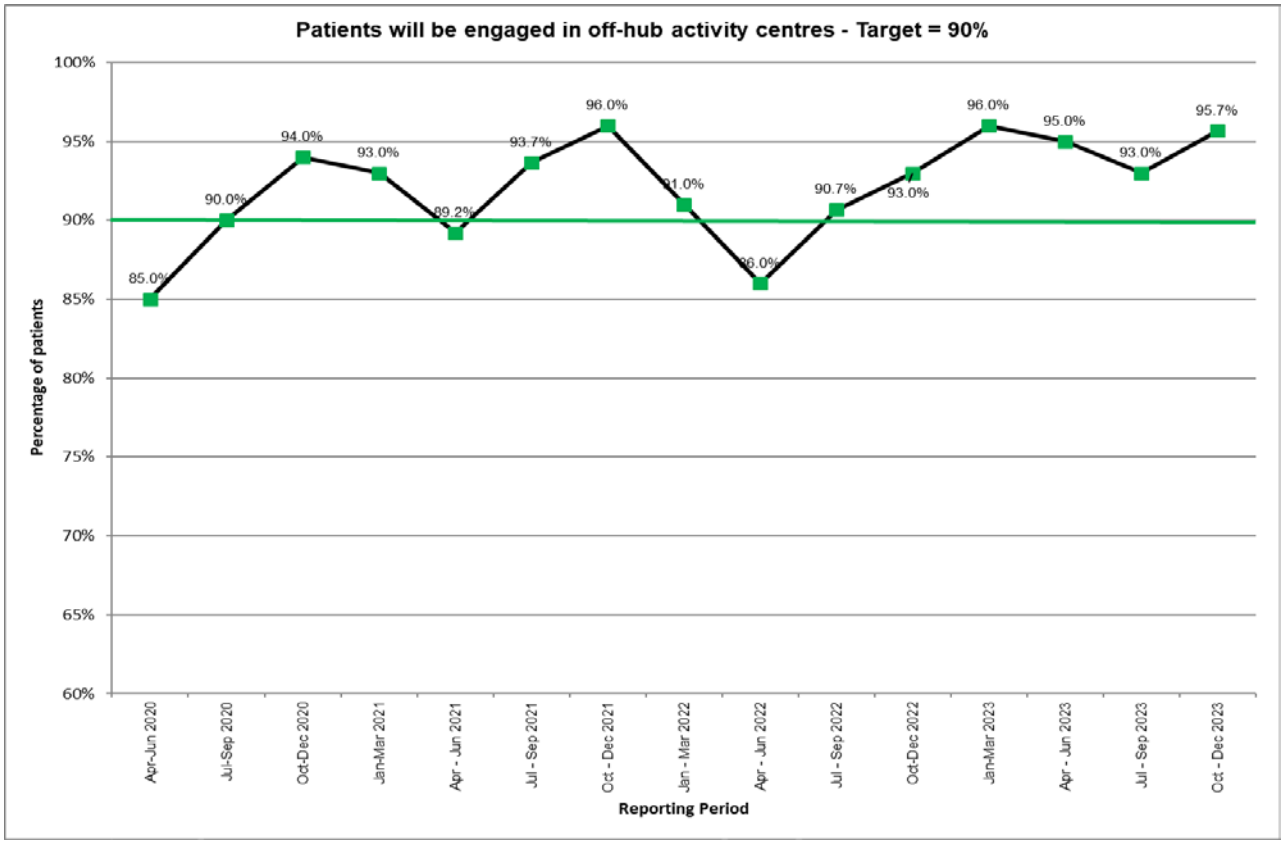


This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In April 2024, the compliance was 90.62%, May 2024 was 89.00% and June 2024 was 92.07% giving a quarterly compliance of 90.56%, which is an increase of 1.15% from the Q4 2023/24 figure. This indicator has remained in the green zone and above the target of 85% zone since Q4 2023/24

No 3: Patients will be Engaged in Off-Hub Activity Centers

Target: 90%
Data for current quarter: 95.67%
Performance Zone: Green

This measures the number of patients who are engaging in some form of timetable activity which takes place off their hub. The sessions may not necessarily directly relate to the objectives in their care plan however are recognised as therapeutic activities. This indicator includes data gathered pertaining to scheduled activity in addition to all off-ward drop-in activity rates at the Skye Centre.



In April 2024 the compliance was 92%, May was 98% and in June 2024 compliance was 97% giving a quarterly compliance of 95.67%, which is an increase of 2.67% from last quarter's figure. This indicator remains in the green zone. This indicator has remained in the green zone since Q3 2020.

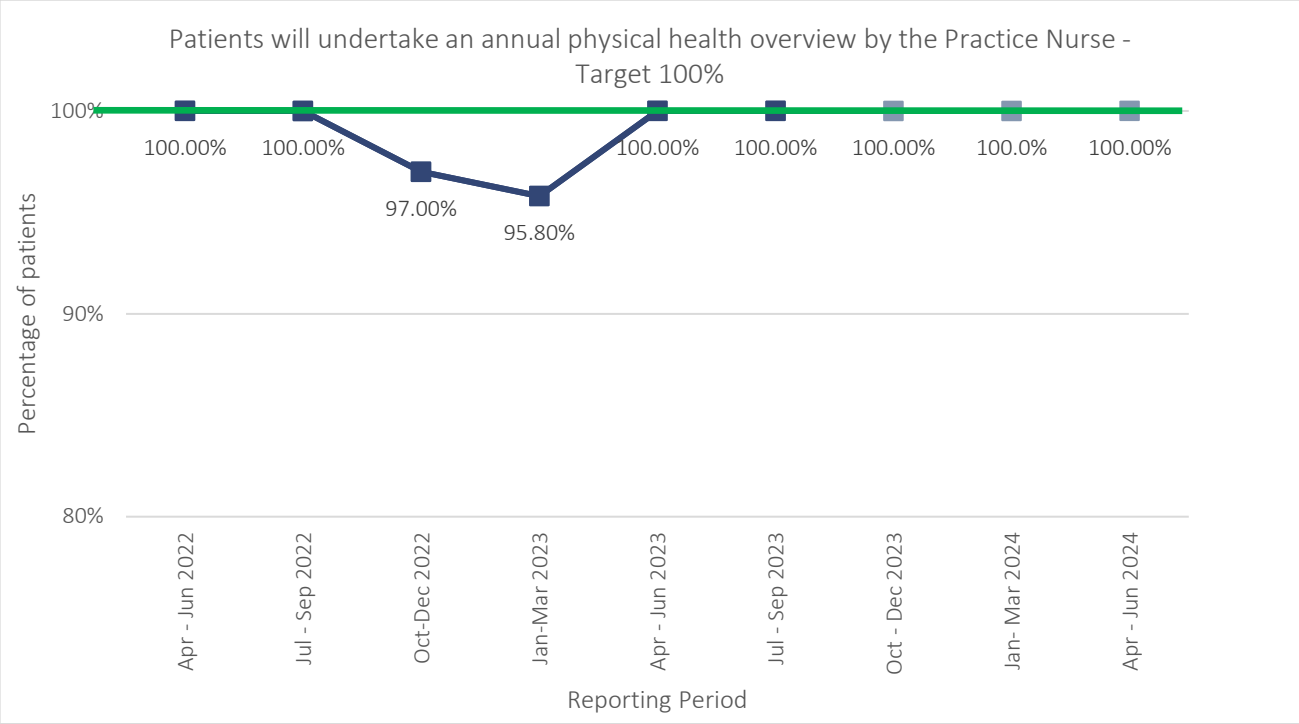
The Activity Oversight Group commissioned a review of this KPI to include all activity within the hospital not just off hub activity. Work is currently underway with the Senior Charge Nurses to review the information being provided through the patients' timetable for ward based activity.

No 4: Patients will Undertake an Annual Physical Health Overview by the Practice Nurse

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

This indicator is linked to the National Health and Social Care Standards produced by Healthcare Improvement Scotland (HIS). The indicator measures the uptake of the annual physical health review. The target has been increased in Q1 of 2022 to 100% from the 90% target to recognize that the Annual Physical Health Overviews should be carried out for every patient every year.

This KPI was amended to incorporate the uptake of an annual physical health review by all patients, rather than the previous data collection of an offering of a review. This KPI now charts the completion of an annual physical health overview by the Practice Nurse. The Practice Nurse then refers appropriate patients on for face to face review by the GP. The GP conducts these consultations to complete the physical assessment of the annual health review.



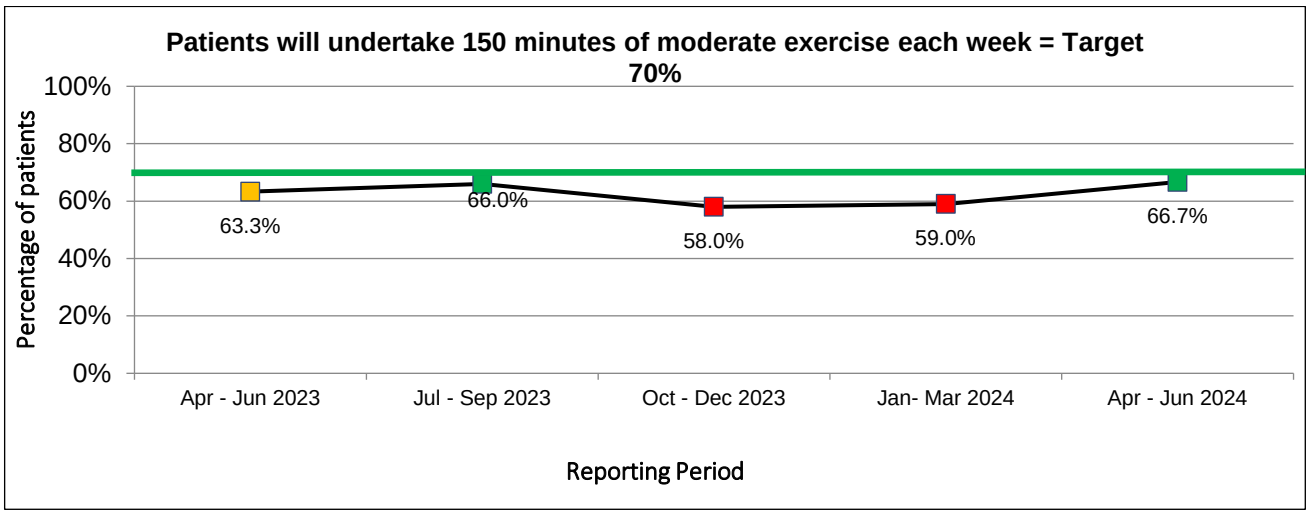
During Q1 2024-25, 100% of patients who were eligible for an annual physical health review were reviewed by the Practice Nurse.

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

Target: 70%
Data for current quarter: 66.67%
Performance Zone: Green

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

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



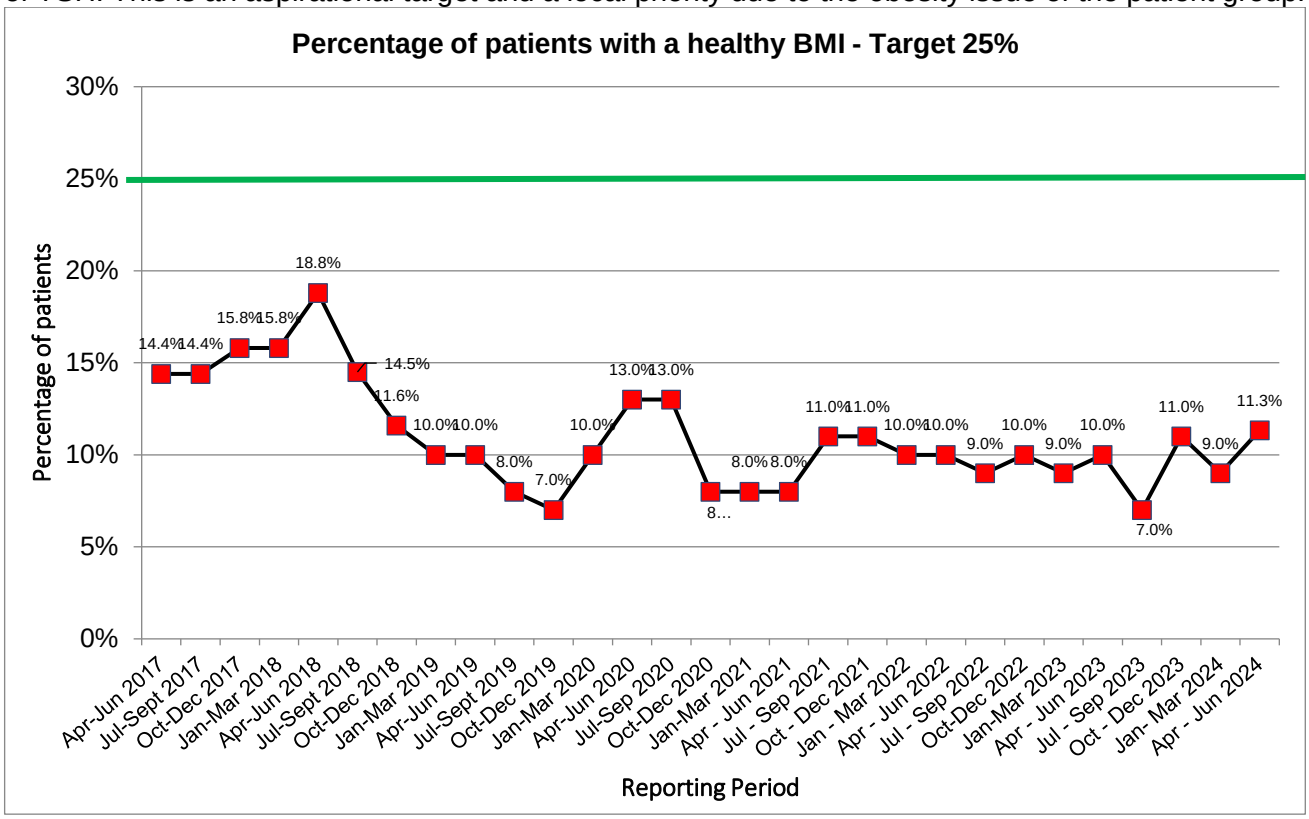
In April 2024 the compliance was 63%, May was 67% and in June 2024 compliance was 70% giving a quarterly compliance of 66.70%, which is an increase of 7.67% from last quarter's figure and an improvement from Q1 2023/24 of 3.4%. This indicator has moved from the red zone to the green

zone. There has been a focus on activity across a 6-week period starting 1 April 2024, 22 patients from all wards participated in Couch to 5k training supported by the Sports Dept. This concluded with a final event on 27 June 2024 where 15 patients participated. Focused sessions continue to be planned for Q2 to reflect national sporting events with an aim to encourage uptake of exercise.

No 6: Patients will have a Healthy BMI

Target: 25%
Data for current quarter: 11.33%
Performance Zone: Red

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



In April 2024 the compliance was 12%, in May 2024 the compliance was 10% and in June 2024 the compliance was 12%. The overall compliance for Q1 is 11.33% which is a 2.33% increase in Q4 2023-24 figures, this is the highest quarter since Q3 2020. However, this indicator remains in the red zone.

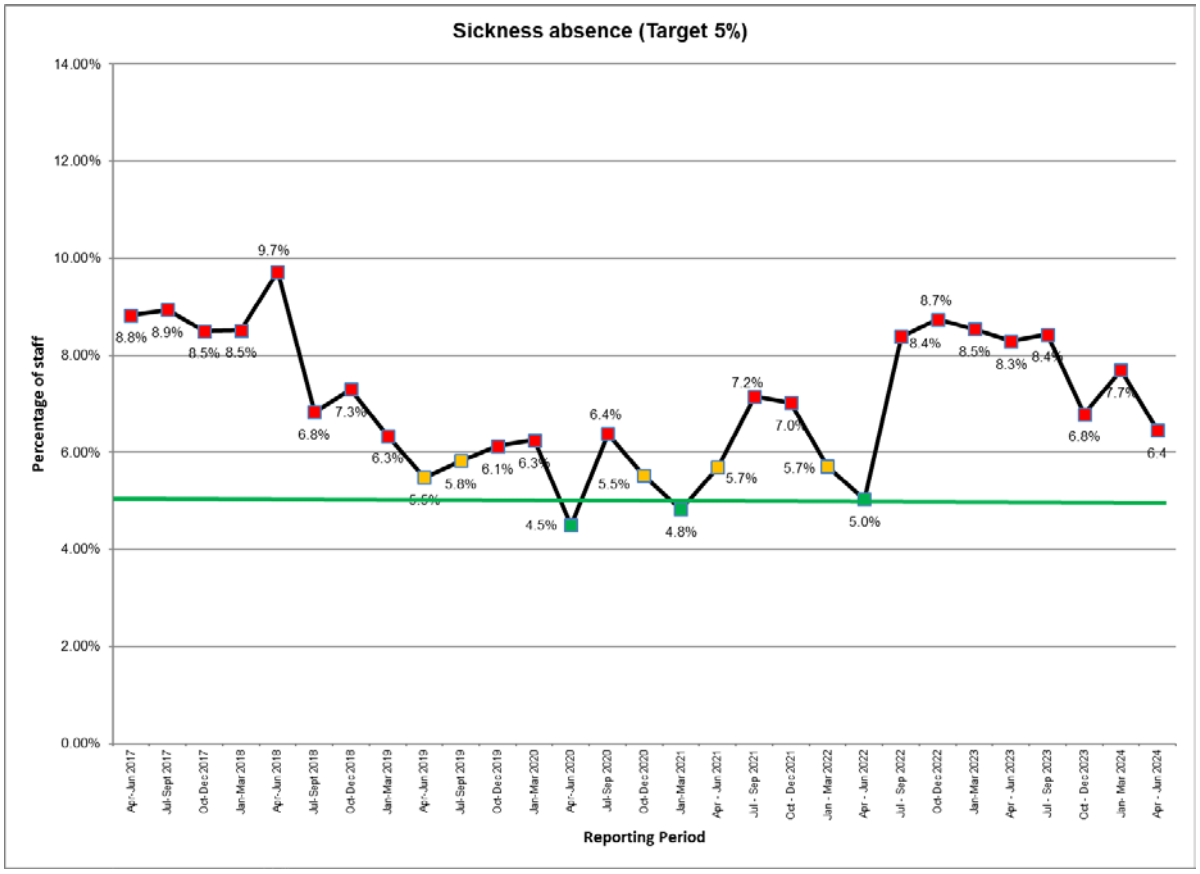
There is a QI project ongoing to address the numbers of patient weights that are not recorded in RiO each month. The Clinical Quality department currently report on weight data collected from across the month. TSH guidance states that weights should be recorded by the first full weekend of the month.

No 7: Sickness Absence

Target: 5%
Data for current quarter: 6.43%
Performance Zone: Red

This relates to the National Workforce Standards and measures how many staff are absent through sickness. This now includes COVID-19 related absences, these had been measured / reported separately until 31st March 2024, and from 1st April 2024 these are now part of the overall absence

figure. The State Hospital uses the data provided from SWISS for this KPI to align with all NHS Scotland Boards to ensure valid comparisons across Scotland can be achieved. The figures provided via SWISS data slightly differ from SSTS figures; this is due to the SWISS contractual hours being averaged over the 12-month period and the figures from SSTS are based on the contractual hours available within that month.



Q 1 has seen a reduction of 1.27 % in sickness absence in comparison in Q4 2023/24. Reducing sickness absence is an organisational priority The Staff Governance Committee agreed to establish a Task and Finish Group over 2023/24 to develop and co-ordinate an action plan with a range of activities to address attendance management and support staff. This group has implemented actions with local teams, which include:

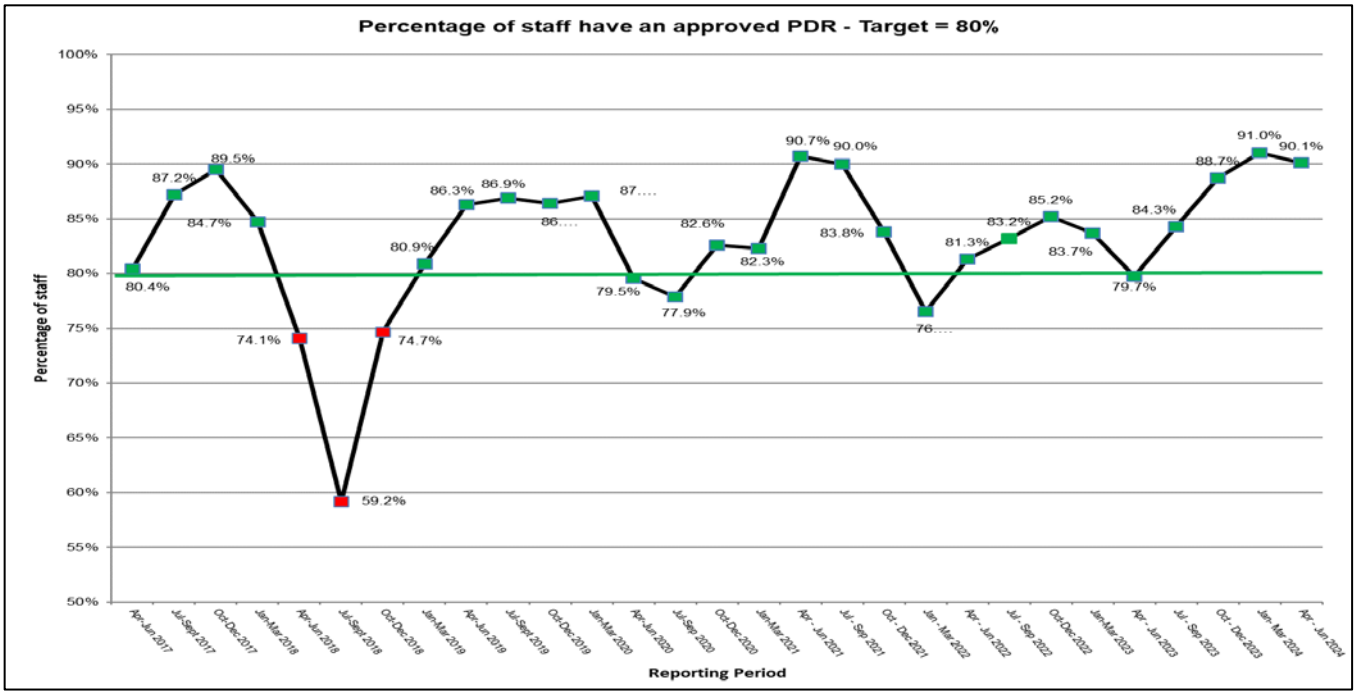
- Development of a Driver Diagram to provide an overview of actions.
- Coordinated management of hot spot areas
- Assurance that the Attendance Management Policy is fully implemented by local teams and managers, along with an understanding of other policies which impact Attendance at Work.
- Detailed absence information is available to highlight key hot spot areas and for the appropriate management to hold responsible managers to account.

The Staff Governance Committee agreed to cessation of the Task and Finnish group at their meeting in May 2024 with the agreement that activities would evolve into business as usual and a maximising attendance process would become embedded. There continues to be an ongoing focus on adherence to policy and accountability for performance managed within existing performance framework. Quarterly Directorate Performance Review meetings are held with Directorates and absence management is a focus for these meetings in areas where performance can be improved.

No 8: Staff have an Approved PDR

Target: 80%
Data for current quarter: 90.1%
Performance Zone: Green

This indicator relates to the National Workforce Standards; measuring the percentage of staff with a completed PDR within the previous 12 months.

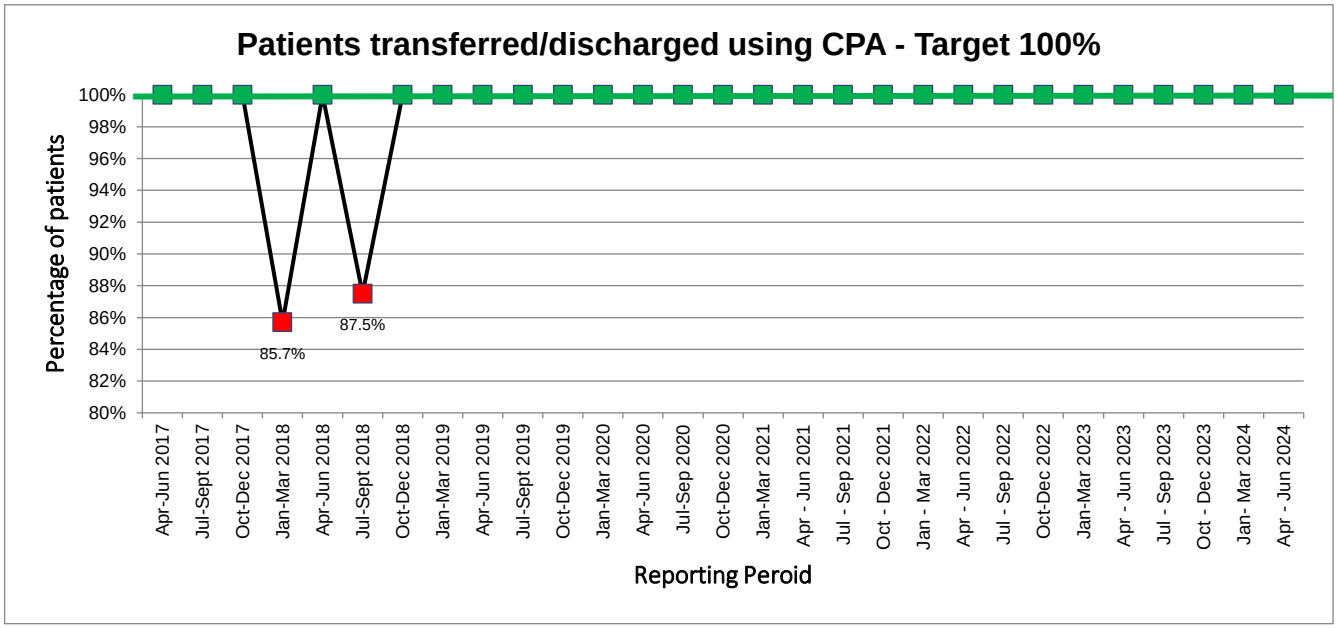


This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In April 2024 the compliance was 90.9%, May 2024 was 90.3% and June 2024 was 89% giving a quarterly compliance of 90.01%, which is a slight decreased from Q4 2023/24 of 90.01%. This indicator remains with the green zone and has remained about target since Q2 2023-24.

No 9: Patients are Transferred/Discharged using CPA

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

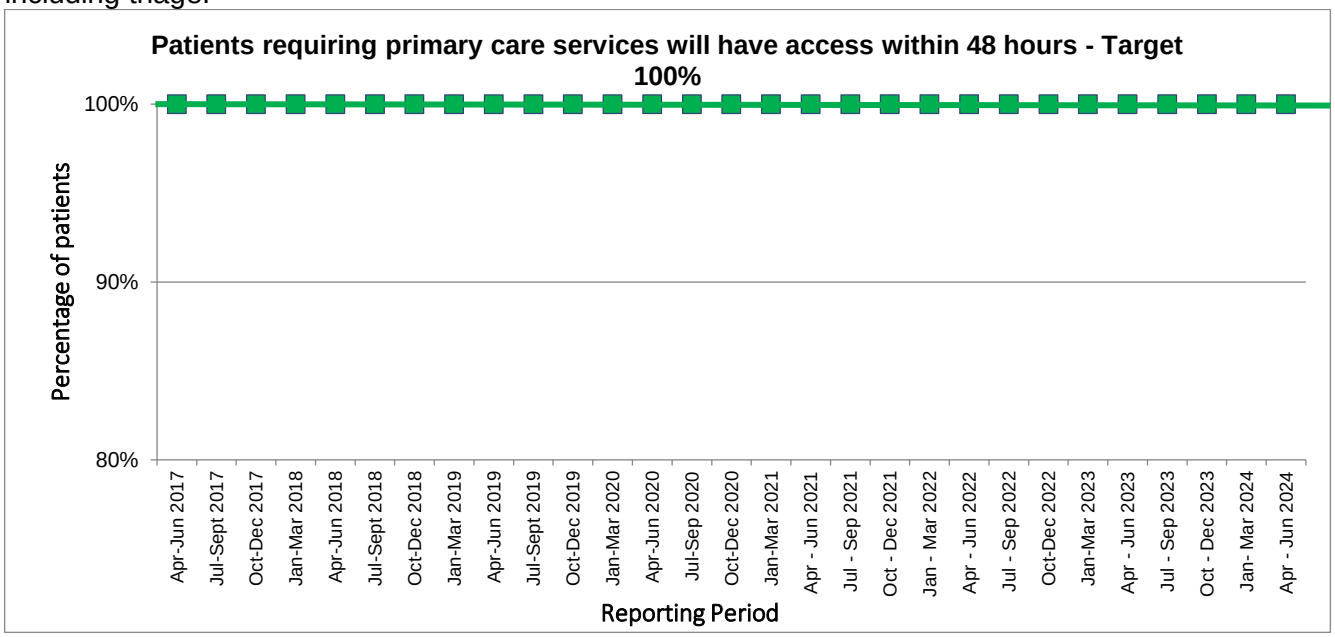
The indicator is linked to the Mental Health Act, 2003 and the streamlining of discharges and transfers. The number of patients transferred out using CPA process are measured through this indicator.



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

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

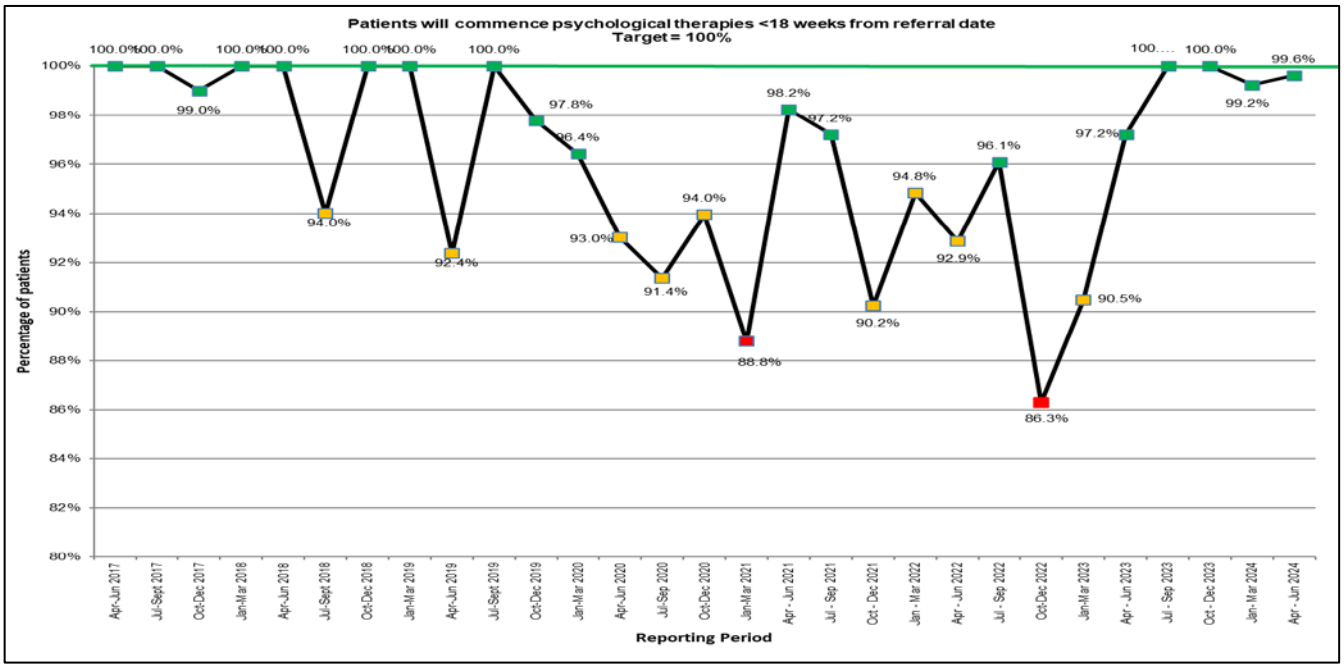
This indicator is linked to National Health and Social Care Standards as published by Healthcare improvement Scotland (HIS). Primary care services include any service at our Health Centre including triage.



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

Target: 100%
Data for current quarter: 99.62%
Performance Zone: Green

The indicator correlates to National Mental Health Indicators for Scotland to ensure that no patient waits more than 18 weeks to commence some form of psychological therapy. The data required for this calculation are the number of patients waiting to engage in a psychological intervention to which they were referred who has not already completed another psychological intervention whilst waiting.

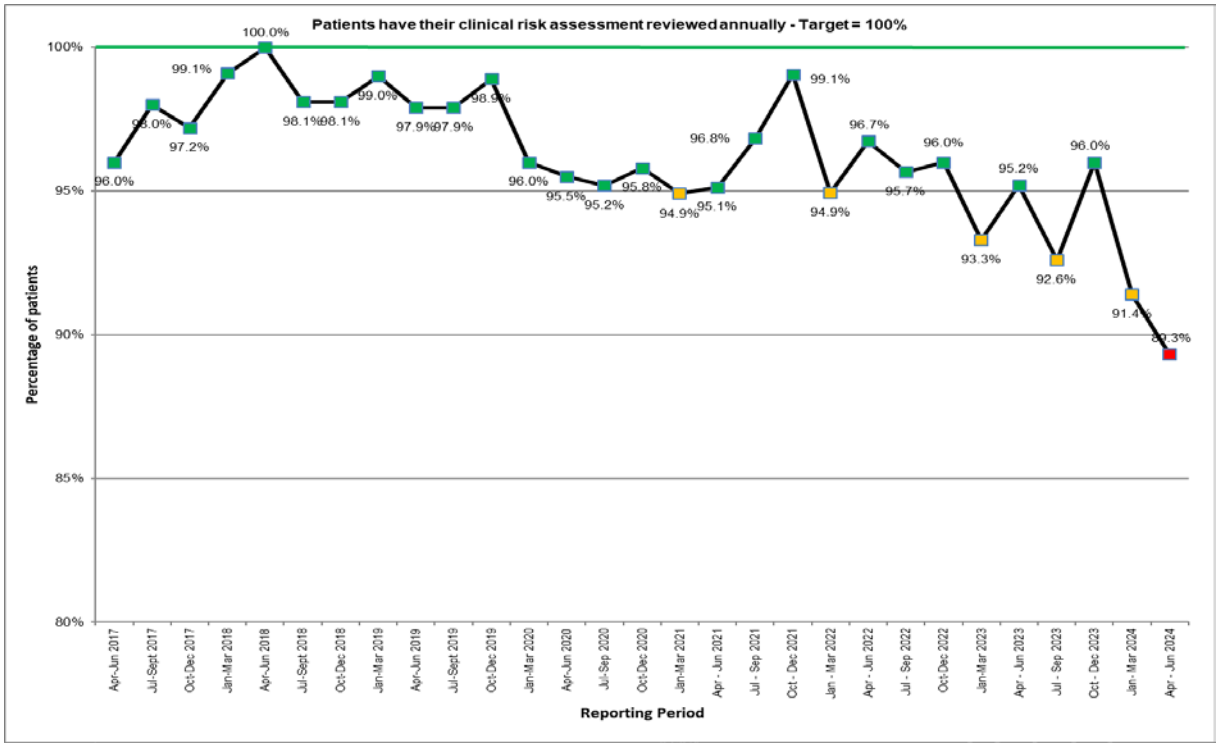


This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In April 2024 the compliance was 98.85%, May 2024 was 100% and June 2024 was 100% giving a quarterly compliance of 99.62%, which is an increase from 0.38% on Q4 2023/24 and remains in the green zone.

No 13: Patients have their Clinical Risk Assessment Reviewed Annually

Target: 100%
Data for current quarter: 89.3%
Performance Zone: Red

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



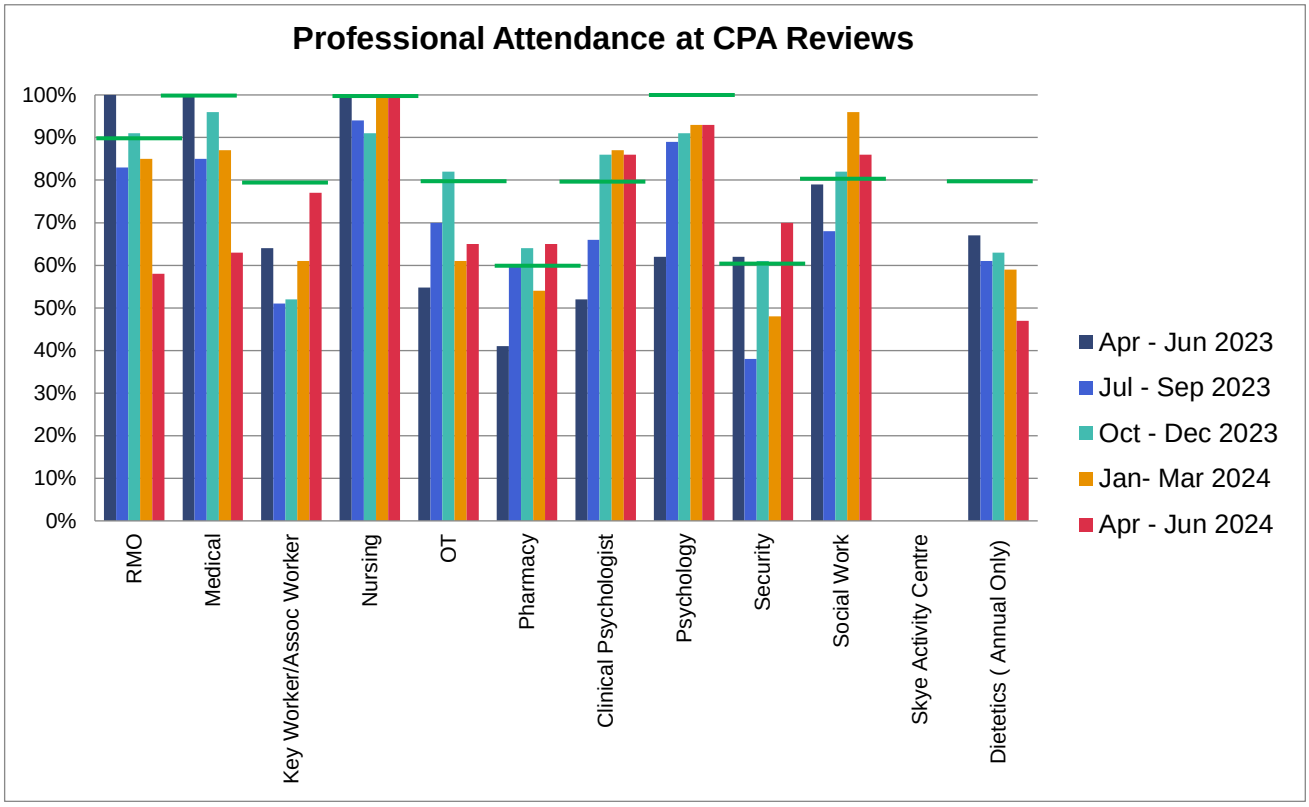
The number of risk assessments which were not closed off within RiO by their expected submission date in April 2024 the compliance was 90.8%, May 2024 was 88.5% and June 2024 was 88.6% giving a quarterly compliance of 89.3%, which is a decrease 2.1% on Q4 2023/24. This indicator decreased to the red zone.

The reasons for the declined in both Q4 of 2023/24 and Q1 2024/25 seems to be processing issues around uploading or closing off of risk assessment on RiO, which is currently being explored by the Psychology Department as an action to rectify from the Mental Health Practice Steering Group.

No 15: Professional Attendance at CPA Review

Target: Individual for each profession

Local priority area set out in within CPA guidance. The reasoning behind this indicator is that if patients have all of the relevant and important professions in attendance, then they should receive a better care plan overall.



Profession	Apr 24 n=11	May 24 n=16	Jun 24 n=16
RMO	64%	50%	63%
Medical	73%	56%	63%
KW/AW	64%	81%	81%
Nursing	36%	100%	100%
OT	64%	75%	56%
Pharmacy	64%	75%	56%
Psychologist	91%	94%	75%
Psychology	100%	94%	88%
Security	100%	56%	63%
Social Work	91%	81%	88%
Dietetics (annual only)	40%	75%	33%

The targets for attendance are set to reflect what is reasonable to expect from each discipline and have been in place for over 5 years. Attendance at case reviews was recorded as both physical and virtual attendance.

RMO – attendance for this profession has decrease from 85% in Q4 2023/24 to 58% in Q1 2024/25. This indicator moves from the green zone to the red zone. On one occasion, there was no reason for Consultant non-attendance and on one occasion the Consultant was on annual leave. On 16 occasions the VAT form was not completed. The last time this indicator was in the red zone was Q1 2022/23.

Medical – attendance for this profession has decreased from 87% in Q4 2023/24 to 63% in Q1 2024/25. This indicator moved from the amber to the red zone. This is the lowest attendance since Q2 2020/21

Key Worker/Associate Worker – attendance figures increased from 61% in Q4 2023/24 to 77% in Q1 2024/25. This indicator moved from the amber to the green zone. This is the highest attendance since Q4 2020/21

Nursing – during Q1, nursing attendance maintained 100%; this profession remains in the green zone.

OT – attendance has increased from Q4 2023/24 from 61% to 65% in Q1 2024/25 this profession remains in the red zone. There is a combination of reason including staff not allocated, staff annual leave and staff not available. There were two occasions where the VAT was not completed.

Pharmacy – attendance for this quarter has continued to increase from 54% to 65% meaning this profession moves from the amber to green.

Clinical Psychologists – this profession's attendance has decreased slightly from increase from 87% in Q4 2023/24 to 86% in Q1 2024/25. This indicator remains in the green zone and over target.

Psychology – this professions attendance has remains at 93%. This indicator remains in the amber zone.

Security - attendance from security has significantly increased this quarter to 70% from 48% in Q4 2023/24. Security moves from the red zone into the green zone.

Social Work – attendance has decreased in Q1 2024/25 from 96% in Q4 2023/24 to 86% however the profession remains green zone and over target.

Dietetics – attendance from dietetics has decreased from 59% in Q4 2023/24 to 47% in Q1 2024/25. This profession remains in the red zone and has remained in the red zone since Q2 2022/23. There is a combination of reason including annual leave, staff not available and staff not on duty.

4. RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of TSH Key Performance Indicators links to both the TSH corporate objectives and the Annual Delivery Plan 2024-2025. The KPI's provide assurance to TSH Board on key areas of performance. Some of the KPI's are national targets which TSH is held accountable for performance nationally, others are local priorities for TSH Board. The TSH Performance Framework proves an overview of how performance is managed across TSH. Scottish Government will receive this report following approval from TSH Board as an indicator of TSH performance.
Workforce Implications	No workforce implications - for information only.
Financial Implications	No financial implications - for information only.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Via Strategic Planning and Performance Group
Risk Assessment (Outline any significant risks and associated mitigation)	If KPI's are off target the improvement plan to address this is detailed in the paper
Assessment of Impact on Stakeholder Experience	Not formally assessed
Equality Impact Assessment	No implications identified.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

Director of Mental Health

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24 June 2024

Dear Gary

THE STATE HOSPITAL DELIVERY PLAN 2024/25

Many thanks for submitting your NHS Board Delivery Plan 2024/25. May I take this opportunity to thank you and your team for all the hard work that has gone into the preparation of this plan over recent months.

Whilst great progress has been made, our NHS continues to face significant challenges as we recover from the ongoing impacts of the Covid pandemic, coupled with a related period of ongoing financial challenge. We welcome the approach being taken by your Board to develop your service delivery and financial planning in an integrated way and to ensure that patient safety and front line services are appropriately prioritised whilst working within agreed budgets.

We fully recognise the significant and ongoing challenge this represents and acknowledge that planning is currently set within a landscape of uncertainty and risk. In particular, we understand that delivery is dependent on achieving the necessary savings as set out in your Financial Plan. This is the lens through which we have been reviewing your plan to ensure that it provides sufficient assurance that it is in line with the priorities of NHS Scotland and the Scottish Government.

In that context, we are satisfied that your Delivery Plan broadly meets our requirements and provides appropriate assurance under the current circumstances, and we are therefore content for you to proceed to seek final approval from your Board. However, even more so than in previous years, whilst these Delivery Plans provide an agreed way forward, they must also remain dynamic and responsive to the fluid situation in which we find ourselves. For example, reflecting the role of TSH in supporting work on sustainable services and, in some cases, re-aligning activities to address areas of national priority.

To help support this continuous improvement, we have included a range of feedback arising from our review of your plan, which is summarised in Annex A. This covers a small number of ‘Priority Areas’ where, as part of our ongoing engagement with your Board, we will be seeking assurance that actions are being undertaken to address. Alongside these, there are a wider range of “Development and Improvement Areas” which you and your colleagues will wish to reflect on in order to drive improvements in your future planning and delivery.

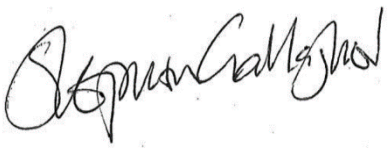
Our approval of the plan as whole is contingent upon the understanding that your Board will continue to work closely with the Scottish Government around its delivery and implementation over the coming year. We will be looking to provide greater clarity and consistency around how we in the Scottish Government commission work from all the

National Boards, and a Scottish Government Directors Letter (DL) will issue in the coming weeks setting out expectations around commissioning of national services.

We also welcome the work being undertaken by all the National Boards to identify opportunities to release efficiency through further collaboration. The Scottish Government Health Planning Team and Sponsor Teams will engage with you over the summer to discuss how we can build on this work to ensure that future planning guidance is more appropriately tailored for National Boards to support a greater shared understanding of core National Board planning responsibilities, areas of collaboration and cross-cutting work.

Once again, many thanks to you and all your colleagues, and we look forward to continuing to work with you as we plan and deliver the highest possible quality of care for patients, improve the experience of our staff and ensure the best possible value for citizens. If you have any questions about this letter, please do not hesitate to get in touch with either myself or Paula Speirs, Deputy Chief Operating Officer for Health Planning (dcoohealthplanning@gov.scot).

Yours sincerely



Stephen Gallagher
Director of Mental Health

Annex A:

General
Priority Areas
None
Development and Improvement Feedback
From a high-level perspective, it appears that there are no substantive changes to The State Hospitals (TSH) delivery of their service. The impacts the current environment is having on TSH is the issue of finance and resource and this is a risk to some of the actions under the drivers. The overall running of the service appears to be unaffected with it only being the delivery of proposed improvements and projects, which may have an impact on performance against some priorities. The main factor that presents itself as an issue for the Board is financial context and resourcing. 84% of the Boards budget goes towards staffing and therefore any saving made outside this figure may have an impact on the Board's ability to achieve the priorities they have set out. This would include maintenance, staffing and fixed term posts coming to an end. Whilst it seems that some of the priorities have actions with no clear 'KPI' or end goal, I believe that the plan appears to be realistic and achievable by the Board. These have been marked on the plan and TSH appear to have been transparent regarding this. The noted priorities where this has been given specific signposting are as follows: **Mental Health (Priority 1.4):** Actions stemming from TSH's preventative maintenance programme 2023-26 may not be achieved depending on affordability/capital group assessment. This is not to say that they will not achieve an improved environment for the service and increase patient safety as the TSH is purpose built and is relatively new. The security upgrade project at the service is to be completed in early 2024-25 and will contribute towards this priority. **Digital Service Innovation Adoption (Priorities 4.5/4.6):** Whilst these priorities are set by TSH themselves, financial constraints may cause issues with progress for patient digital inclusion and the development of digital maturity within the service. Where it is identified that work is achievable, progress will be made. There is an expected delay in patient digital inclusion and a business case is to be considered for 2025-26. Further e-Health projects are to be prioritised and monitored against the available resource as well. This may well be that these priorities may not be able to be fully achieved in 2024-25. This is a big project for TSH as they already feel that there is significant digital deprivation for patients at the service. **Climate Emergency and Environment (Priority 5.4):** Financial pressures may affect the pace in which the Board moves to an all-electric vehicle fleet, therefore potentially impinging on an overall deadline of 2025 for cars and light commercial vehicles in line with the set actions from the commission. The plan does set out assurance that it is in line with the priorities set out in the guidance as these appear on the plan and have actions related to them where applicable. TSH is a niche service, so some of the priorities/drivers are not relevant, however, TSH have also included priorities which are bespoke to themselves as well.

Development and Improvement Feedback (continued)

The plan also references actions as set out in the Mental Health and Wellbeing Delivery plan for Forensic services (Strategic Action 8):

- Strategic Planning and Governance of Forensic Mental Health Services (Recommendation One of the Independent Review).
- Deliver services in Scotland for women who need high secure care and treatment in the short and long-term (Recommendation Three of the Independent Review)
- Consider changes to practice and legislation, beyond the Independent Review, that will improve or simplify the delivery of forensic mental health services for service users and put in place a plan for taking these improvements forward.

These relevant priorities can be found in TSH's plan under section 1. Mental Health. That being said the Mental Health section plan does not contain any specific wording which references the strategic Action 8.1.3 of the Mental Health and Wellbeing Delivery plan for data collection. However, this can be inferred by looking at their section 4 for Digital Service Innovation Adoption, as they state they will link in with national programmes as well as their action to actively collaborate with stakeholders within the forensic mental health estate. Although it may be worth spelling this out within the relevant section to provide the link in with the Mental Health and Wellbeing Strategy.

It is recognised that the Board has been working with other National Boards and participating in a series of workshops during February and March 2024 to identify opportunities to release efficiency through further collaboration. This will form a workplan to be overseen by the National Boards Collaborative Programme Board. National Board Chief Executives have also agreed a Collaborative Charter. The Scottish Government Health Delivery Planning Team will wish to engage with the outputs of this work to help support how it frames planning of National Board priorities in future.

Recovery Driver	Take forward the actions in the Women's Health Plan and support good **child and maternal health**, so that all children in Scotland can have the best possible start in life.
Priority Areas	
• None	
Development and Improvement Feedback	
It is recognised that any actions taken would be for the workforce population. Note that the workforce was considered by age and job family but not by gender. As it may be expected for women to be more present within some job families more than others, this would give better insight in to the needs of the work place population and would link nicely with the implementation of the menopause and menstrual health work place policy.	

Recovery Driver	Implementation of the **Workforce** Strategy
Priority Areas	
• None immediately specific to the Delivery Plan; however the Board should continue to work with the Scottish Government to drive closer alignment between workforce and delivery planning.	
Development and Improvement Feedback	
The State Hospital continue to review the local workforce plan to ensure this is reflective of the current and future priorities, based on local data and emerging national trends, aligned to the Mental Health and Wellbeing: Workforce Action Plan 2023-2025. From the information provided NHS State Hospital's actions appear appropriate and realistic.	

Recovery Driver	Optimise use of **digital & data technologies** in the design and delivery of health and care services for improved patient access and fast track the national adoption of proven **innovations** which could have a transformative impact on efficiency and patient outcomes

Priority Areas

- None

Development and Improvement Feedback

It is welcome that the Plan has a really clear and considered approach to digital inclusion and has set out an options appraisal, with funding options are being considered based on the financial challenge. The plan lacks detail of delivery milestones to appropriately assess progress against national programmes but this can be picked up with Digital Health and Care in SG and through Digital Leads meetings.

The State Hospital have set out actions against the national priorities that are relevant to them. These appear to be in line with the national direction. Key points pulled out that may require further discussion:

- Engagement with national programmes including M365, Sharepoint and e-rostering – difficult to get a feel for progress against these with information provided.
- Digital skills programme could be stronger on how the Health Board's wider workforce can develop their digital skills and understanding.
- HEPMA – introduced in TSH in April 2022. Training requirements have been identified as part of roll out (can be picked up through national HEPMA programme roll out).

The plan indicates the financial position will impact on TSH ability to deliver its overall digital ambitions and is placing pressure on digital teams. It would have been useful to have seen more on how digital mental health resources are being considered but recognise this is linked into their digital inclusion funding consideration.

Recovery Driver	**Climate** Emergency and Environment

Priority Areas

- None

Development and Improvement Feedback

There are opportunities to consider active and sustainable travel alongside staff recruitment, retention, and improved public health as stated in planning priorities 2.1 and 2.2.

On waste, the Board has identified that they are going to progress with a high level route map, this is already in place for NHS Scotland Boards so they could develop a Board specific route map from work previously done.

A newly established Climate Change and Sustainability Group will provide required strategic support to prioritise sustainability and decarbonisation measures across the site. There is no significant mention of building energy upgrades outside of LED lighting. Outside of the Delivery Plan itself, NHS Assure have engaged with State Hospital who have significant decarbonisation measures planned to lower emissions through installation of renewables however this requires significant capital investment, hence not a priority identified for 2024/25.

The Board has identified potential impacts of climate change on their healthcare assets and services but is still in the process of finalising its adaptation plan.

The Board have noted their intention to complete a biodiversity action plan.

Sections 2.1 & 5.3 of the plan contains some detail and shows a level of understanding, and references to local employment are acknowledged and welcomed. Little detail if provided about Board specific actions in relation to procurement and if the Board is contributing to national work streams. The plan indicates waste work to be completed by Q4, in effect this means the Board will not meet regulatory targets due by 2025 which were set in 2012, and it would be helpful to engage further with the Board on this.

Supporting Theme	Finance & sustainability
Priority Areas	
• None immediately specific to the Delivery Plan; however, the Board should continue to work with the Scottish Government *Health Finance Team* on their Financial Plan and ensure that this is fully aligned with updates to the Delivery Plan.	
Development and Improvement Feedback	
None.	

Supporting Theme	Value Based Health & Care
Priority Areas	
• None	
Development and Improvement Feedback	
Realistic Medicine firmly embedded throughout this Delivery Plan and clearly viewed as an enabler of recovery and reform. The Delivery Plan demonstrated real commitment to supporting the workforce to practise Realistic Medicine in order to deliver better value care . This is precisely the approach we'd like to see, with Boards recognising the benefits that Realistic Medicine and Value Based Health and Care can deliver. The Board should be commended.	

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 August 2024
Agenda Reference:	Item No: 23
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Programme Director
Title of Report:	Perimeter Security and Enhanced Internal Security Systems Project
Purpose of Report:	For Noting

1. SITUATION

This report to the Board summarises the current status of the Perimeter Security and Enhanced Internal Security Systems project. Board members are asked to note the overall project update, the financial report and any current issues under consideration by the Project Oversight Board.

2. BACKGROUND

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

- Twice weekly *(Mon & Wednesday)*: Site operational meeting
- Weekly Technical Review Meeting
- Weekly: 'Look ahead' meeting
- Twice monthly: Strategic Oversight Group
- Monthly: Project Oversight Board

The Project Oversight Board meeting last took place on 15th August 2024; The next Project Oversight Board is scheduled for 19th September 2024. At the meeting of 15th August the Programme Director provided an update on the current status on the project, the Project Risk Register and financial details.

3. ASSESSMENT

a) General Project Update:

The project is in the final stages. All quality targets are being met; project completion is now scheduled for 22 October 2024 (see Project Timescales for a detailed overview of current progress at 3b below) and costs are projected to overspend (See Finance – Project Cost at point 3c below).

b) Project Timescales

Programme revision 60a has been accepted. A verbal update on progress since the time of writing will be available to the Board.

The installation of technology is substantially complete. Remaining works are final elements of installation, Site Acceptance Testing of the installation and production of documentation. Quality assurance testing and acceptance associated with the CCTV issues remain the primary cause of recent programme delays. Other final elements of installation include commissioning of external perimeter cameras, and a quantity of minor works that are still outstanding.

c) Finance – Project cost

The project is proceeding according to the current projected cost plan, in that the contract with Securitas is due to underspend against budget, including available contingencies. Project management costs and associated contingencies have been affected by changes in the project timescale. The project currently has a potential overspend (exclusive of VAT) of approximately £723k. This has increased by approximately £43k since the June 2024 report to the Board.

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

Project Start Date:	April 2020
Planned Completion Date:	October 2024
Contract Completion Date:	May 2022
Main Contractor:	Securitas Technology Limited
Lead Advisor:	Thomson Gray
Programme Director:	Doug Irwin

Total Project Cost Projection (Exc. VAT) at 10/08/24:	£9,514,960
Total costs to date (exc. VAT & retention) at 10/08/24:	£9,369,126
Total costs to end of project (Exc. VAT & retention)	£ 145,834

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

While it is not a prerequisite of the project, regular reports to the SG Capital team are also being provided to notify of progress against total budget. A letter to Scottish Government was issued week commencing 29 January 2024 as part of the financial planning for 2024 – 2025 outlining the projected spend from April 2024 to anticipated end date and this has been accepted.

A Rounded breakdown of actual spend to date (Exc. VAT) at 10/08/24 is:

Securitas	£ 7.274m
Thomson Gray	£ 1.105m
Doig & Smith	£ 0.008m
HVM	£ 0.192m
Staff Costs	£ 0.895m
Income	-£ 0.105m
Total	**£ 9.369m**

VAT has been excluded from calculations of amounts paid due to the potential for final adjustments on project completion.

4 RECOMMENDATION

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

MONITORING FORM

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