THE STATE HOSPITALS BOARD FOR SCOTLAND
BOARD MEETING

THURSDAY 24 OCTOBER 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 22 August 2024	For Approval	TSH(M)24/07
4.	**Matters Arising:** **Rolling Actions List: Updates**	For Noting	Paper No. 24/80
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
9.50am	**RISK AND RESILIENCE**		
7.	**Corporate Risk Register** Report by the Acting Director of Security, Estates & Resilience	For Decision	Paper No. 24/81
8.	**Finance Report – to 30 September 2024** Report by the Director of Finance & eHealth	For Noting	Paper No. 24/82
9.	**Bed Capacity Report:** **The State Hospital and Forensic Network** Report by the Medical Director	For Noting	Paper No. 24/83
10.15am	**CLINICAL GOVERNANCE**		
10.	**Clinical Model – 12 Month Evaluation** Report by the Medical Director	For Noting	Paper No. 24/84
11.	**Quality Assurance and Quality Improvement** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 24/85
12.	**Medical Education Report** Report by the Medical Director	For Noting	Paper No. 24/86
13.	**Medical Appraisal and Revalidation Annual Report** Report by the Medical Director	For Noting	Paper No. 24/87

11.05am	**BREAK**		
11.15am	**STAFF GOVERNANCE**		
14.	**Staff Governance Report** Report by the Director of Workforce	For Noting	Paper No. 24/88
11.30am	**CORPORATE GOVERNANCE**		
15.	**Board Improvement Plan** Report by the Head of Corporate Governance	For Noting	Paper No. 24/89
16.	**Communications Annual Report** Report by the Head of Communications	For Noting	Paper No. 24/90
17.	**Information Governance Annual Report** Report by the Director of Finance and eHealth	For Noting	Paper No. 24/91
18.	**eHealth Annual Report** Report by the Director of Finance and eHealth *Reporting deferred to December 2024*	For Noting	Paper No. 24/92
19.	**Network and Information Systems: Progress Update** Report by the Director of Finance and eHealth	For Noting	Paper No. 24/93
20.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 24/94
21.	**Audit and Risk Committee:** Approved Minutes of meeting held 20 June 2024	For Noting	ARC(M) 24/03
	Report of meeting held 26 September 2024	For Noting	Paper No. 24/95
22.	**Any Other Business**		Verbal
23.	**Date of next meeting:** 9.30am on 19 December 2024		Verbal
24.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
25.	**Close of Session**		Verbal

Estimated end at 12.30pm

THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 24/07**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 22 August 2024.

This meeting took place in the Boardroom at the State Hospital and also by way of MS Teams, and commenced at 9.30am

Chair:	Brian Moore

Present:

Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	Cathy Fallon
Chief Executive	Gary Jenkins
Director of Nursing and Operations	Karen McCaffrey [from Item 13]
Vice Chair	David McConnell
Director of Finance and eHealth	Robin McNaught
Non-Executive Director	Pam Radage
Medical Director	Lindsay Thomson

In attendance:

Associate Nurse Director	Josie Clark
Mental Health Social Work Manager	David Hamilton
Acting Director of Security, Estates & Resilience	Allan Hardy
Head of Communications	Caroline McCarron
SCN Skye Centre	Alex McLean [Item 7]
Head of Planning, Performance and Quality	Monica Merson
Head of Corporate Governance/Board Secretary	Margaret Smith [Minutes]
Director of Workforce	Stephen Wallace

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone, and noted that apologies for the meeting from Ms Shalinay Raghavan, Non-Executive Director.

2 CONFLICTS OF INTEREST

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

3 MINUTE OF THE PREVIOUS MEETING

The minute of the previous meeting held on 20 June 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 20 June 2024.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

There were no matters arising for discussion, from the previous meeting minute.

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, including two meetings of NHS Board Chairs with the Cabinet Secretary for Health and Social Care. There had been focus on two important issues; delayed discharges and the financial challenges facing NHSScotland. Further, an update was provided on the development of a ten-year population health framework for Scotland highlighting the major challenges that exist. There had also been a review of the recent cyber-attack on NHS Dumfries & Galloway, and the lessons learned, and Mr Moore noted the importance of this for the State Hospital (TSH) in terms of gaining assurance on preparedness.

Mr Moore also advised that he had been delighted to attend the TSH Couch to 5K event, were patients completed a 5k run within the hospital grounds, as a finale to weeks of training for this. Mr Moore commended the strong sense of mutual support and encouragement among patients, as well as staff. A wide range of staff groups attended the event in support, with some taking part in the run itself.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins provided a summary of his activities since the last Board, and noted that NHS Board Chief Executives had also been focused on any lessons that could be learned from the recent cyber-attack. They had received a presentation from the Chief Executive of NHS Dumfries & Galloway on the key learning points. Mr Jenkins noted that he had arranged for a presentation for the Corporate Management Team (CMT) by the Head of eHealth focused on TSH, and this would take place at the meeting on 4 September. Mr McNaught added that a key point was that audit work around Network Information Systems (NIS) related to systems and process, but was not an assurance mechanism for preparedness against cyber-attack in of itself. It was noted that reporting would come back to the Board in this respect.

Action – Mr McNaught

Mr Jenkins advised that Board Chief Executives (BCE) had received a helpful update from the Chief Executive of COSLA, particularly on the development of a National Care Service and the link to meeting the challenge of delayed discharges within the system. He referenced his involvement in the BCE Integrated Care Portfolio, to help put mental health care at the core of this.

He noted the aspiration to create a female high security service for Scotland on the part of Scottish Ministers, and noted that discussions on finance were at a very early stage following presentations on the likely capital and revenue requirements. Mr Jenkins also noted the publication of DL(2024)18 'Update on Strategic Planning and Governance for Forensic Mental Health in Scotland' on 8 August. It was anticipated that the Terms of Reference for the Forensic Governance Advisory Group would be available shortly, and that the group would report their findings within six months.

Mr Jenkins noted that he had also been very pleased to attend the 5k run in the hospital, to support patients. Along with Ms Merson, he had also attended a cheque presentation to the Beatson Cancer

Charity for £625.50. This was the result of TSH patients walking, running, or cycling over one thousand miles collectively - the equivalent distance from Hampden Park to the Olympic Stadium in Berlin.

He advised that there had been an engagement session for the TSH Executive Team with NHSScotland Chief Operating Officer, Mr John Burns, and this had been a helpful and constructive session. On 26 August, there would be the next scheduled quarterly meeting with the Scottish Government Sponsor Team.

Within TSH, Ms Merson and Mr Wallace had led a strategic planning and organisational development (OD) session linking this to the Medium Term Plan, as well as the Workforce Plan. Work was also progressing on a review of front line resourcing within Nursing and Operations, following the implementation of the new clinical model. This was to evaluate the metrics and lead on a proactive solution. Updates on these workstreams would be brought to the Board.

Action(s): Ms Merson/ Ms McCaffrey

Mr Jenkins highlighted the announcement of a national Agenda for Change (AfC) pay offer of a 5.5% pay uplift for 2024/25, which was currently under consideration by Trade Unions and their members.

He also advised the Board that he would be attending a range of national and regional meetings in the coming weeks; including the Mental Health and Wellbeing Strategy Board chaired by the Minister, and the Strategic Planning Board where his focus would be the fit of forensic mental health care with the wider reform and transformation agenda.. He noted that he would meet with the Central Legal Office in September to review performance.

Finally, Mr Jenkins gave assurance to the Board that progress had been made in relation to the maintenance work required on site, including the Skye Centre, following some delay in this. Works would commence at the end of the month and were expected to take approximately ten weeks to complete.

Mr Currie commented on the cyber-attack, underlining the point that a high rating under the NIS audit process did not necessarily mean that the organisation may necessarily be protected in terms of cyber security. He also noted the focus on the challenge of delayed discharges at a national level, and the importance of seeking potential solutions at a primary care level, as otherwise patients may seek help directly from Accident and Emergency Departments. Mr Moore commented that whole system planning was central to the discussion, adding that there were also challenges within primary care delivery leading to a complex picture overall.

<u>The Board:</u>

1. Noted the update from the Chief Executive.

7 PATIENT/CARER STORY: *"Reflections of a long term carer"*

Mr Hamilton introduced a story from a carer of a patient, who had been very worried about him being admitted to the State Hospital (TSH). When she had visited, staff had been friendly at reception and this had really helped. The carer's story described how the patient had improved over the course of time, and also the types of activities he had become involved in, especially arts and crafts. Soon, the family started to see a real change in him for the better. The carer talked about her journeys to TSH, especially in past years when there had been a bus service, which had been helpful for carers as well as providing an opportunity to share experiences. Many had kept in contact with each other over the years. It was also a good opportunity to help first time visitors, and make them feel more comfortable. She went on to speak about how welcoming the Family Centre was, though she had enjoyed the visits to the ward and the beautiful scenic views. She described the hub parties and special events that had been arranged, and how carers were able to join in on these, especially at Christmas.

In her story, she also paid tribute to clinical staff, saying that doctors and nurses were good at keeping in contact, including student nurses. It was helpful to be involved in CPA meetings. She thought that her family member was getting on well, being involved in lots of activities including shopping on the internet, going to the café. She thought that TSH had been a lifesaver for him. She said that she was trying video calls, and that this was very new for her. Her family member was progressing into the Transitions Service, and she had a lot of hope for him for the future, as he may be able to move to a medium secure setting in the future.

Mr Moore noted how interesting it was to hear a direct account of a carer's experience, and that this would link with the new strategy under development. There was some clarification in respect of the bus service referred to in the story – this had been a run by a charitable organisation and had stopped some years ago.

Mr Currie noted how important it was to facilitate contact for patients and carers, and that any financial cost of doing so would need to be balanced against any benefits for patients. It would be worth exploring what could be arranged. He also noted the positive addition of video visiting as it helped to be able to see loved ones in this way. Lastly, that this story helped to show how patients could progress in their care journey, and also the way in which carers may provide peer support for each other.

Ms Radage added that this was a very optimistic story, with lots of great details contained within it – positive messaging about the care provided, and the support staff gave in difficult circumstances. She also noted that peer support between patients could be seen often, especially older patients helping younger peers. In relation to the bus service, she noted the relevance of the Anchors Strategy. Ms Fallon said how powerful the story was, and how this could help with public perceptions of TSH. She also noted the link to the Carers' Strategy, and also that the staff involved should get positive feedback. SCN McLean added that the story showed the impact that different staff groups could have on patients, and that staff would receive feedback. Professor Thomson noted that the clinical team should be made aware of the story.

Mr Jenkins noted the reference to a discontinued bus service to TSH, and advised that this would be picked up in terms of whether any action could be taken, or if any funding was available in this respect. It may be possible to consider how to improve connectivity to the hospital for carers. This would be brought to the CMT and would come back to the Board with the Carers' Strategy.

Action – Mr Hardy/ Ms McCaffrey

It was also agreed that it would be helpful to create a section on the TSH website for patient and carer stories, to increase public understanding and awareness of the hospital.

Action – Ms McCarron

<u>The Board:</u>

1. Noted the story, and the positive reflections it presented.
2. Agreed that further consideration should be given to a bus service/ connectivity for the hospital for carers.
3. Agreed that patient/carer stories should be promoted on the TSH website.

8 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 24/61) from the Acting Director of Security, Resilience and Estates, which provided an overview of the Corporate Risk Register including movement on risk gradings. Mr Hardy confirmed that all the risks had been reviewed appropriately, and that there remained three risks graded as "high". He noted that work was progressing in relation to ND70: Failure to utilise resources to optimise patient care and experience, with data analysis to help understand

nursing resourcing across service demands. The aim was to move this to bring together the range of measures in place to mitigate this risk, and to help understand the underlying position. He also noted

that Risk MD32: Absconsion of patients had moved to its target level, with the current control measures in place being adequate to support this. Mr Hardy also noted that work was progressing to develop the Corporate Risk Register further, but that resourcing was challenging presently with the team focusing on the completion of Serious Adverse Event Reviews.

Mr McConnell asked for clarification around Risk ND90: Failure to implement a sustainable long term model, in terms of Scottish Government funding i.e. was this built into the existing risk or was there potential for this risk to increase? Mr Jenkins commented on the likelihood of this risk increasing, as pressures across NHSScotland may increase significantly. Ms Radage asked about the decrease in incidents relating to ND70, and Mr Hardy advised that this referred to staffing resource incidents, which were decreasing overall. However, the aim was to get better intelligence around these to help build the appropriate control measures. Presently, reporting was through Datix where some duplication was observed.

Mr Moore noted the Board's agreement to the paper being an accurate statement of risk. He noted that the Board was focused in particular on the financial landscape and the risk of not reaching a break-even position.

The Board:

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

9 FINANCE REPORT TO 31 July 2024

The Board received a paper (Paper No. 24/62) from the Finance and eHealth Director, to provide the detailed financial position as at 31 July 2024. Mr McNaught provided an overview of this, highlighting that there was a small adverse variance of £0.115m mainly relating to nursing staffing. However, a break-even position was predicted for year-end at this stage. He advised that Scottish Government colleagues remained content with the position to date, and with the savings plan in place for 2024/25. He noted that specific pressures related to care delivery within the Intellectual Disability (ID) Service had been raised with government, given the additional funding required in support. He also confirmed the position in relation the current allocation for capital; and that spending was agreed and planned for the current year.

Mr Currie asked about when it would be possible to have a clear view of the likely outturn for the year, and Mr McNaught said that accruals were phased in throughout the year in line with directorate plans. For areas where there may be unexpected accruals (e.g. energy) these would be tracked to try to level these out across the year. There may be some unexpected aspects, but it would be unexpected to see this occur in the final months of the financial year.

Mr McConnell asked about the capital allocation, in terms of the possibility of funding for future schemes, and whether there was the chance that the current allocation could be reduced. He also asked for clarification around the funding for the reduction in the working week for Agenda for Change (AfC) staff. Mr McNaught noted that the adjustment for the reduced working week had been made to territorial boards, and this was awaited for national boards. He noted that the capital allocation had remained steady in recent years, and he had no indication that this would change. He referred to the need for Boards to submit business continuity plans for estate maintenance in January 2025, which would factor in all known estates work for coming year and be the basis for planning in the next 10 years.

Ms Fallon asked whether there was any further information in respect of the additional funding required presently in the ID Service, as well as in relation to out boarding of patients to general hospital when required. Mr McNaught noted that costs were being monitored, and had been raised with Scottish Government for consideration. Mr Jenkins added that there was work underway to assess the different

components of spending, and to disaggregate these to get a clear picture. Nursing staffing was the core pressure, and there may be a need for re-alignment of budgets to ensure that the organisation was

making best use of its resources.

Mr Moore summed up for the Board, noting the position a outlined, as well as the need for continued focus on achieving a break–even position.

The Board:

1. Noted the content of the report.

10 BED CAPACITY REPORT

The Board received a paper (Paper No. 24/63) from the Medical Director, which detailed the position for bed capacity within TSH for the period 1 June to 31 July 2024, in the context of the wider Forensic Network. Professor Thomson summarised this position, referring also to the flow of patients across services within TSH. She noted the continued over occupation within the ID service, and the reasons for that. She also provided an update in respect of Forensic Network Capacity, and in particular reduced capacity in the Orchard Clinic due to maintenance work. There was one case requiring an escalation process to the Medical Directors involved for resolution as to placement of the patient, who had been admitted to TSH on an exceptional circumstances basis. However, overall the position across the wider estate was tenable with continuing flow of discharges from TSH to medium secure generally.

Mr Moore asked about the position between medium and low secure, and also if there was any analysis available in respect of resources within community settings. Professor Thomson advised that there was reduced resourcing within the community for all mental health patients including forensics e.g. in terms of supported accommodation.

Mr Moore noted the helpfulness of the update, and suggested that it may be relevant to TSH to use the language of delayed discharges in this context, should it be relevant for delayed transfers.

The Board:

1. Noted the content of report.

11 IMPLEMETATION OF SPECIFIED PERSONS REPORT

The Board received a paper (Paper No. 24/64) from the Acting Director of Security, Resilience & Estates, relating to the implementation of regulations relating to the safety and security, use of telephones and correspondence on the part of patients within TSH, under the Mental Health (Care and Treatment (Scotland) Act 2003.

Mr Hardy presented the paper to the Board, outlining the key points on restrictions relating to “specified persons” which supported the safety and welfare of the patient and others by allowing the clinical team to manage controls proportionately in defined areas.

The Board:

1. Approved the content of report, for submission to the Scottish Government.

12 QUALITY STRATEGY 2024-29

The Board received a paper (Paper No. 24/65) from the Medical Director in respect to the TSH Quality Strategy 2024 – 29. Professor Thomson introduced this item, emphasising the intent to provide a high level strategy, and that the Clinical Governance Committee had reviewed it in detail at its meeting

earlier in the month. The proposal was that monitoring of implementation would be through the Clinical Governance Group. Ms S Smith then led the Board through the content of the strategy highlighting the

five key priority areas, as well as the wide consultation process undertaken. In particular, patients' views had been sought through the Patient Partnership Group. Once approved, the next stage would be implementation of the strategy, and the plan to do so was included within reporting.

Ms Fallon complimented the presentation of the report, and gave assurance to the Board that the Clinical Governance Committee had discussed the strategy in detail and provided approval for it to be presented to the Board. The Committee was also content for monitoring to be through the Clinical Governance Group (CGG). She asked how carers would be involved in this strategy, and also noted the importance of leadership walkrounds in relation to quality improvement. Mr Jenkins noted that this latter aspect related to Quality of Care, which was also on today's agenda for discussion. Ms S Smith added that the patient and carer links would be factored into the implementation plan as it was taken forward.

On this basis, there was agreement around the table to approve the Quality Strategy 2024-29.

The Board:

1. Approved the Quality Strategy 2024-29

13 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 24/66) to report on progress made in quality assurance and improvement activities, since the date of the last meeting. Ms Merson summarised the content of the report for the Board, noting that the clinical audits undertaken had shown good compliance rates, and provided assurance. She highlighted the most recent flash report in respect of hospital wide variance analysis. She then noted the projects ongoing as part of the QI Forum, as well as the training available within the hospital as well as externally to build capacity in this area. She highlighted the work continuing through Realistic Medicine, and that the Board would receive an update on this at their next development session. Lastly, she noted the positive movement in progressing the Evidence for Quality matrix.

Ms Fallon referred to the variance analysis flash report, and asked whether the non-attendance of staff at Multi-Disciplinary Teams reviews (MDTs) could impact the outcome. She noted attendance rates for key workers, nursing staff and dieticians in particular. Mr McConnell followed this question by asking whether attendance rates were related to challenges within those staffing group, or were related to the organisation and working of the MDTs themselves. Ms Clark provided assurance that within nursing, attendance was considered and prioritised in terms of what was required. Professor Thomson added that it was importance to note that Responsible Medical Attendance (RMO) was 100% as this was essential. However, attendance by each staff group may not always be required e.g. in relation to dietetics, it may that that specific input was not required in each case at the MDT. The CGG was reviewing how professional attendance was measured, and currently the view was to retain the set targets. Presently, attendance rates were not concerning from a clinical perspective, and the CGG would keep close oversight of this.

Mr Moore asked about QI training in terms of the investment being made in this area, and how it would be possible to demonstrate the benefits that this then brought to the organisation. It was agreed that this aspect would be considered in reporting going forward.

Action – Ms Merson

The Board:

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

14 QUALITY OF CARE REVIEWS (LEADERSHIP WALKROUNDS)

The Board received a paper (Paper No. 24/67) from the Director of Nursing and Operations, which provided an update in regard to participation by TSH in the development of a "Once for Scotland" approach to Quality and Safety/ Care Assurance visits, formerly referred to as "Leadership Walkrounds".

Ms Clark provided an overview of the paper, noting that the national development work was continuing through a Quality of Care Review Short Life Working Group, and that she was a part of this. Guidance had been developed, and would be shared following testing. This guidance supported a multi-disciplinary approach, and would be taken forward through the TSH Patient Safety Group. Ms Clark noted that it was important to reinstate walkrounds and the intention was to do so from October 2024.

Professor Thomson noted the difference in Quality of Care reviews from the previous Leadership walkrounds, and Mr Moore emphasised the importance of Non-Executive Director involvement in walkrounds, and in finding a way forward with that aspect. These had been helpful to provide insight and connection across the organisation, and it was essential that these were put in place as soon as possible, even if not within the Quality of Care framework. Mr Jenkins provided assurance that this would be an area of focus, to ensure that there was a proposal for taking this forward, and this would be actioned through the CMT.

Action – CMT/ Ms M Smith

The Board:

1. Noted the update from the Chief Executive.

15 SECTION 22: APPROVED MEDICAL PRACTITIONER

The Board received a paper (Paper No. 24/68) from the Medical Director, to consider approval of Approved Medical Practitioner (AMP) status for a Specialty Doctor. Professor Thomson outlined the background, and need for Board approval based on the assurance provided within the paper.

The Board then provided formal approval on this basis.

The Board:

1. Approved Dr Mason McGlynn as an AMP, and agreed that he should be added on TSH list of AMPs.

16 CLINICAL GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting that took place on 23 May 2024; as well as a summary report (Paper No 24/69) of the key areas of reporting and discussion at the meeting, which had taken place on 8 August 2024.

As Chair of the Committee, Ms Fallon highlighted in particular the launch of the National Specification for the Delivery of Psychological Therapies, as well as the successful recruitment to the Infection Control Lead role this month.

The Board:

1. Noted the content of the approved minutes CGC(M) 24/02.
2. Noted the update in relation to the meeting held on 8 August 2024.

17 STAFF GOVERNANCE REPORT

The Board received a report from the Director of Workforce (Paper No. 24/70) summarising workforce performance through a range of metrics. Mr Wallace summarised the content of the report, noting in particular that there had been a spike in sickness absence during July, both in short term and long term rates. A substantial cause of this had been covid and/or respiratory related, and this trend had been reflected in the position seen nationally. A full range of support was available to staff through line managers and Occupational Health Services to support a return to work, as appropriate. He noted the continued focus on recruitment and retention of staff, with a low turnover rate of 2.85% compared the national rate of approximately 10%. Finally, he highlighted the high compliance rate for PDPRs at 90% to the end of July,

Mr Currie commented that the Staff Governance Committee received detailed reporting in these areas, which supported close scrutiny of the position. Further, it would be helpful to have evidence to support whether the investment being made in wellbeing activity, was having a positive impact on the trends seen - especially sickness absence rates. Mr Wallace advised that presently these factors did appear unrelated, and that the rise in sickness absence was disappointing. The approach taken was through active implementation of the relevant policy framework, supporting line managers to take this forward. He agreed that the evaluation of wellbeing activity currently underway should provide the evidence needed, and that resourcing had to be focused on the measures that were seen to be effective.

In response to a query from Mr Moore, Mr Wallace confirmed that absence due to Covid-19 was now included within overall sickness absence data. It was also noted that national guidance was for staff to attend work provided they did not have a temperature, and symptoms experienced meant that the individual was able to do so. Therefore, it would be the case that spikes would be experienced over time.

Mr Moore summed up for the Board, noting that the increase in sickness absence for July was disappointing, and that the focus would be on achieving a gradual decrease; detailed oversight would continue through the Staff Governance Committee.

The Board:

1. Noted the content of the report.

18 WHISTLEBLOWING:
- QUARTER 1 REPORT
- WHISTLEBLOWING UPDATE

The Board received two papers from the Director of Workforce in relation to the Whistleblowing Quarter 1 position (Paper No 24/71) as well as an update in relation to the re-launch of the approach to Whistleblowing and preparation for Speak Up Week (Paper No 24/71).

Mr Wallace noted that there had been no new cases during Quarter 1 as outlined in the report. He provided an overview of activity underway for preparation for Speak Up Week across the hospital. He also outlined the proposed change to the TSH approach to the national standards in this area, including administrative support, and arrangements for investigation as well as confidential contacts. Finally, that a change in Executive Lead should be agreed. On this last point, Mr Jenkins advised that this was being taken forward and would be confirmed to coincide with the Launch of Speak Up Week.

Action – S Wallace

There was agreement around the table to the direction of travel as outlined, as well as the challenge that could be experienced in a small organisation, and the need for trust and confidentiality so that individuals did feel that they could come forward to raise concerns. It would also be important to raise

the profile of the Non-Executive Whistleblowing Champion going forward, and this was a good opportunity to do so.

The Board:

1. Noted the update provided for Quarter 1.

2. Approved the approach proposed to improve the model procedure within TSH.

19 STAFF GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting that took place on 16 May 2024; as well as a summary report (Paper No 24/73) of the key areas of reporting and discussion at the meeting, which had taken place on 15 August 2024. As Committee Chair, Ms Radage noted that at the last meeting there had been focus in particular on assurance reporting for the Occupational Health Service, as well as on sickness absence rates in line with the discussion at the meeting today, and the action being taken to address the recent increase.

The Board:

1. Noted the content of the approved minutes SGC(M) 24/02.
2. Noted the update in relation to the meeting held on 15 August 2024.

20 COMPLAINTS ANNUAL REPORT

The Board received a paper (Paper No. 24/74) from the Head of Corporate Governance, which provided a summary of activity within complaints handling for the year 1 April 2023 to 31 March 2024. The content of report would form the annual submission to Scottish Government in this respect.

Ms Smith provided an overview of reporting, noting that it included the nationally set Key Performance Indicators related to the NHS Model Complaints Handling Procedure. She highlighted the continued success within TSH to resolve most complaints as the early resolution stage, as being very positive. Further, that reporting helped to demonstrate the integrity of complaints investigations through the spread of outcomes found. There was a clear focus on quality improvement, and taking lessons from complaints, using the process to support best practice. Ms Smith noted that the report did elucidate some themes, but that size of the hospital and the specialist nature of care tended to mean that that complaints would be focused on individual patient care experiences. Lastly, she noted the positive feedback from the Scottish Public Services Ombudsman, as well as from internal audit reporting.

In response to a query from Mr McConnell, regarding the increase in the number of complaints received compared to previous years, Professor Thomson noted that this may reflect the way in which numbers fell during the Covid-19 pandemic. Mr Jenkins added that it may also be due to the way in which there was now increased direct contact with patients through the complaints service. It may be that with more transparency in the process, there was increased confidence in raising concerns in this way. Ms Fallon agreed with these points, and noted that the outcomes data provided assurance about the integrity of the process. She also noted the inclusion of complaints awareness in the staff induction process, as well as the high uptake of the LearnPro module.

Mr Currie echoed these points, and highlighted that the main issues raised were linked to interactions with staff, including communication, and the need to take concrete action in this regard in terms of making improvement. He thought the inclusion with staff induction as a positive addition. Ms Radage commented that the report showed that once issues had been identified as a concern, simple solutions could be found. She noted that it would be helpful to compare with data from other high secure hospitals. Ms McCaffrey was pleased to see the focus on early resolution, and the work progressed to provide patients with a safe space within which to raise concerns.

Mr Moore noted agreement around the table on the positive nature of reporting, and that the

presentation of the report was very helpful.

The Board:

1. Noted the update
2. Approved the content of reporting for submission to Scottish Government.

21 SCHEDULE OF BOARD AND COMMITTEE MEETING DATES

The Board received a paper (Paper No. 24/75) from the Head of Corporate Governance, setting out the proposed schedule of meeting dates for 2025. Ms smith confirmed that these dates had been shared with colleagues, and was being presented for final approval. There was agreement on this basis.

The Board:

1. Approved the schedule of Board and Committee dates for 2025.

22 PERFORMANCE REPORTING:
- **QUARTER 1 REPORT**
- **ADP 2024/25 – APPROVAL**

The Board received a paper (Paper No. 23/76) from the Head of Planning, Performance and Quality to provide a high-level summary of organisational performance for Quarter 1 of the current year.

Additionally, the report included a copy of the letter of approval from the Director of Mental Health, Mr Stephen Gallagher, which had been received on 24 June 2024.

Ms Merson highlighted the key points of reporting, focusing on the four areas in which target performance rates had not been reached, within the Red/Amber/Green ratings (RAG). In relation to the target for six monthly reviews of care and treatment plans, she noted that a process map had been developed of the CPA process to identify where the delays occurred. In particular, there was a challenge in documentation being uploaded timeously. The target for a healthier BMI for patients continued to be in the red zone, and it was acknowledged that a review of the target may be appropriate. She noted that the sickness absence rate was off target, and that this had been discussed at the meeting today. Finally, that the target had not been met for patients to have their clinical risk assessment reviewed annually. Ms Merson advised that this area was being monitored through the Mental Health Steering Group, and that the dip in performance appeared to be related to processing issues. Psychology had an action plan in place to make the necessary improvement.

Mr McConnell asked about the CPA process, and the evidence that showed that this was an administrative issue, so that assurance could be taken that the reviews were taking place as appropriate. Professor Thomson provided this assurance, and noted that it may be helpful to amend the way the target was assessed so that it related more to demonstrating any delays in the CPA process itself. At the same time, if the documentation was not uploaded then that was problematic clinically as those involved required to see what had been agreed and/or any actions to be taken forward. Therefore, there was a planned course of action to ensure that there was a consistent process in place across teams.

Ms Radage provided positive feedback on meeting the target for patient undertaking 150 minutes of moderate exercise each week. She asked if there was any further feedback in relation to the work being progressed in relation to patients within the Admissions Service in respect of their BMI. Professor Thomson advised that it was too early to provide detailed feedback on progress, and confirmed that the aim was to try and stop patient BMI increasing following admission to TSH.

Mr Moore asked about the definition of activity in target 3 relating to patient activity. Ms Merson advised that patients could be taking part in activities both on and off the hub, and that these could be vocational

or education as well as physical. There was work progressing to trial standards for each service, which would be helpful in defining this target.

Mr Moore thanked Ms Merson and her team for the comprehensive and helpful nature of reporting. He also noted the positive nature of the letter of approval for the ADP 2024/25, from Scottish Government.

The Board:

1. Noted the content of the report.
2. Noted the content of the letter of approval from Scottish Government for the ADP 2024/25.

23 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report from the Acting Director of Security, Resilience and Estates (Paper No. 24/77) to confirm the updated position. Mr Hardy provided a summary of the position with the project in its final stages. He confirmed that the expectation was for completion of the project as scheduled for 22 October 2024.

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.

24 ANY OTHER BUSINESS

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

25 DATE AND TIME OF NEXT MEETING

The next public meeting would take place at 9.30am on Thursday 24 October 2024.

26 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.

27 CLOSE OF MEETING

The meeting ended at 12.40pm

ADOPTED BY THE BOARD _____

CHAIR _____

DATE _____

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	**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. **CLOSED**
2	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: Discussed and agreed re-freshed approach** **CLOSED**
3	April 24	A.O.B	Reporting template review around the monitoring report, and how to re-frame report template	M Smith	December 2024	**August Update:** Review underway and suggested approach shared through Non Exec Directors and CMT for feedback, and will return to the Board. **October Update:** Review and align to governance arrangements for committees, and bring back to the Board in December.
4	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. Reviewed at Board, and incorporated into reporting. **CLOSED**

5	June 24	Workforce Plan – Annual Review	Update requested on gender balance workstream	K McCaffrey	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. **October Update:** Reviewed by CMT, and fully detailed report and plan to return to CMT on 6 November, and outcome then to be reported to Board.
6	August 24	CEO Update	Re cyber security – further update to Board following eHealth presentation to CMT	R McNaught	October 24	**October Update: reporting on agenda**
7	August 24	CEO Update	Re Medium Term Plan and link to WF Plan/ OD – update to Board	M Merson	October 24	**Progressed as part of the Development Session on 3 October, and added to workplan for updates to the Board in December 24, then final draft in February 25** **CLOSED**
8	August 24	CEO Update	Nursing resourcing – progress on data analysis . Update to CMT 23 September, then Board update	K McCaffrey	October 24	**Progressed as part of the Development Session on 3 October** **CLOSED**
9	August 24	Carers Story	Travel scheme to TSH – for carers and to come back along with Carers Strategy (note link to staff transport)	K McCaffrey/ A Hardy	December 24	**Will be added to December agenda**

10	August 24	Carers Story	Comms to look at way to capture this story and potential to promote/add to website	C McCarron	October 24	**Communications have added a section for patient and carer stories on the website, and this story is captured. CLOSED**
11	August 24	QA and QI Report	Update re QI/ScIL training – in terms of how these skills are then put into practice, and what is the benefit of investing in this training for staff	M Merson	October 24	**October Update – reporting on agenda**
12	August 24	Quality of Care	Quality of Care Reviews implementation Consider how to progress informal Non-Executive Walkrounds	K McCaffrey M Smith	December 24 October 24	**Update re formal programme to return to Board.** **October Update - Separate programme for informal walkrounds now in place – corporate services confirming dates for commencement. CLOSED**
13	August 24	Whistleblowing	Agree new Exec Lead & re- launch Non Exec Champion role	S Wallace	October 24	**October Update - Refreshed approach re Speak Up Week progressed to raise awareness across organisation. Update on agenda as part of Board Improvement Plan. Establish change of Exec Leadership/ re launch Non-Exec role as next steps.**

Last updated 17.10.24 M Smith

Paper No. 24/81

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2024
Agenda Reference:	Item No: 7
Sponsoring Director:	Acting Director of Security, Estates and Resilience
Author(s):	Risk Management Team Leader
Title of Report:	Corporate Risk Register Update
Purpose of Report:	For Decision

1 SITUATION

A corporate risk is a potential or actual event that:

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

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

2 BACKGROUND

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

3 ASSESSMENT

3.1 Current Corporate Risk Register - See appendix 1.

3.2 Out of Date Risks

All risks are in date.

3.3 Update on Proposed Risks for inclusion on Corporate Risk Register

N/A

3.4 Corporate Risk Register Updates

Security
SD50 – Serious Security Incident or Breach
SD53 Serious Security Breaches and SD50 Serious Security Incident have been combined into SD50 Serious Security Incident or Breach. It was noted upon review the contents of both risk assessments are similar in terms of the hazards and control measures. The term 'Serious' has been defined as any Security related incident that meets the 'High' or Very High' criteria as detailed in the NHS Scotland Risk Matrix. The risk has been reviewed and is now graded as Moderate x Rare giving a 'Low' grading due to the low number incidents that are defined as 'Serious'.

SD51 – Major or Extreme Failure of Physical or Electronic Security System
SD51 was reviewed with slight changes made to the risk and the grading. The risk will now focus on "Major or Extreme Failure of Physical or Electronic Security System". Datix will be screened to determine the number of incidents that meet the criteria prior to review each month. The risk is now graded as Major x Unlikely giving a medium rating following a small number of incidents.

SD52 – Resilience Arrangements Not Fit for Purpose
SD52 is in the process of being updated. In addition to ensuring the resilience plans are in date, the Risk and Resilience Team will ensure each plan has been tested at least once following approval. Testing will identify any gaps in the plans or provide assurance the content is adequate for managing the relevant incident. Risk grading remains the same as data on the testing schedule is gathered.

SD57 – Adverse Event Review and Action Completion
SD57 has been increased from Moderate x Possible to Moderate x Likely, raising the overall grading from 'Medium' to 'High'. 80% of the last six Category 1 and 2 Reviews have been overdue at the time of completion, with two still outstanding. The team suffered from pressures relating to a number of reviews being commission at the same time alongside issues in staff and staff availability for interview. The teams focus moving forward will be to ensure that the workload of the reviews can be shared amongst the team and appropriate training is provided.

Nursing
ND73 – Lack of SRK Trained Staff
ND73 was removed from the CRR and added to the Nursing Local Risk Register. ND73 was reduced to low in December 2023 and has remained low due to the level of training amongst the nursing cohort being above target level and there being zero incidents recorded relating to SRKs being unable to be applied for this reason. Should the position of the Risk change, this can be managed locally by the relevant department and will only be escalated back to the Corporate Risk Register if the risk can not longer be managed or reaches a 'high' level.

Finance
FD97 – Management of Smartphone Access
Updates made to the risk assessment to include latest Microsoft Cloud App Security updates, this adds an extra layer of security measures tailored the type of device and platform ie. managed and unmanaged devices, providing further assurance. Details in the risk assessment, no incidents recorded and risk remains at 'Low'.

FD99 – NIS Audit
Risk reduced to Moderate x Rare giving a 'Low' grading, previously graded as 'Medium'. Following the latest audits TSH has regularly demonstrated compliance with the audit, there are no concerns relating to being unable to comply in future audits. Risk will be reviewed every 6 months to ensuring the position remains the same.

FD91 – IT System Failure
Risk reduced from Moderate x Unlikely to Negligible x Possible, reducing from 'Medium' to 'Low'. Risk reduced after reviewing the number of incidents recorded. Current control measures are adequate, few incidents recorded which had a negligible impact on service within TSH. Risk will be reviewed every 6 months or sooner if a serious incident is recorded.

HR
HRD113 – Risk to Operation Services – Job Evaluation
The risk rating remains the same. Although evidence (No longer a delay in the Job Evaluation Process, regular meetings taking place and additional job matchers have been trained) suggests the risk being realised is low, there is possibility the workload could increase drastically over the next few months following the review of the Band 5 and 6 Nursing posts. The risk will be reviewed again in January when the impact of the review will be clearer.

HRD110 – Failure to Implement and Continue to Develop the Workforce Plan
Risk reduced from Moderate x Unlikely to Moderate x Rare. Reducing the risk from Medium to Low. The current workforce plan is underway and progressing, no concerns noted at this time or previously throughout the implementation of the current plan. A new workforce plan is in development for 2025, which will allow for clearer monitoring.

3.5 High and Very High Risk – Monthly Update

The State Hospital currently has 4 'High' graded risks, up from 3 in the previous report:

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

Monthly Update:

Overweight and obesity in September was 89% (Increase) (100pts) (with 3% data missing)

- 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 two 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:

- 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.
- Risk Management Team Leader is in the process of meeting with Head of Clinical Quality and Business Support Manager to review the current data and establish a baseline level of risk.
- A meeting will be held thereafter with the Director of Nursing to agree the reframing and presentation of this risk.

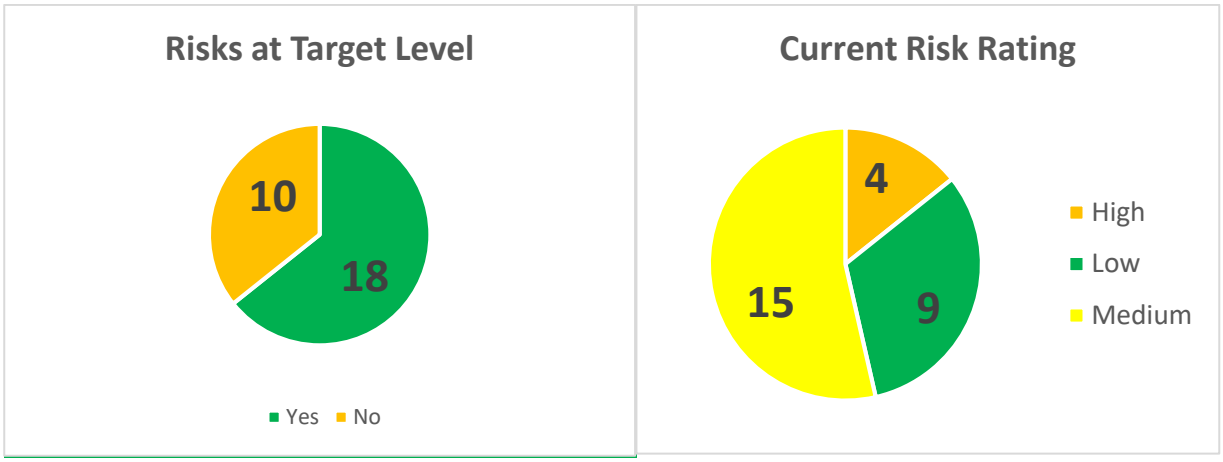
Finance Director: FD90: Failure to implement a sustainable long-term model

- 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. The risk will remain at 'High' until national funding is at a sufficient level where annual savings requirements are reduced to a manageable level on a recurring basis.

Security Director: SD57 - SD57 – Adverse Event Review and Action Completion

- SD57 Recently increased to 'High' following a review in October 2024. The Risk and Resilience Team have identified the risk of adverse event reviews and resultant actions not being completed on time has increased following recent pressures within the team. The team will continue to review the risk and share the next steps that will reduce the risk to target level.

3.6 Risk Distribution



Currently 18 Corporate Risks have achieved their target grading, with 10 currently not at target level.

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

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

CRR Development is underway with many of the Directorates having completed their reviews, changes in individual risk assessments detailed in Section 3.4

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 almost complete with ND71 and ND73 (Now moved to Local Risk Register) having been fully reviewed and positive feedback received about new format. ND70 has been reviewed and is awaiting a meeting with several key stakeholders to establish baseline data.
- Finance Directorate review has been completed. No risks were added or removed although some changes were made to the grading as referenced in Section 3.4.
- Security Directorate review has been completed. Changes referenced in Section 3.4. No new risks added. Two risks were combined into one risk assessment.
- HR Directorate Review is underway. All risks remain on the CRR although some updates made to grading as detailed in Section 3.4. Consideration is being given to adding Corporate Risks relating to Staff Absence, Breaching the Working Time Directive and Reduction in hours over 2025 and 2026. Updates will be given on decisions.
- Medical Directorate Review is scheduled for mid-October, updates will be shared with The Board upon completion.
- Chief Executive CRR Review is due to be scheduled in November 2024, updates will be shared with The Board upon completion.
- 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.

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 and Risk 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

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	Nov 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	Nov 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	Nov 24	Finance and Performance Group	Monthly	-
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Likely	Moderate x Likely	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	Nov 24	Security, Risk and Resilience Oversight 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	Feb 25	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	Feb 25	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	Feb 25	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	Feb 25	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 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	Jan 25	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	Jan 25	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	Jan 25	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	Moderate x Possible	Moderate x Rare	Security Director	Head of Estates and Facilities	Jan 25	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 96	Service/Business Disruption	Cyber Security	Moderate x Likely	Moderate x Unlikely	Moderate x Unlikely	Finance and Performance Director	Head of eHealth	Jan 25	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	Jan 25	Information Governance Committee	Quarterly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x unlikely	Major x unlikely	HR Director	HR Director	Jan 25	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	Jan 25	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 SD 50	Service/Business Disruption	Serious Security Incident or Breach	Extreme x Likely	Moderate x Rare	Moderate x Rare	Security Director	Security Director	April 25	Security, Risk and Resilience Oversight Group	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 91	Service/Business Disruption	IT system failure	Moderate x Likely	Negligible x Possible	Negligible x Possible	Finance & Performance Director	Head of eHealth	April 25	Finance and Performance 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	April 25	Information Governance Committee	6 Monthly	-

Corporate FD 99	Reputation	Compliance with NIS Audit	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	April 25	Information Governance Committee	6 Monthly	↓
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Rare	Moderate x Rare	HR Director	HR Director	April 25	HR and Wellbeing Group	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	-

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2024
Agenda Reference:	Item No: 8
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 30 September 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 was submitted to SG and signed off, with regular meetings between TSH and SG to monitor progress against targets. An interim meeting has been held with SG in early October to review the draft position and ensure any new key risk areas could be alerted – in principle these remain those noted in section 3.3 and will be reviewed in full detail at the Q2 meeting later this month.

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

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £46.513m 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). In common with the other national boards, we have now received an allocation relating to the 2024/25 ½-hour AFC reduction.

The September accounts (being the end of Q2) show an over spend to date of £0.087m, 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 is 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 as – while not currently expected – there remains a risk that, until the process is completed, 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 £'k	Year to Date Budget £'k	Year to date Actuals £'k	Variance (budget less actuals) for period	Budget WTE	Actual WTE (volume)
Pay	39,633.47	19,426.37	19,660.68	(234.30)	628.90	636.61
Non Pay	5,104.79	2,549.35	2,579.33	(29.97)	0.00	0.00
Purchase Of Healthcare	813.86	406.93	405.51	1.42	0.00	0.00
Hch Income	(645.23)	(322.62)	(344.22)	21.60	(6.14)	(6.50)
Other Operating Income	(796.18)	(398.09)	(564.02)	165.93	(3.40)	(3.00)
Savings	(709.57)	4.34	0.00	4.34	0.00	0.00
Capital Charges	3,112.13	1,556.06	1,568.44	(12.37)	0.00	0.00
Right Of Use Assets	0.00	0.00	3.25	(3.25)	0.00	0.00
	46,513.25	**23,222.35**	**23,308.95**	**(86.60)**	**619.36**	**627.11**

The allocation regarding the reduction in shifts from 37.5 to 37 hours was received in the September allocations, which has partly been released for April to September costs, and will continue to be released monthly. We have also submitted expected costs for the confirmed AFC 5.5% pay award.

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 –

- OU Students Backfill, phase 2 £50k
- Distinction Awards £36k

Directorates	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	Variance (budget less actuals) for period	Budget WTE	Actual WTE
Chief Exec	2,363	1,183	1,192	(9)	25.17	24.15
Finance	3,209	1,643	1,636	7	29.18	31.95
Human Resources Directorate	1,101	560	548	12	16.30	15.61
Medical	3,411	1,706	1,686	20	20.95	17.20
Nursing And Ahp's	24,962	12,724	12,882	(158)	404.13	421.15
Security And Facilities	7,660	3,900	3,769	132	123.63	117.05
Cap Charges	3,112	1,556	1,568	(12)	0.00	
Central Reserves	794	0	50	(50)	0.00	0.00
Misc Income	(100)	(50)	(22)	(28)	0.00	
	46,513	**23,222**	**23,309**	**(87)**	**619.36**	**627.11**

Chief Executive
A small variance is noted arising from savings currently being below trajectory.

Finance
As approved through CMT in August, the 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.

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

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

Nursing & AHPs
Ongoing vacancies and sickness absence, alongside in-month variations arising from clinical acuity and outboarding, remain the main contributors to overtime costs. The Directorate continue to actively recruit to all Band 5 nursing vacancies in an attempt to mitigate against overtime spend with the most recent onboarding taking place w/b 14th October 2024. Alongside this there are ongoing robust attendance management processes in place regular reviews of employee relations cases.

Following a successful round of recruitment, there are currently 2.2 WTE Band 5 vacancies (a reduction from 15.8 in early October following the induction of 8.6 WTE RNs, and 5 OU students qualifying).
There are no other nursing vacancies (i.e. Band 6, 7 or 8) at this time.

Clinical acuity fluctuates regularly which impacts on our operating model (i.e. we require an increased number of staff per shift to provide care and operate safely). Over recent weeks there have been no protracted periods of outboarding however there remains a number of external outings (e.g. court and transfers) that have required to take place.

As noted in previous reports, we opened an additional ward in July to care for a patient who's clinical and risk needs determined care could only safely be delivered in a standalone area. This patient requires a minimum of ten staff per day (four in the AM; four in the PM, and two overnight) which places an additional pressure eon the daily operating model. The hospital continues to explore additional funding options for this bespoke area of care. This will help to alleviate some financial pressures experienced within the Nursing Directorate budget.

We continue to trial a small outboarding team which consists of one registered and unregistered nurse. This trial is due for midway review at the end of October.

SCN performance reviews continue monthly with support from Finance. This enables 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 meetings are chaired by the Associate Director of Nursing.

Security & Facilities & Utilities
Some accruals brought forward are supporting funding of 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 now released in August, following 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.

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.

Miscellaneous Income
The timing of income (mainly VAT, CNORIS) is slightly at variance from budget phasing.

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 years set up costs, the charge via Payments on Behalf (POB) has now been received for 24/25 at just under £11k, although not specifically funded.

M365
Quarter 1 and 2 are now charged from NSS. It is envisaged this pressure will be met from reserves, though with an element of reserves potentially required for Utilities, as noted below, pressures in the latter months of the year may require funding attention.

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

- 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 (identified and, as noted above, this is now funded while awaiting SG provision for the following– for which funding is expected).
- Adjustment of a number of posts – yet to be determined – from B5 to B6.
- AFC pay uplift in year (our estimate has been forwarded to SG).

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).

Savings by Directorate	Annual Target £'k	Achieved Apr - Sept 24 £'k	still to achieve £'k
Chief Exec	-74	10	-64
Finance	-101	58	-43
HR	-25	10	-15
Medical	-74	17	-58
Nursing And Ahp's	-828	470	-358
Security And Facilities	-233	60	-173
Total	**-1335**	**625**	**-710**
Underachieved to date (1/12ths)	**-667**	**625**	**-42**

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 were agreed and taken from Quarter 1, and are now recognised monthly thereafter in agreement with budget holders.

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 October, with retention spend due.

FOR SG RETURN SEPT 24	ANNUAL	YTD
CAPITAL CRL 2024/2025	PLAN	SPEND
	£'k	£'k
PERIMETER SECURITY		
STANLEY SECURITY SOLUTIONS LTD		7
SECURITY CONTRACTING SERVICES LTD		0
DOIG & SMITH		0
THOMSON GRAY LTD		107
TSH STAFFING APR - MAY '25		87
SENSTAR CORP		0
INCOME RE COVID RECHARGES, SALE OF RADIOS ETC.		0
PERIMETER SECURITY TOTAL	**563**	**201**
CAPITAL		
IM&T		52
OTHER		50
CAPITAL	**269**	**103**
Total CRL	**832**	**303**

6 RECOMMENDATION

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

Revenue

The year to date position is an over spend of £0.087m (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

The budget is fully committed with 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:	24 October 2024
Agenda Reference:	Item No: 9
Sponsoring Director:	Medical Director
Author(s):	Associate Medical Director
Title of Report:	Bed Capacity within The State Hospital and Forensic Network
Purpose of Report	For Noting

1 SITUATION

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

2 BACKGROUND

a) TSH

The following table outlines the high level position from the 1 August 2024 until 30 September 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	16	48	21	12 + 3 ID surge	100
Admissions	4 (external) 0 (internal)	0 (external) 7 (internal)	0 (external) 5 (internal)	1 (external) 0 (internal)	5 (external) 12 (internal)
Discharges/Transfers	2 (external) 6 (internal)	1 (external) 6 (internal)	4 (external) 0 (internal)	1 (external) 0 (internal)	8 (external) 12 (internal)
Bed occupancy as at 30/09/2024	66.7%	100%	87.5%	125% (ID beds) 62.5% (all beds)	83.3% (available beds) 71.4% (all beds)

Please note that in total there were 100 patients as of 30th September 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 referral and admission

Date	6 weeks or less	More than 6 weeks	Total Number
30/09/2024	5	0	**5**

All 5 patients were admitted within the 6 weeks policy requirement.

There are 7 patients identified for external transfer (6 MMI and 1 ID), 2 of whom have been fully accepted. No patients have been waiting longer than 12 months. There have been 6 excess security appeals won (3 x S264, 3 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

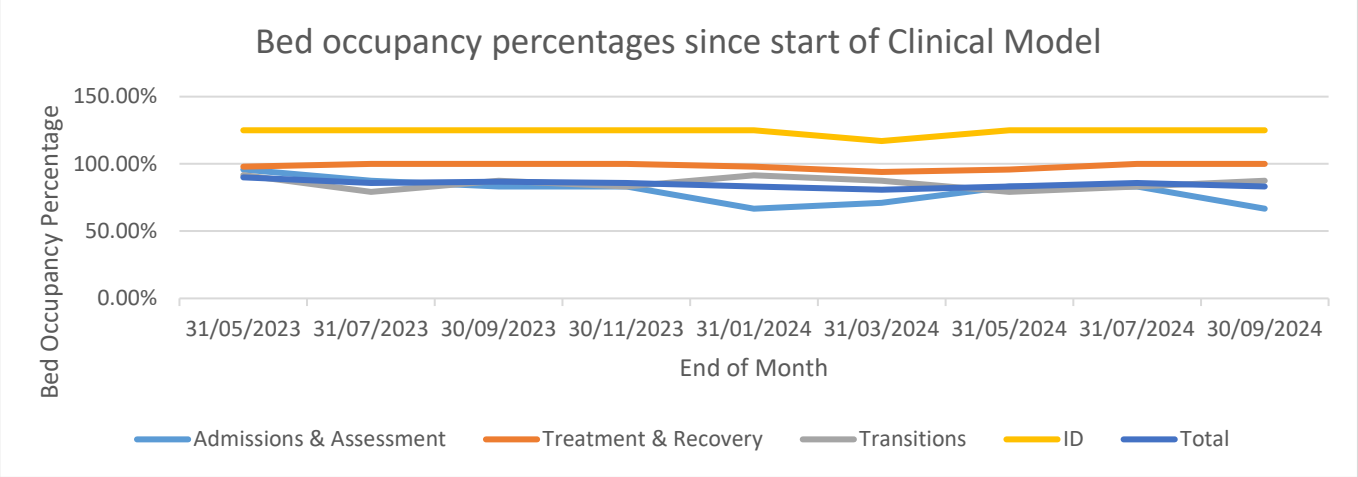


Table 2 Bed Occupancy by Service and in Total

Service	31/05/2023	31/07/2023	30/09/2023	30/11/2023	31/01/2024	31/03/2024	31/05/2024	31/07/202
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 the transitions service and fewer in admissions & assessment, which reflects the greater number of discharges and internal moves as 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

We receive a weekly forensic estate update report from the Forensic Network to aid patient flow. Full details are attached as Appendix 1. The Orchard Clinic has temporarily reduced its capacity for over one year by 7 beds for urgent repairs.

On 26/9/24 the Scottish Government requested that the Forensic Network carry out further work on capacity across the estate. The Network have been asked to take a collaborative, all-inclusive, and whole-systems approach that focuses on patients' interests in relation to the bullet points below. The Forensic Network should coordinate this work, culminating in a report setting out a plan of action with approximate timescales for delivery. The intention would be to bring together again the representatives from high-, medium-, and low-secure mental health services to ensure agreement and commitment to its delivery.

- **Referrals** — The Barron review found widespread consensus that clarity over referral pathways and processes for individual services would support decisions about the appropriateness of referrals. Variation in referral criteria should be minimised.
- **Multiple assessments** — The Barron review was told that the "repeat assessment process is not in the interests of the person requiring forensic mental health hospital treatment. It seems to add additional delays to the process to reassure the professionals within it."
- **Waiting lists** — Differences in how waiting lists are managed should be minimised. It is imperative that patient needs are the primary factor in decision-making in a patient-centric approach.
- **Regional agreements** — Existing regional agreements, particularly at medium security, may be the basis of some variation in referral and assessment processes and waiting list management. We should explore how we move towards greater cohesion in the delivery of secure inpatient services.
- **Dispute Resolution** (disagreement as to the level of security) - Feedback at the meeting indicated that not all services are content with the dispute resolution process, suggesting that it is not quick enough and cumbersome when a service must manage increased risk. **Escalation** (agreement as to level of security but difficulty finding a bed): An escalation process that can be quickly activated is needed.
- **Prison to Hospital transfers** - At the meeting, it was noted that the routine sharing of information when an individual is awaiting admission to a hospital is a critical aspect that needs to be addressed across all medium secure services.
- **Inter-Regional Group (IRG)** – Recognised as a critical group that highlights current and future pressures across secure services. How can it give low secure and community services a voice? To effect change, it needs to tie in with local planners. Could it have a function in relation to estimating future demand at different levels of security?

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 has now commenced.

4 RECOMMENDATION

The Board is asked to note the report.

MONITORING FORM

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

W/c 30 September 2024	High Secure		Medium Secure							Low Secure													
	TSH Male MI	TSH Male LD	Orchard Clinic Male (as at 23/09)	Orchard Clinic Female (as at 23/09)	Rohallion Male	Rowanbank Male	Rowanbank Female	National LD Male	National LD Female	Beckford Lodge Male	Bellsdyke Male (as at 23/09)	Bellsdyke Female (as at 23/09)	Leverndale Male	Leverndale Female	Leverndale Male LD	Rohallion Male	Blair Unit Male	Blair Unit Female	Stratheden Male (as at 02.09.24)	Woodland View Male	Kirklands Hospital Mixed ID	Lynebank Male ID	Strathmartine Male ID
Bed capacity	108	12	28	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	84	15	28	3	29	48	3	8	2	15	9	5	38	4	9	19	34	2	10	7	1	9	8
	11	-3	1	0	2	8	3	0	2	0	3	1	0	1	1	5*	0	0	2 in lodge (not external admitting beds)	1	1	1	0
No. empty beds																							
No. available beds	11	0	1	0	0	7 (acute)	2	0	2	0	2	0	0	1	0	0*	0	0	0	1	0	1 regional	0
No. on waitine list for access to service	0	0	4	1	3	1	0	1	0	4	1	0	21	0	1	0	5	0	1	0	2	0	0
No. on waiting list currently placed out of area	0	0	1	0	0	1	0	0	0	0	0	0	17	0	1	0	5	0	1	0	2	0	0
No. of patients on transfer list for lower security settings	6	1	3	2	6	9	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	0	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	4	0	0	0	0	2	1	11	1	2	4	4	0	0	0	0	5	0
No. of delayed discharges	0	0	2	0	0	2	0	0	0	4	0	0	1	0	2	2	4	0	0	0	0	3	0
No. of patients on transfer list fully accepted for transfer	1	1	0	0	6	3	0	1	1	0	1	0	8	0	0	0	3	0	0	0	0	0	0
No. of admissions in the last week	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2	0	1	0	0	0	0	0
No. of those admissions that were an emergency	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
No. of discharges in the last week	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Any foreseen potential issues this week in terms of capacity	No	No			No beds available			ID pt in Elm acute adm ward			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 - otherwise no beds available	in addition to the above we have 1 patient in another ward	One further patient is decanted out of the ward for operational reasons			Review of beds being undertaken by the service		

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

Paper No. 24/84

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2024
Agenda Reference:	Item No: 10
Sponsoring Director:	Medical Director
Author(s):	Medical Director
Title of Report:	Clinical Model 12 Month Evaluation
Purpose of Report:	For Noting

1 SITUATION

This report provides the Board with a 12-month evaluation of the Clinical Model since its commencement in July 2023.

2 BACKGROUND

The Board was fully sighted on the origins and development of the new Clinical Model. The Clinical Model Project safely transitioned patients and staff from the previous service model to the new Clinical Model. A paper to the Board on 22/6/23 concluded the planning work and final patient moves took place on 22nd May 2023. Guidance documents for the new Clinical Model were agreed towards the end of July 2024. A formal commencement date of 24/7/23 was agreed for evaluation purposes. An interim evaluation of the Clinical Model was presented at a Board development day on 2/5/24.

The new Clinical Model delivery aims are:

- More tailored security based on risk and clinical presentation, aligned with the least restrictive practice principle
- A sense of progression for patients through their clinical care journey in high security
- Streamlined integration between sub specialty wards and the Skye Centre, enabling best use of resources to support physical health, therapeutic activity and treatment goals
- Meeting the ID specific patient need through a more tailored and specialised environment. This involves distribution of patients across 2 wards rather than 1 to improve the therapeutic milieu.
- Improved clinical case mix, with admissions accommodated in specified wards
- The ability for staff to specialise in sub specialty areas of care and practice

Outcomes to be achieved are:

- An enhanced treatment environment with a more tailored and individualised approach
- Effective use and deployment of available resources

- Increased patient activity for the betterment of their physical health
- Feeling of progression for patients
- Management of patients with similar risks together with adequate staffing levels
- Staff feeling of improved safety within the workplace
- More positive recognition of staff and the support available to them

Since the launch of the new clinical model work has been ongoing to ensure the original clinical model delivery aims are being met. Additionally, work to develop tools through which to monitor fidelity to the new clinical model has taken place. These aims and outcomes are tracked through the Clinical Model Oversight Group and reported to the Clinical Governance Group.

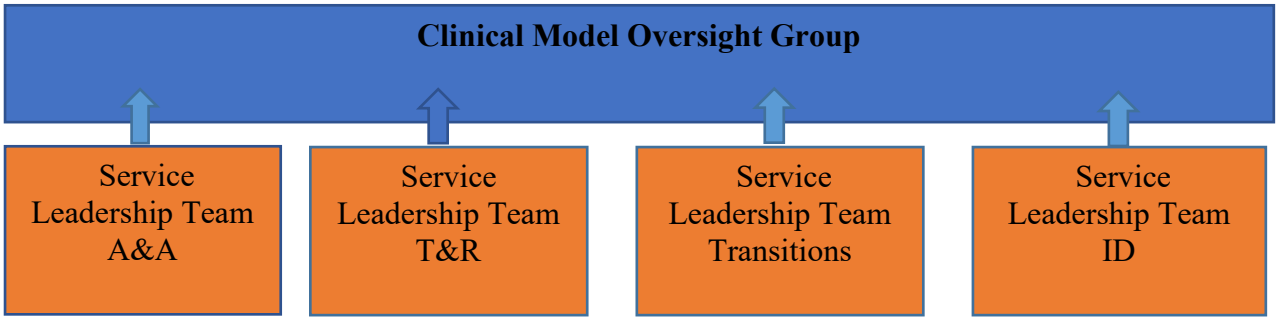
3 ASSESSMENT

Clinical Guidance

An overarching Clinical Model Guidance document was developed and implemented on 17/7/23 with detailed sections on the four new services: Admissions and Assessment, Treatment and Recovery, Transitions, and Intellectual Disability. This remains in place and is unmodified. The guidance provides part of the basis against which progress of the new Clinical Model can be measured.

Service Leadership

Fig.1 Service Leadership Model



Service Leadership Teams are in place for each service. These teams support the operationalisation of the model and guidance. They have full responsibility for reporting on their service as part of business as usual approach. Each has had an away day to discuss their working methods, issues and progress; and are working with the Organisational Development Manager.

The Clinical Model Oversight Group (CMOG) was established in May 2023 to provide an overarching forum for collaborative leadership working across the hospital under the new clinical services structure. This meeting is co-chaired by the Associate Medical Director and the Associate Nursing Director, and attended by key personnel for each of the clinical service areas. Meetings occur on a monthly basis. CMOG reports to the Clinical Governance Group.

CMOG Terms of Reference

- Review the operationalisation of the Clinical Model
- To be a conduit for shared learning between the services
- Coordinate patient movement through the model and any use of the contingency arrangements

- Address any issues emerging with the pathway
- Review in collaboration with the Skye Centre, what and how activity is being delivered
- Oversee the model bedding in and address any snags
- Have oversight of the Clinical Guidance and ensure ongoing coherence of service delivery to the guidance
- Have oversight of the key indicators of clinical care delivery and identify any issues / learning emerging from data
- Have oversight of the overall resource allocation and usages to ensure efficiency
- To ensure fair and equitable allocation of office space across the services and be mindful in this of departments that work across the services
- Ensure reporting of progress and escalation of issues.

Contingency Planning

A standard operating procedure (SOP) was developed for MMI or ID (in excess of 12) contingency patients to receive day and night care in the ID service in the event that all other beds were in use. This includes the criteria for patient to be considered for this approach and the process for identifying the model of care for each of these patients. The Clinical Model Oversight Group manages this process but to date it has not been utilised for MMI patients.

Patient Flow

Table 1 Patient Flow

01/08/2023 – 31/08/2024	Admission & Assessment (A&A)	Treatment & Recovery (T&R)	Transitions (Tr)	ID	Total
External Admissions	30	0	0	3	33
Internal Admissions	0	29	17	7	53
External Transfers	12	11	12	3	38
Internal Transfers	25 - 24 T&R - 1 Tr	19 - 12 Tr - 7 T&R	2 -2 T&R	7 3 – I2 to I3 3 – I3 to I2 1 – I3 to I1	53*

* All external and internal transfers are different patients except for three - two who went from T&R to transitions and were then externally discharged, and one who went from Admissions to T&R then was externally discharged.

Conclusions

1) Patients are moving through the three major mental illness (MMI) services as planned.
2) External transfers from A&A are an expected part of the model for those patients who do not require ongoing care in TSH.
3) In the second half of this period, more patients have been discharged via the Transitions Service suggesting that the patient flow expected from the model is occurring.

Patient Feedback

No patient feedback has been gathered to date. The Patient Partnership Group (PPG) will begin gathering information for presentation as a Patient Story at the TSH Board meeting in December 2024.

Activity Planning

The implementation of the new Clinical Model offers the opportunity to reconsider how activity is delivered at TSH, and how staff and environmental resource are best utilised. Activity Planning is an integral aspect of the clinical guidance and clinical model implementation and is a core role of the Service Leadership Teams. With changes to the timetable, the ability to track individual activity and monitor how closely this aligns to activity goals is now available. The Activity Oversight Group reviews activity across the four services. Each service is developing plans to improve activity levels.

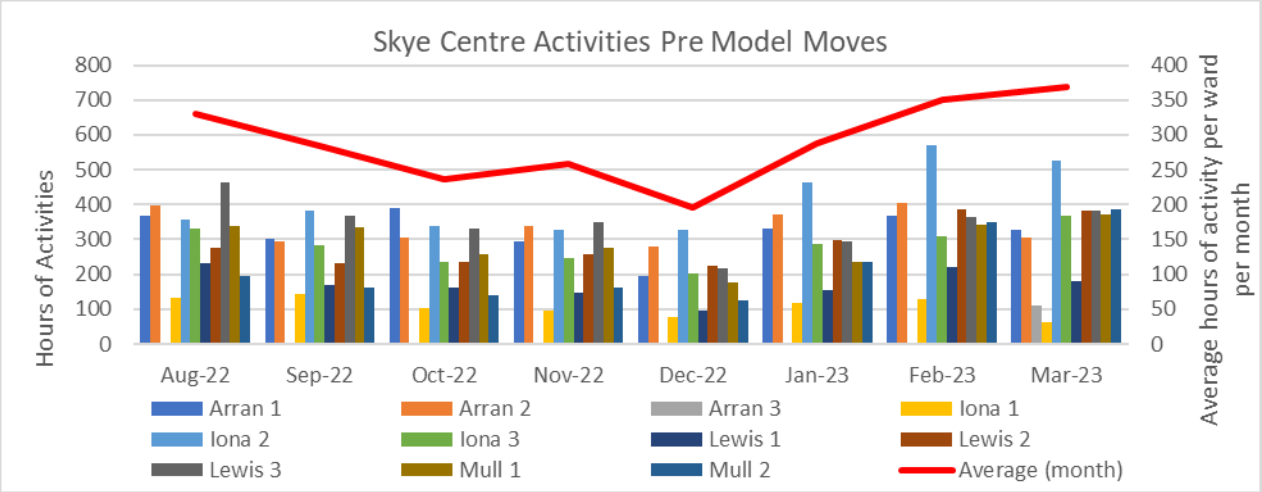
Activity Data

Full activity data pre and post the implementation of the clinical model were analysed. Caution is required in interpreting the data as there are known to be differences in the way that wards record activities. This is currently being fixed. For this reason, the data below focuses on Skye Centre activity alone as this is consistently recorded across all services.

Table 2 Skye Centre Activity Data – Patient Hours

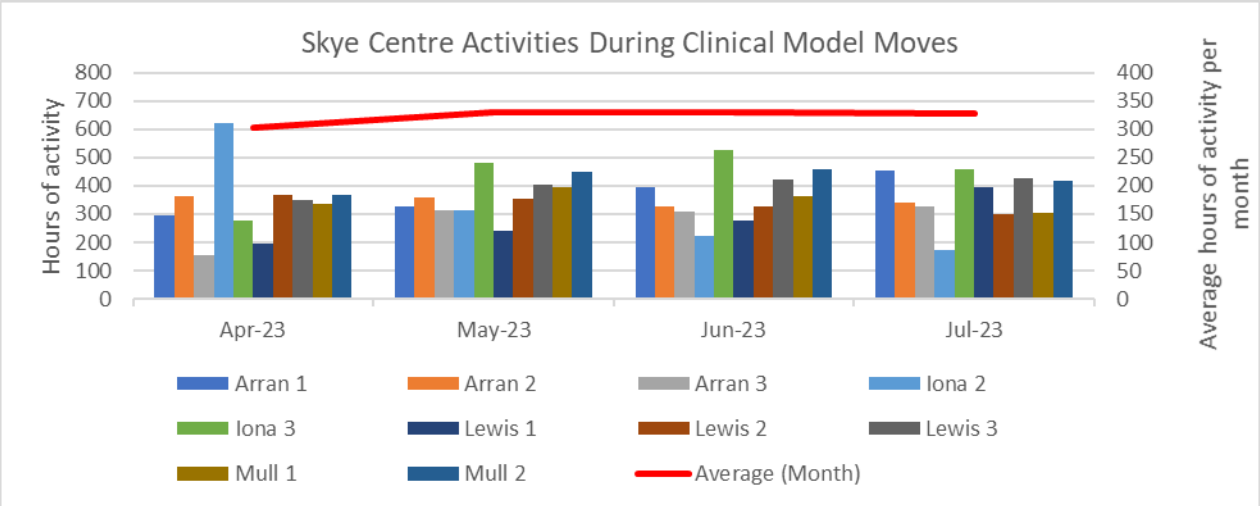
Review Period	Average monthly hours of activity per ward over review period
Pre Clinical Model - Old Model	288.9
Transition Clinical Model	322.3
Post Clinical Model	333.9

Pre Clinical Model



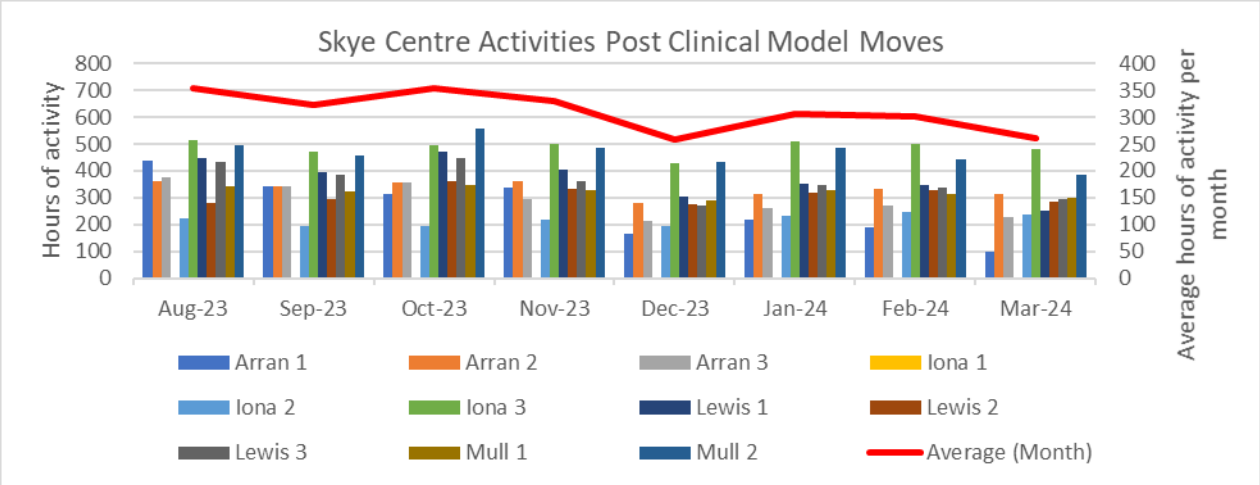
	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Total Skye Centre Activities (hrs)	3085	2670	2499	2492	1918	2786	3443	3401
Total No. of Patients	114	111	108	111	110	109	105	104
Average weekly activity per patient (hrs)	6.8	6.0	5.8	5.6	4.4	6.4	8.2	8.2

Transitional Clinical Model

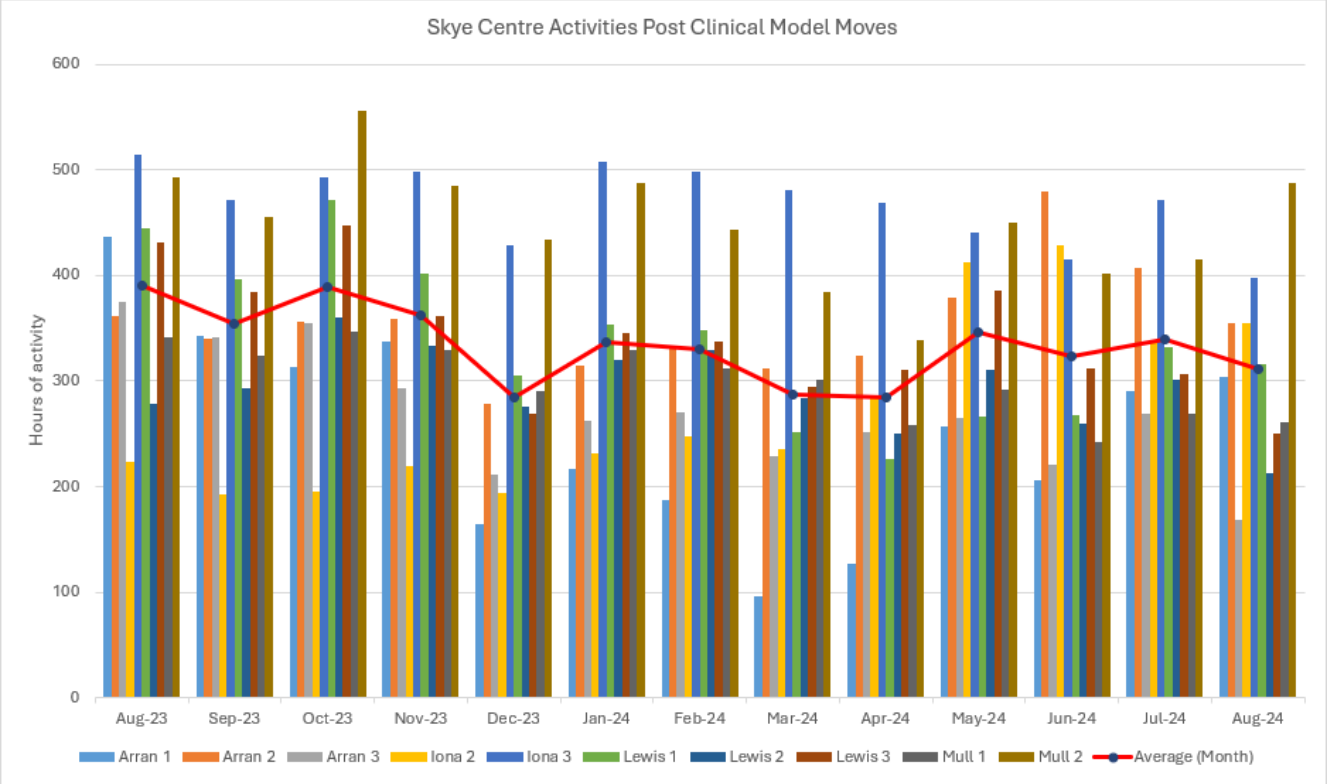


	Apr-23	May-23	Jun-23	Jul-23
Total Skye Centre Activities (hrs)	3328	3631	3624	3596
Total No. of Patients	109	108	105	104
Average weekly activity per patient (hrs)	7.6	8.4	8.6	8.6

Post Clinical Model



	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Total Skye Centre Activities	3901	3541	3894	3620	2851	3369	3306	2867
Total No. of Patients	101	102	105	104	104	102	95	92
Average hours per patient	9.7	8.7	9.3	8.7	6.9	8.3	8.7	7.8



From August 2023 – August 2024, the average number of hours of activity has been 333.9 hours.

Conclusions

1) Overall Skye Centre activity has increased with the introduction of the new clinical model from 289 to 334 hours/month/ward.
2) This equates to an average increase per patient from 6.1 hours/week in Skye Centre activities to 7.7, or from just under to just over on average one hour per day.
3) The work of the service leadership teams alongside the Activity Oversight Group is important in improving activity opportunities for patients and activity data.

Incidents

This section summarises incidents under the previous clinical model, the transition period and the new clinical model. It does this for all patients and then by service. This allows comparison of time periods. Incident statistics for the full period to 31/8/24 since the introduction of the new clinical model are also provided.

Due to concerns regarding incidents raised by the ID Service an incident data review was carried out in February 2024. These data were given to the reflective review of care in the Intellectual Disability Service.

Table 3: Incidents for all patients under previous clinical model, transition period and new clinical model

Incident Type	Previous Clinical Model 1/8/22-31/3/23	Transition Period 1/4/23-31/7/23* [Pro-rated figures to 8 months]	New Clinical Model 1/8/23-31/3/24	New Clinical Model 1/8/23 to 31/8/24
Assault	**19**	**8 [16]**	**41**	**95**
Attempted assault	**54**	**17 [34]**	**43**	**95**
Behaviour	**196**	**53 [106]**	**185**	**330**
Verbal	**65**	**23 [46]**	**91**	**177**
Sexual	**27**	**6 [12]**	**14**	**21**
Self-harm	**63**	**26 [52]**	**115**	**229**
Total	**424**	**133 [266]**	**489**	**947**
Number of patients Average (range)	**109 (104-113)**	**106 (103-110)**	**101 (95-105)**	

* This period is only 4 months whereas the 2 direct comparison periods are both 8 months in length.

Conclusions:
1) The total number of incidents increased by 15.3% from 424 to 489 under the new clinical model using the comparative periods. This rise in incidents has been maintained: 489 in first 8 months (61/month) and 458 (92/month) in subsequent 5 months.
2) There appears to have been an incident honeymoon period during the transition period (allowing for the reduced timescale) with a reduction of 52.1% from 424 to 266 pro-rated.
3) Of note, up to 3 modified secure rooms have been required for use by the Admissions Services at the same time.

Table 4: Serious Incidents (assault, attempted assault and sexual) by service type under previous clinical model, transition period and new clinical model

Service	Previous Clinical Model 1/8/22-31/3/23	Transition Period 1/4/23-31/7/23* [Pro-rated figures to 8 months]	New Clinical Model 1/8/23-31/3/24	New Clinical Model 1/8/23 to 31/8/24
Admission and Assessment	43	0	21	36
Treatment and Recovery	48** includes transitions***	7 [14]	43	85
Transitions	Included above	3 [6]	1	1 (Sexual comment)
Intellectual Disability	17	7 [14]	30	86

*This period is only 4 months whereas the 2 direct comparison periods are both 8 months in length.
**This includes 13 incidents by a patient based in a treatment and recovery ward that took place in a general hospital.
***The transition service did not exist under the previous model so all data from the rehabilitation wards are combined.

Conclusions:

1) Serious incidents within admission wards have decreased from 43 to 21 but please note the admission service now contains 24 rather than 36 beds. However, even allowing for this proportionately, the decrease appears real. If only Arran 1 and Lewis 2 are compared against Arran 1 and Lewis 1, the incidents are stable going from 24 to 21. Caution is required in interpreting these data as the previous admission wards would have contained some patients who will now be located in treatment and recovery wards.
2) Serious incidents within the Admission and Assessment Service in the first 13 months of the new model were relatively stable: 21 or 2.6/month in the first 8 months; and 15 or 3/month in the subsequent 5 months.
3) Serious incidents within the recovery and rehabilitation wards combined were stable: decreased by 5 from 48 to 44 (includes R&R and Transitions) in the comparison period.
4) Serious incidents within the Treatment and Recovery Service in the first 13 months of the new model showed some increase: 43 or 5.4/month in the first 8 months; and 42 or 8.4/month in the subsequent 5 months
5) The Transitions Service has a low level of serious incidents reflecting its planned clinical function. This has continued throughout the 13 months of the new model.
6) Serious incidents within the ID service have increased by 13 (76.5%) from 17 to 30 within the comparison periods. These incidents were largely due to the activity of 3 patients.
7) Serious incidents within the ID Service in the first 13 months of the new model showed an increase: 30 or 3.8/month in the first 8 months; and 56 or 11.2/month in the subsequent 5 months. Most are by one patient.
8) The honeymoon period is again evident.

Table 5: Self-harm by service type under previous clinical model, transition period and new clinical model

Service	**Previous Clinical Model 1/8/22-31/3/23**	**Transition Period 1/4/23-31/7/23* [Pro-rated figures to 8 months]**	**New Clinical Model 1/8/23-31/3/24**	**New Clinical Model 1/8/23 to 31/8/24**
Admission and Assessment	4	0	3	8
Treatment and Recovery	47 includes transitions**	4 [8]	3	12
Transitions	Note above	0	0	0
Intellectual Disability	35 over 6 months [47)	19 [38]	109	208

*This period is only 4 months whereas the 2 comparison periods are both 8 months in length.

**The transition service did not exist under the previous model so all data from the rehabilitation wards are combined.

Conclusions:

1) Self-harm within the admission wards / service is low and stable.
2) Self-harm within the treatment and recovery service combined showed a significant decline from 47 to 3 during the comparative periods but most of this decrease is accounted for by the 3 patients with intellectual disability who were previously cared for in MMI wards. They would account (pro-rated for 8 months) for 37 of the 47 episodes of self-harm.
3) The level of self-harm in the treatment and recovery service since the introduction of the new clinical model is low.
4) There have been no incidents of self-harm in the Transitions Service suggesting it is functioning as planned.
5) Self-harm within the ID service has increased by 62 from pro-rated 47 to 109. The baseline of 35 includes 28 incidents of self-harm by 3 patients with intellectual disability who were cared for in MMI wards.
6) Self-harm within the ID Service in the first 13 months of the new model showed an increase: 109 or 13.6/month in the first 8 months; and 99 or 19.8/month in the subsequent 5 months. Most are by one patient.
7) The honeymoon period is again evident.

Evaluation of the implementation and utility of the new State Hospital Clinical Model

Implementation of the new Clinical Model (CM) is a major investment for the hospital. Development guidance has specified a range of intended outcomes and benefits to patients and staff resulting from these changes to the model of care. The Clinical Model Implementation Evaluation is a three-year, mixed method, multi-informant evaluation of the implementation and utility of the new model. The study was designed to assess each of the eight specified intended outcomes of the model.

See Appendix 1: Clinical Model Implementation Evaluation Timetable

Staff data linkage will link together information at an individual level for 6 months over each of the time periods. Staff demographics and information regarding shifts, absence, engagement with training, and involvement in incidences at person level will be linked to establish an overview of the work pathway of individual staff members. A similar process will examine individual patient pathways.

A Process Evaluation examines at two review periods (Aug-Dec 2023 &2024) if services are operating in accordance with the guidance documents, to capture evolution of the core outcomes within each service and the decision making behind further development. The first process evaluation has been completed and each service leadership team provided with a report on matters progressing well and to be addressed. See **Appendix 2**. These have been converted into a Clinical Model Adherence Tool and an example of this is shown for the Admissions and Assessment Service.

The online staff questionnaire has been repeated in July 2024 to explore any changes in staff perception, with deeper exploration among staff, carers and patients being obtained through interview with additional participatory action research with patients.
As a complete body of work the information should allow the implementation and utility of the new clinical model to be assessed along with an exploration of the evolving staff perception of the model and wider hospital environment.

Regular updates outlining progress and findings to date are provided to the Research Committee.

Research findings are shared throughout to ensure that any required action can be taken.

Planned internal audits

RSMUK auditors reported to the Audit and Risk Committee on 20th June 2024 regarding the implementation and monitoring of the new Clinical Model. They gave a rating of reasonable assurance.

Clinical Model Oversight Group Reporting

Following an interim evaluation of the implementation and utility of the new clinical model (April 2024) the Clinical Model Oversight Group was tasked with developing a report through which monitoring of the new model would occur. The evaluation measures are based on the aims:

- More tailored security based on risk and clinical presentation, aligned with the least restrictive practice principles

  Measures: adherence to clinical model guidance for each service; modifications to routine practice in transitions service

- A sense of progression for patients through their clinical care journey in high security

  Measures: patient flow and service waiting lists

- Streamlined integration between sub specialty wards and the Skye Centre, enabling best use of resources to support physical health, therapeutic activity and treatment goals

  Measures: Skye Centre activity data by patient and service; to be further developed to include service-based activity.

- Meeting the ID specific patient need through a more tailored and specialised environment. This involves distribution of patients across 2 wards rather than 1 to improve the therapeutic milieu.

  Measures: activity, incident, serious incident and self-harm data across service.

- Improved clinical case mix, with admissions accommodated in specified wards

  Measures: activity, incident, serious incident and self-harm data across service.

- The ability for staff to specialise in sub specialty areas of care and practice

  Measures: Staff are learning to work within the new service of the clinical model. Specific training is in place for the IDS. Staff education and training programmes are in place across the hospital. In the future consideration will be given to the development of an application system for the different services.

A standard set of KPIs has been developed through involvement of the individual service teams at CMOG. These KPIs are for operational management and include data on SRK Usage, seclusion use, patients with no physical activity in a week, patients with no fresh air in a week, patients with no timetabled sessions in a week, PRN medication use, enhanced care plan use, patient flow, daytime confinement, Skye Centre activities, Skye Centre usage and challenges with referrals. The August 2024 data are shown in **Appendix 3**. Several of the KPIs are useful in reporting functioning of the clinical model. There will be further development of the KPIs to ensure that they are monitoring adherence to the model aims.

CMOG was tasked to report on adherence to the clinical guidance developed by each of the clinical service leadership teams. An example of a variance tool developed for this purpose for Admissions and Assessment is appended for discussion, see **Appendix 2**. This is still in the development phase.

Aim: More tailored security based on risk and clinical presentation, aligned with the least restrictive practice principles
Assessment – Across the hospital the median for the numbers of patients on enhanced care plans has reduced, again evidencing that the new clinical model aligns with least restrictive practices. We can see through the increased levels of activity in the Transitions Service that a more tailored approach to risk within this service is allowing higher levels of attendance at activities. We note that over the time of the model being in place that there has not been an increase in SRK use (though we note a separate evaluation of pre model SRK use is underway showing increased use} or seclusion to date. CMOG believes that through completion of the variance tool (**Appendix 2**) that it will be able to provide further evidence of adherence to this aim.

Aim: A sense of progression for patients through their clinical care journey in high security
Assessment – We can see through the patient flow data as at 19th September that there remains a good availability of beds in admissions, no bed availability in treatment and recovery and some bed availability in transitions. This would indicate that patients are appropriately progressing through the services. To support patients' progression through the services an electronic referral process has been developed related to internal referrals to ensure that patients are identified at an early point as suitable to move to the next service. Through the Patient Pathways Meeting we will use data from this new internal referrals' process to support adherence to this aim.

Aim: Streamlined integration between sub specialty wards and the Skye Centre, enabling best use of resources to support physical health, therapeutic activity and treatment goals
Assessment – The model would appear to show that patients in the Intellectual Disability Service and Transitions are accessing Skye Centre activities at a higher level than Admissions and Treatment and Recovery. This would be indicative of integrated working between the Skye Centre and the services, as would be expected if the model is functioning as anticipated. Integration between the services and the Skye Centre is also supported through their attendance at CMOG. Adherence to this aim would be strengthened by monitoring achievement of the 150 mins of physical activity target across the services, this will be taken forward through CMOG.

Aim: Meeting the ID specific patient need through a more tailored and specialised environment. This involves distribution of patients across 2 wards rather than 1 to improve the therapeutic milieu.
Assessment – We can see a steady improvement in patients in Iona 2 engaging in activities at the Skye Centre and patients in Iona 3 continuing to show high levels of Skye Centre access. This would indicate that the model is providing a tailored and specialised environment to this patient group. There remains a significant problem with an increase in

incidents with this service. CMOG believes that through completion of the variance tool (**Appendix 2**) that it will be able to provide further evidence of adherence to this aim.

Aim: Improved clinical case mix, with admissions accommodated in specified wards
Assessment – The patient flow data at 19th September shows good bed availability within the Admissions Service. Additionally, the Treatment and Recovery Service being at capacity would indicate the model has supported an improved clinical case mix and admissions being accommodated in specified wards.

Aim: The ability for staff to specialise in sub specialty areas of care and practice.
Assessment – Through updates received from the clinical services at CMOG there is evidence that staff within the services are developing their sub specialty expertise. Notably in the Intellectual Disability Service and Transitions. Within the Intellectual Disability Service PBS (Positive Behavioural Support) training has been delivered to all nursing staff. Transitions Service staff are developing their expertise in relation to transferring patients to lower secure settings. CMOG believes that through completion of the variance tool (Appendix 2) that it will be able to provide further evidence of adherence to this aim.

CMOG is continuing to work towards ensuring that the clinical services are working towards adhering to the guidelines developed by their services. In coming months, CMOG will be asking services to complete the variance tool shown in **Appendix 2**.

Summary

Table 6 sets out a summary of the progress of the Clinical Model to date based on the information above.

Table 6 Summary of Clinical Model Evaluation

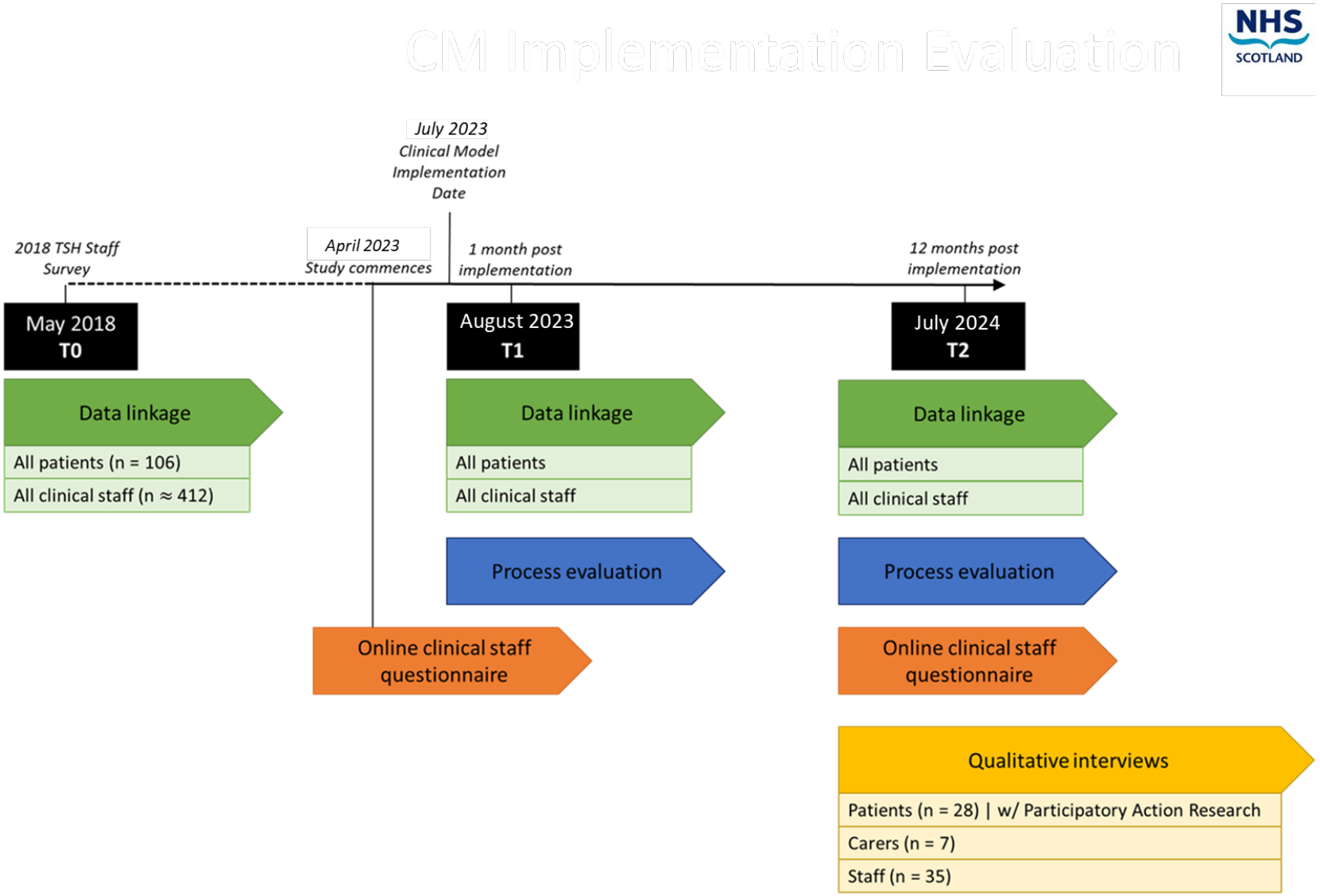
Going well	**Developing**	**Issues**
New Clinical Model fully implemented	Service leadership teams	Daytime Confinement*
Clinical Model Guidance in place	Clinical Model Oversight Group	Fidelity to Clinical Model
Contingency Plan in place	Patient Flow	Tailored Security
	Activity	Activity
Treatment setting appropriate to an individual's need	Electronic referral system and waiting lists	
Serious Violent Incidents in Transitions Service – very low	Serious Violent Incidents in Admissions & Assessment and Treatment and Recovery stable	Serious Violent Incidents in IDS – significant increase
No self-harm incidents in Transitions Service	Self-harm Incidents in Admissions & Assessment and Treatment and Recovery stable and low	Self-harm in IDS – significant increase
Marked reduction in self-harm in Treatment and Recovery Service (note effect of 3 ID patients)		
Evaluation	Action tables in place for service leadership teams based on process evaluation of guidance.	Honeymoon Period

*An accurate measure of DTC was introduced in September 2023 so no analysis can be made of its effects pre-, during and post the introduction of the new clinical model.

4 RECOMMENDATION

The Board is invited to note the content of this report.

Appendix 1: Clinical Model Implementation Evaluation Timetable



Appendix 2

Admission and Assessment Service (A&A)

These items are based upon assessment of elements from the guidance documents against evidence accrued from RiO documentation, ward visits and discussions with other relevant staff

RiO examination	
Area of Effectiveness	**Area of Improvement**
Admission physical completed in timeframe	Interest checklist and timeframe for completion
Development of Psychological formulation and availability to MDT pre CPA.	Encouragement/engagement with physical activity each day
Timeframe for admission CPA (within 12 weeks)	DASA observations by each shift /noting in RiO DASA form.
Movement from A&A to T&R within the same hub	Development of activity plan within 7 days
No return to A&A service following progression	Development of progress check-in (4-6 weeks) by clinical team against key assessment objectives (initial case conference)
A&A patients mingling with T&R patients within the hub area.	

These items are based upon observation and integration of information / SLT reporting contained within IDS SLT/CMOG meeting minutes and IDS flash reporting to CMOG

Observation from SLT/CMOG meeting minutes/flash reports	
Area of Effectiveness	**Area of Improvement**
Increase in overall patient activity	SLT member attendance
Attending Skye Centre as a service	Adoption of a standard agenda
Pre admission needs assessment	Systematic recording and review of action points
Clear areas of improvement proposed/being actioned	Discussion and action on data provided
Clear process and monitoring of patients suitable for progression to T&R/waiting list	Communication, ownership and decision making within the SLT and to the wider TSH environment

Admissions and Assessment Clinical Model Adherence Tool

Admission and Assessment Service Clinical Model Adherence Targets	Date carried out:	Evidenced by:	Variance Please write “not done” or “late” in space provided along with reason:
Admission physical completed in timeframe			
Development of Psychological formulation and availability to MDT pre CPA.			
Timeframe for admission CPA (within 12 weeks)			
Movement from A&A to T&R within the same hub			
No return to A&A service following progression			
A&A patients mingling with T&R patients within the hub area.			
Interest checklist and timeframe for completion			
Encouragement/engagement with physical activity each day			
DASA observations by each shift /noting in RiO DASA form.			
Development of activity plan within 7 days			
Development of progress check-in (4-6 weeks) by clinical team against key assessment objectives (initial case conference)			
Increase in overall patient activity			
Attending Skye Centre as a service			
Pre admission needs assessment			
Clear areas of improvement proposed/being actioned			
Clear process and monitoring of patients suitable for progression to T&R/waiting list			
SLT member attendance			
Adoption of a standard agenda			
Systematic recording and review of action points			
Discussion and action on data provided			
Communication, ownership and decision making within the SLT and to the wider TSH environment			

Treatment & Recovery (T&R)

These items are based upon assessment of elements from the guidance documents against evidence accrued from RiO documentation, ward visits and discussions with other relevant staff

RiO examination	
Area of Effectiveness	**Area for Improvement**
Ensuring CPA completed prior to transfer	Development of a referral process/waiting list
Ensuring working formulation	Evidence of MDT agreement suitability for progression
Ensuring VRAMP	Review of interest checklist on transfer
Ensuring engagement with clinical team, activity and physical health	Frequency (days) engaged in planned (non shop) Skye centre activities.
Ensuring positive response to antipsychotic medication	Improve number of patients functioning within 'ideal' criterion: symptom management/impact on functionality, grounds access and engagement with rehab/ psychotherapeutic activity
Ensuring Skye centre induction	Establish CTM arrangements, frequency, staff attendance etc. which provides most benefit to patients and staff.
Ensuring engagement with grounds activity	Ensure psychological formulation available for review by MDT in the formulation/psychology admission report area of RiO.

These items are based upon observation and integration of information / SLT reporting contained within IDS SLT/CMOG meeting minutes and IDS flash reporting to CMOG

Observation from SLT/CMOG meeting minutes/flash reports	
Area of Effectiveness	**Area of Improvement**
Active core members of SLT	Increase effective membership across the MDT but in particular clinical security, social work and from the Skye centre.
SLT/wider service communication	
Communication/negotiation with other departments (hospital wide)	
Seeking patient feedback/input	
Issue escalation (CMOG)	
Reviewing/engaging with utility of data provided to service	

Transitions Service

These items are based upon assessment of elements from the guidance documents against evidence accrued from RiO documentation, ward visits and discussions with other relevant staff

Area of Effectiveness	Area for Improvement
Development of a referral process & defined criteria across the whole transfer event	Consideration of any exceptions to progress patients, particularly if being made to free up space elsewhere in the system.
Sharing referral documentation with other services to encourage development of their own processes	Development of a tailored Patient Welcome Pack
General compliance with referral criteria	Development of clear criteria to assist timely decision making around the return of a patient to the T&R service.
Compliance with criteria for transfer to T&R service.	Work in conjunction with the Skye centre to develop or preferentially offer volunteer posts or opportunities for peer support to Transitions patients.
Patient engagement with OT leavers group	
Patient engagement with volunteer/leadership roles	

These items are based upon observation and integration of information / SLT reporting contained within IDS SLT/CMOG meeting minutes and IDS flash reporting to CMOG

Observation from SLT/CMOG meeting minutes/flash reports	
Area of Effectiveness	**Area for Improvement**
Information sharing with CMOG	Increase number and regularity of SLT meetings
A comprehensive and standardised approach to recording patient referrals, those awaiting discharge, bed status and RMO order or beds with information regularly shared across the Transitions team.	Discussion/sharing best practice and exploring any learning points from any patient discharge/transfer
Good morale	Support the patient community and activity groups to grow, develop and act
Positive patient feedback	Reinstate patient self-report/reflection upon their day
	Make appropriate self-help resources available to patients within the ward environment.
	Aligning of ward expectations

Intellectual Disability Service (IDS)

These items are based upon assessment of elements from the guidance documents against evidence accrued from RiO documentation, ward visits and discussions with other relevant staff

RiO examination	
Area of Effectiveness	**Area for Improvement**
All patients with ID diagnosis managed in IDS at all stages of their admission.	Patient numbers exceed stated optimal levels
Frequency of CTM review	OT interest checklist to be completed with new admissions
Invitation of named person and carers to CPA meetings.	Activity levels could be improved.
PAS support to patients at CPA	Involvement of PCIT in activity support and provision.
PAS provision to wards and ID training of advocacy workers	Recording/conducting Pre CPA discussions and use of 'path to progress' pro forma.
	Communication assessment and plan for each patient and shared with PAS & PCIT
	Ensuring VRAMP updated within 12 months and available on RiO

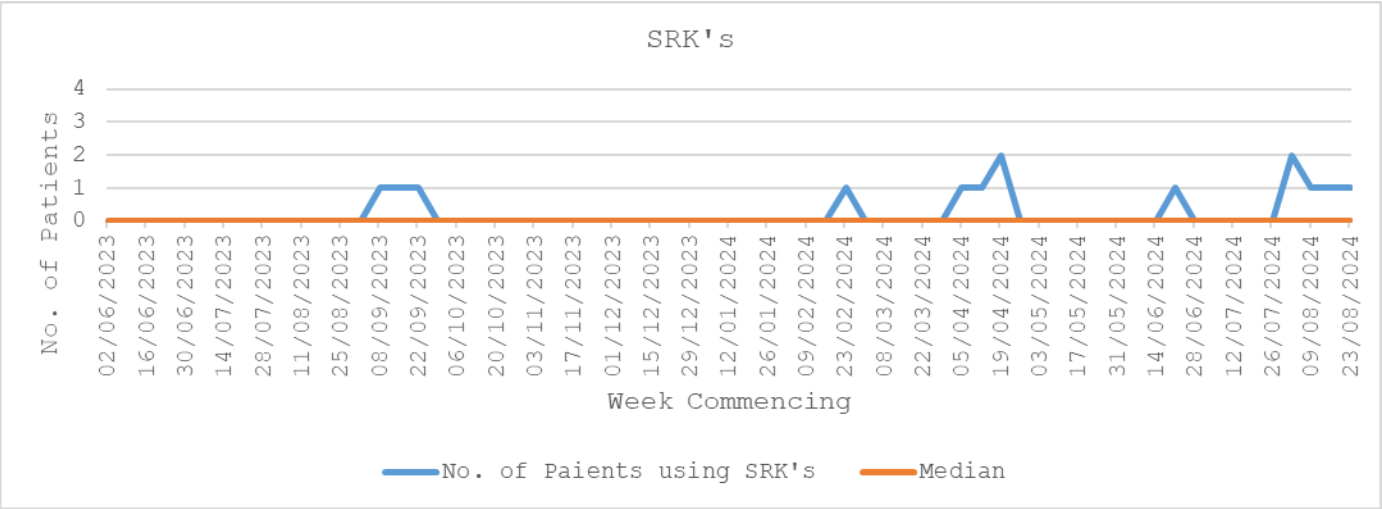
These items are based upon observation and integration of information / SLT reporting contained within IDS SLT/CMOG meeting minutes and IDS flash reporting to CMOG

Observation from SLT/CMOG meeting minutes/flash reports	
Area of Effectiveness	**Area for Improvement**
Review of a range of data to inform service performance and areas for improvement	Attendance at CMOG by another SLT representative if clinical lead/lead nurse can not attend.
Focus on facilitating and supporting initiatives to increase activity	Need to focus efforts to reducing incidences of aggression and self-harm
PBS training to enhance staff skills	Need to improve internal and external environment aesthetically and for practical use
Recognition of need to improve communication and joint working to increase the number of planned activities that go ahead.	To work towards patient numbers being at an optimal level of 12 across both ward areas
Attempts to create sense of one service across the two wards for both staff and patients through shared activities.	

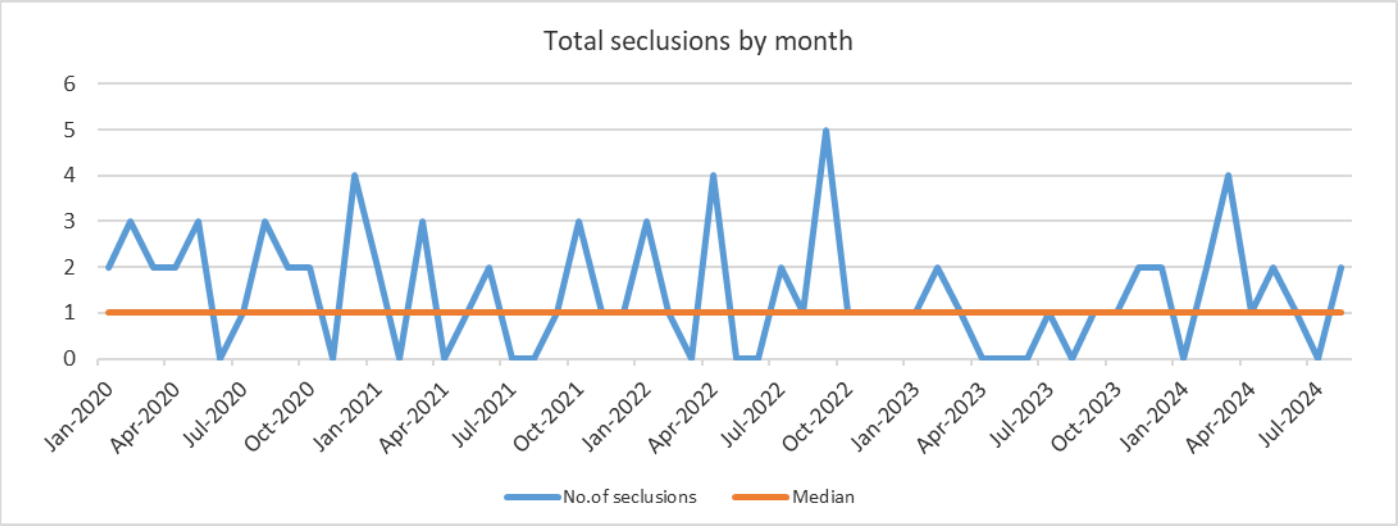
Appendix 3

Clinical Quality Data for Clinical Model Oversight Group – August 2024 Data

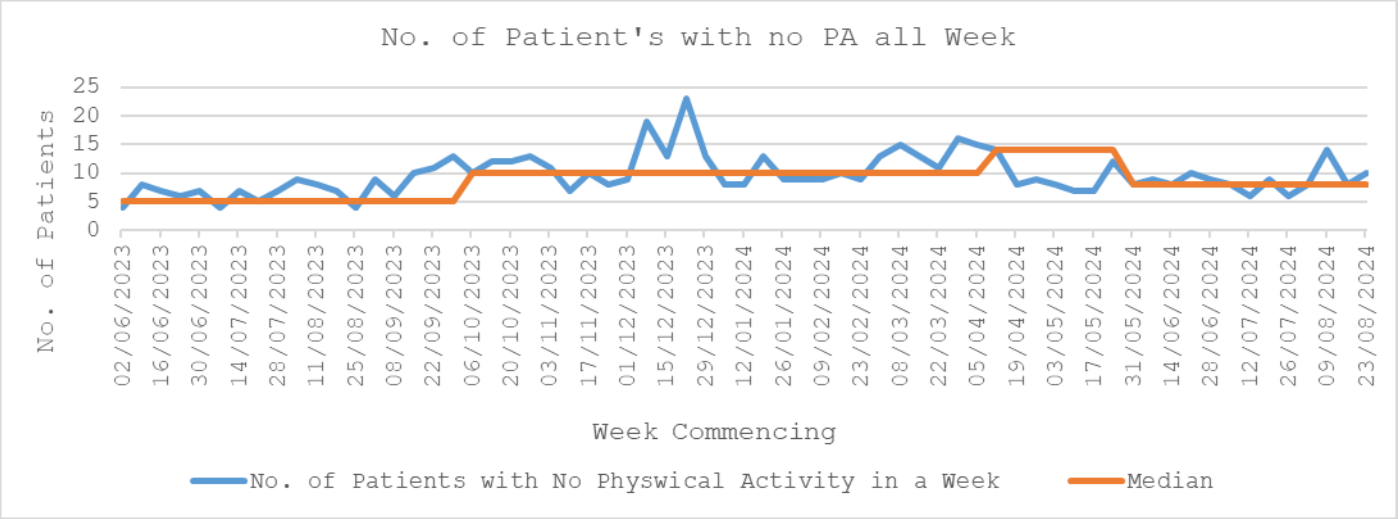
SRK Usage:
SRK usage is showing random variation with no areas of concern at present. In recent weeks we have seen SRK used on a patient in the treatment and recovery service.



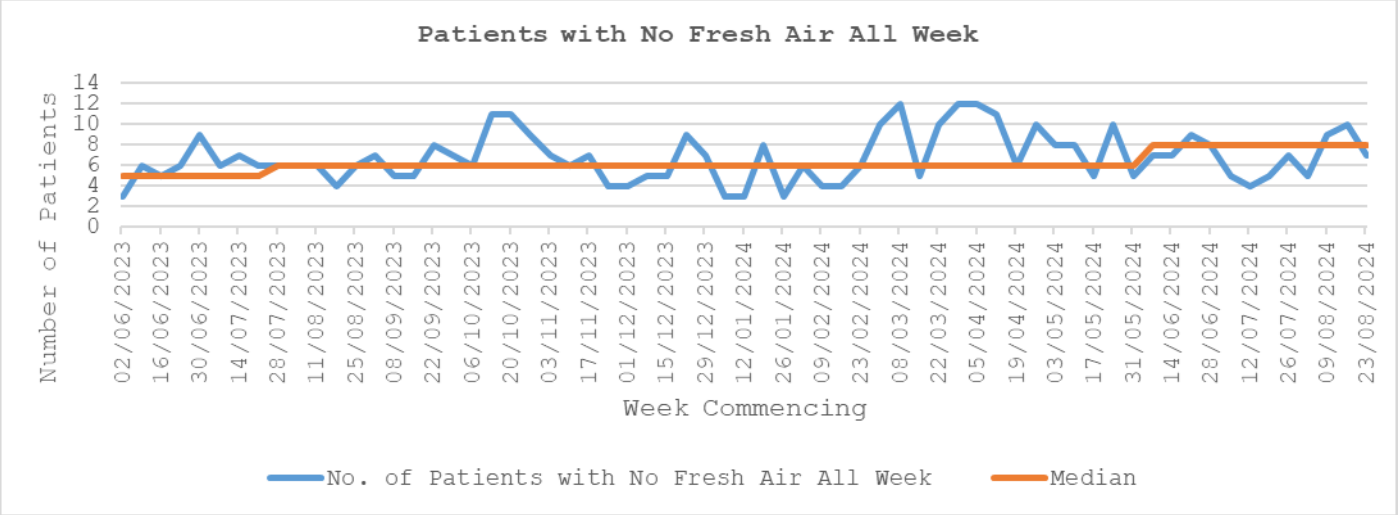
Number of seclusions:
The number of seclusions increased from 0 in July to 2 in August. The median remains at 1 with random variation being seen. Both seclusions were in the Treatment and Recovery Service (Lewis 2 and Lewis 3).



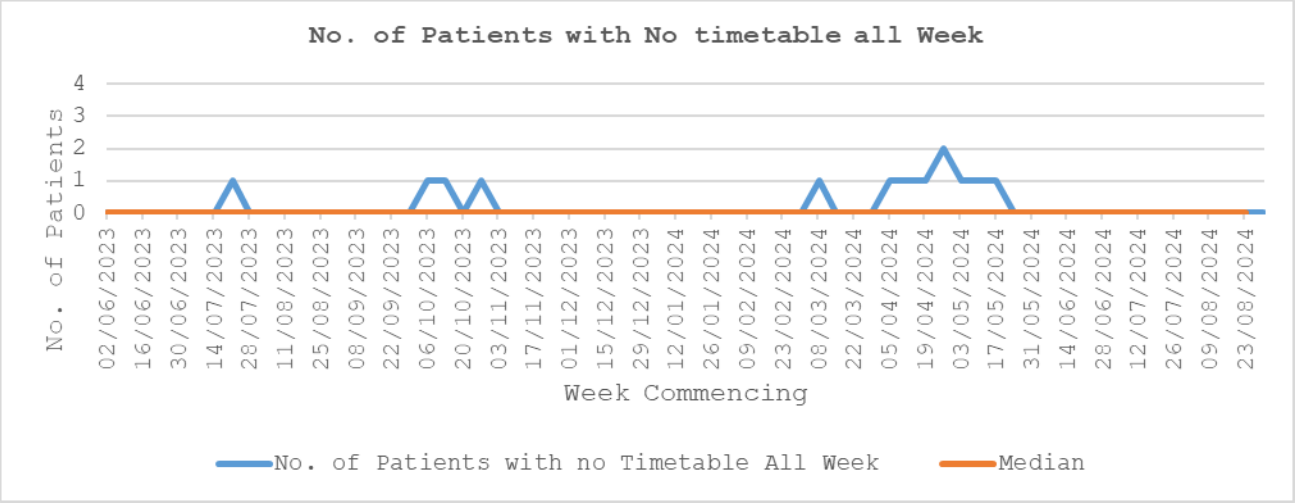
Number of patients with no physical activity all week:
We continue to see random variation with this indicator, with the median at 8 since the end of May.



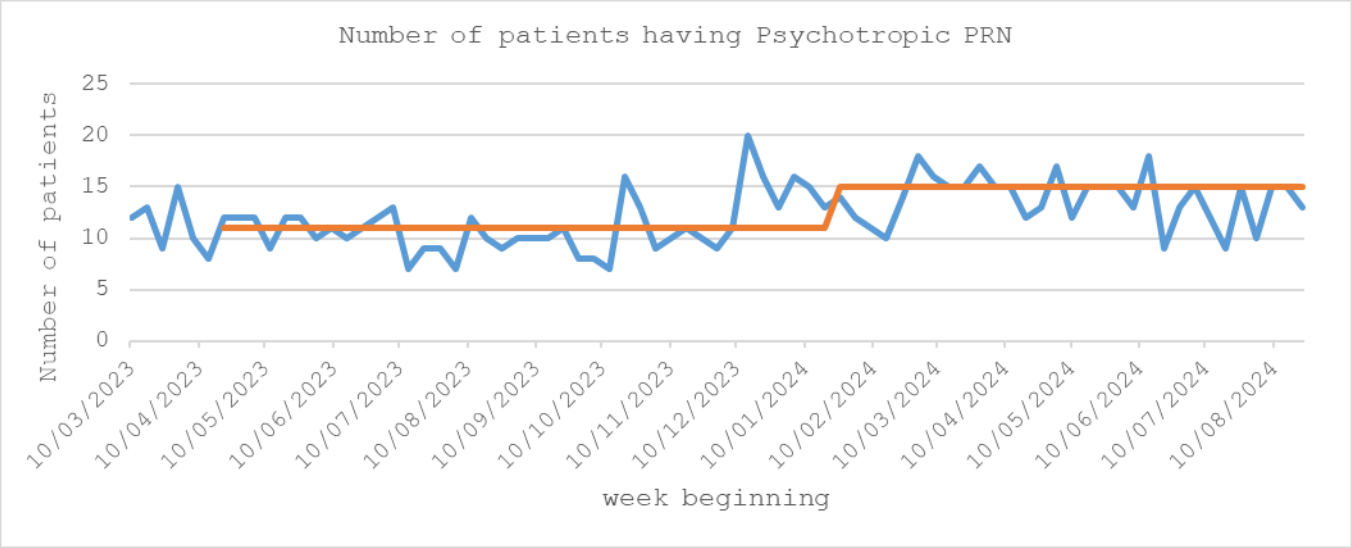
Number of patients with no fresh air all week:
We have seen an improvement in the number of patients with no fresh air all week with August seeing 5,9,10 and 7 across the 4 weeks.



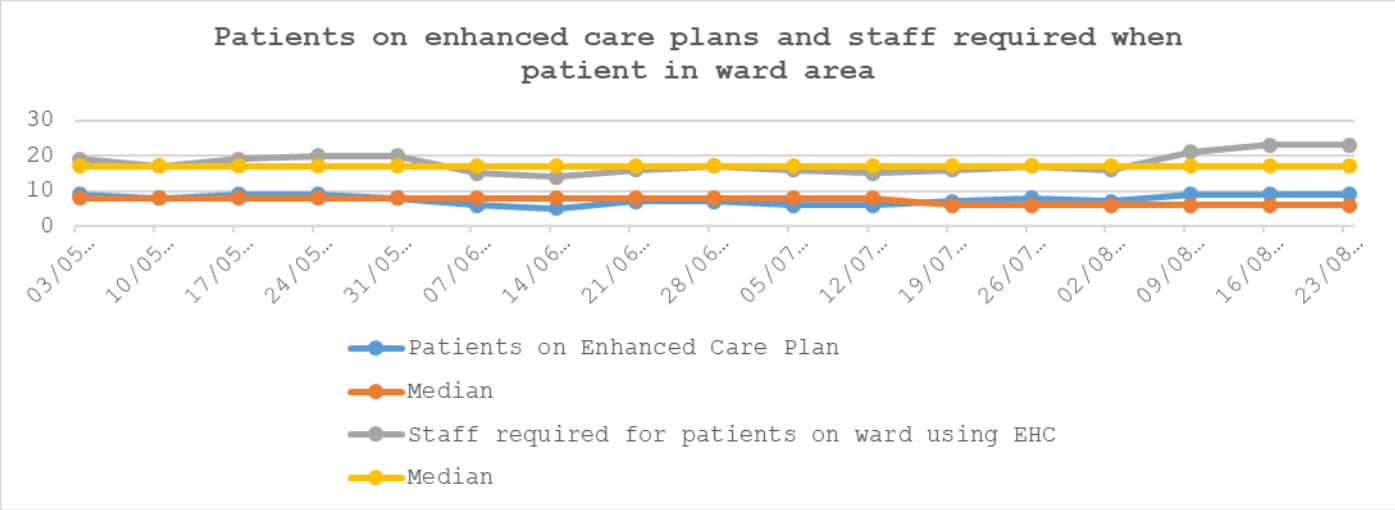
Number of patients with no timetable all week:
This continues with random variation. We have seen all patients within the hospital accessing some form of timetable activity at some point in the week in August.



Number of patients having psychotropic PRNs:
We continue to see random variation with this KPI. The highest number of PRNs we saw administered (within 1 week) in August was 47, week beginning 16th August – these pertained to 15 patients.



Patients on enhanced care plans:
We had seen random variation since we started collecting the data in May for the new enhanced care plans. July saw a positive shift in the data with the median number of patients on an enhanced care plan moving from 8 to 6. We are close to a negative shift as we have seen sustained increases since week beginning 19th July.



Patient flow as at 19th September:
As at 19th September, there are 5 active referrals from admissions & assessment. There are no Treatment & Recovery beds at the current time. We do have 3 Transition beds, but no referrals from Treatment & Recovery.

Admissions & Assessment to Treatment & Recovery

Active Referrals from Admissions	Bed availability T&R
	Arran 2

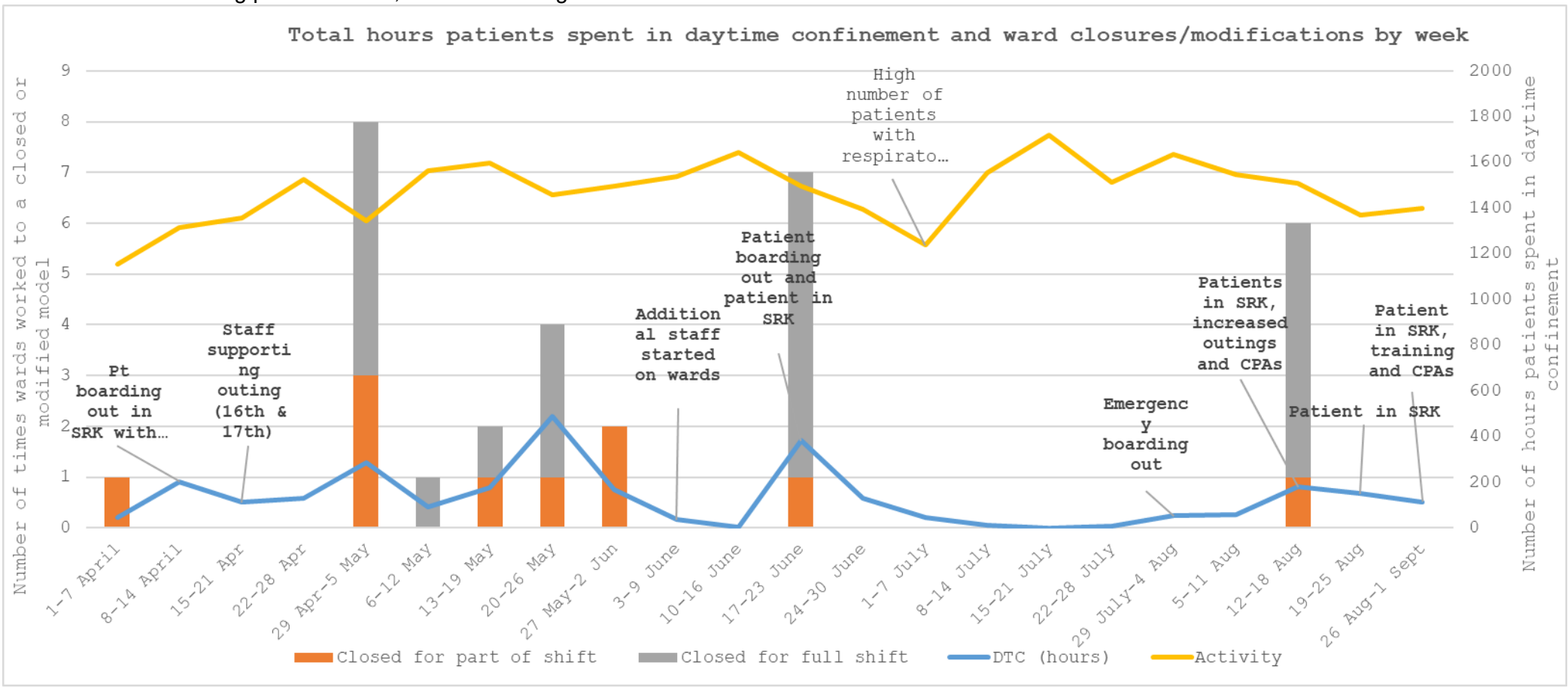
	Arran 3
Lewis 1 	Lewis 2
	Lewis 3

Treatment & Recovery to Transitions

Active Referrals from T&R	Bed availability Transitions
Arran 2	Mull 1 
Arran 3	
Lewis 2	Mull 2
Lewis 3	

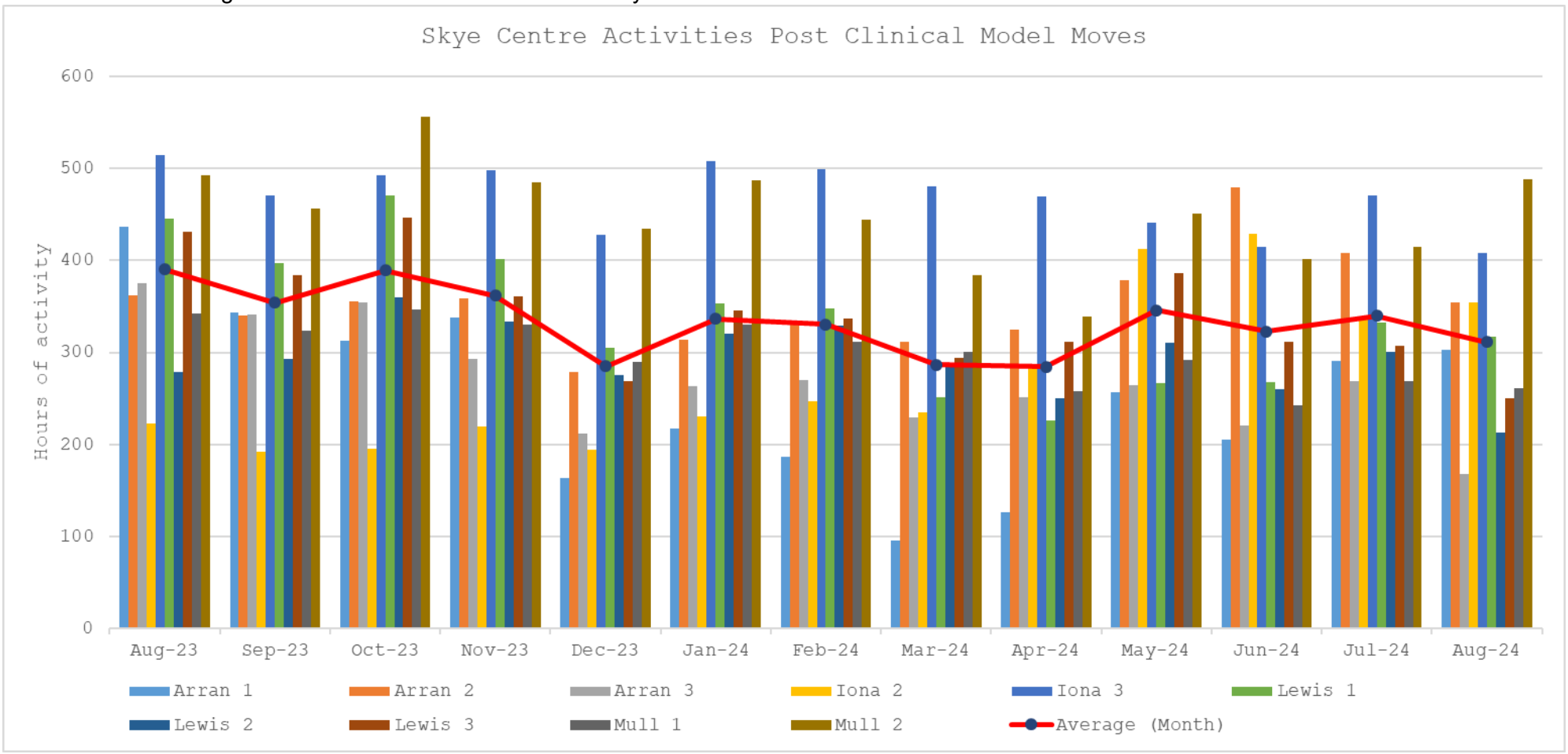
Daytime Confinement:

Daytime confinement increased in August with the most seen week beginning 12th August with 180 hours experienced by our patients. There were various reasons for this including patient in SRK, increased outings and CPAs.



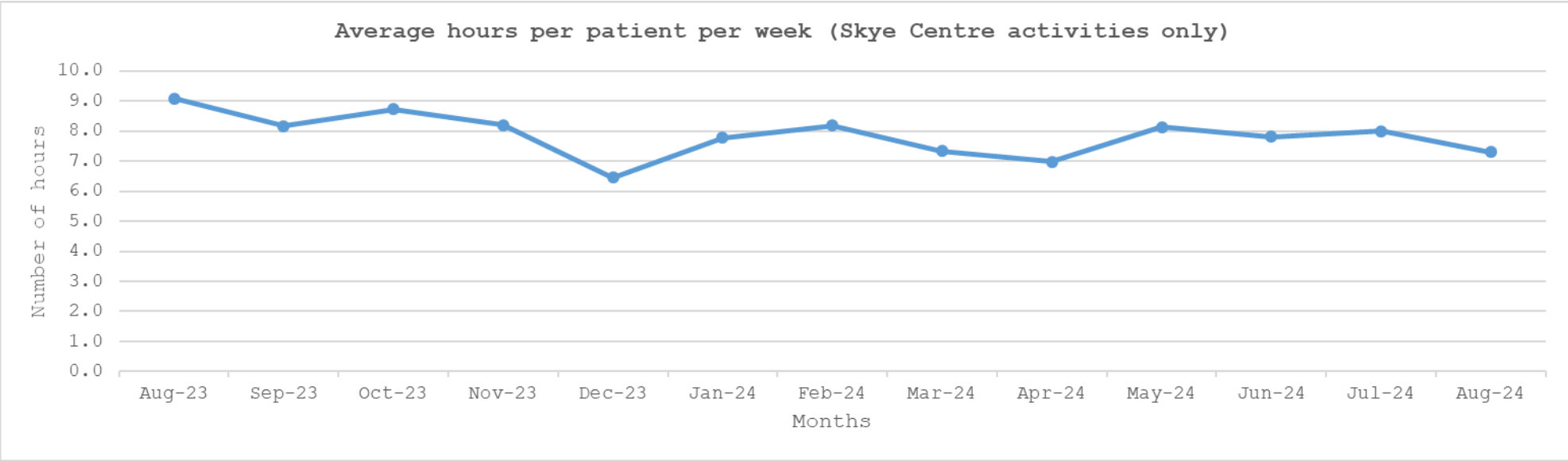
Skye Centre Activities:

The wards with the highest number of activities over at the Skye Centre are Iona 3 and Mull 2.



Average hours per patient per week (Skye Centre Only):

The average hours per patient decreased slightly in August from 8 to 7.3 hours per week.



Challenges with referrals:

We are still seeing challenges with patients not having a referral form completed as soon as the patient meets the criteria, rather than when we have a bed ready for them within the service.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Evaluates new clinical model, the establishment of which was a Board aim
Workforce Implications	Workforce implications monitored through Workforce Governance Structure.
Financial Implications	N/A
Route To Clinical Governance Group Which groups were involved in contributing to the paper and recommendations.	CMOG co-chairs
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2024
Agenda Reference:	Item No: 11
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning, Performance and Quality Head of Clinical 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 October 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

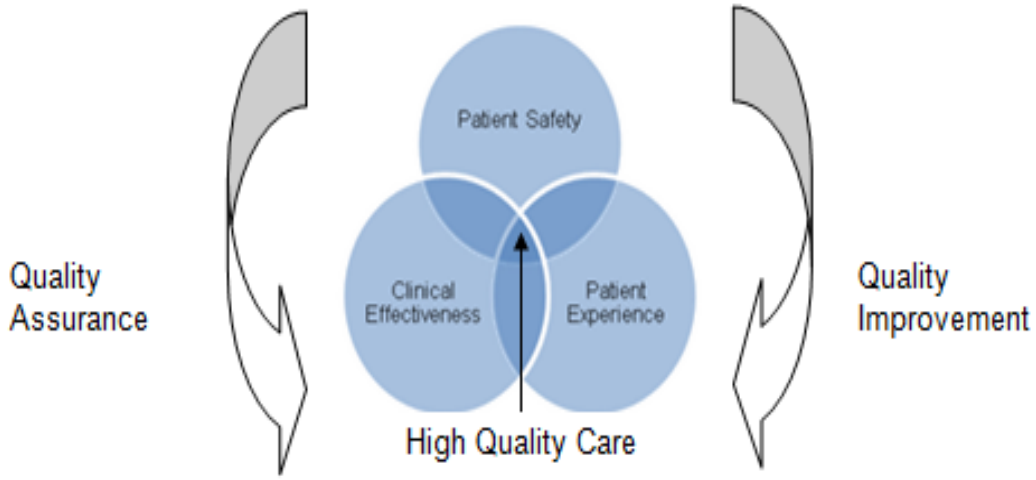
Quality assurance and improvement in TSH links to the Clinical Quality Strategy 2024 – 2029. This strategy was presented to TSH Board in August 2024 and adopted as TSH current strategy to progress clinical quality. The Clinical Quality Strategy sets out the direction, aims and ambitions for the continuous improvement of clinical care. 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. It outlines the following aims to ensure the organisation remains focussed on delivering our quality vision.

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.

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.

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 four clinical audits:
    - Unvalidated progress notes
    - Nurse progress note on each shift
    - Clinical Care Policy (first cycle audit)
    - PMVA Post Physical Intervention Policy
- 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 AUGUST/SEPTEMBER 2024

ASSURANCE OF QUALITY

Clinical Audit

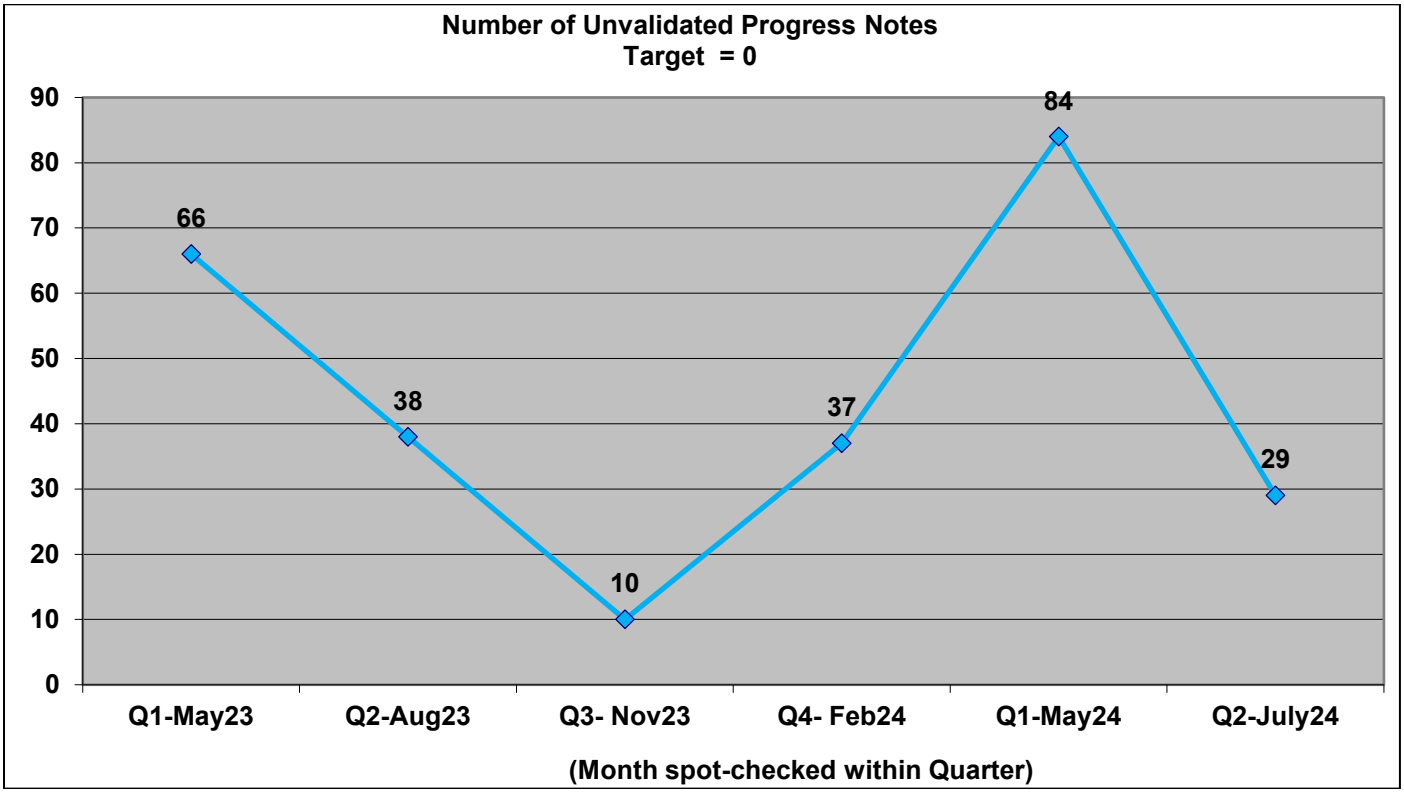
The Clinical Quality Department carries out a range of planned audits. Over the course of a year there are usually 21-25 audits carried out. These aim to provide feedback and assurance to a range of stakeholders that clinical policies are being adhered to. All clinical audit reports contain recommendations to ensure continuous quality improvement and action plans are discussed at the commissioning group.

There have been 4 audits completed and actioned during this reporting period.

- Unvalidated progress notes
- Nurse progress note on each shift
- Clinical Care Policy (first cycle audit)
- PMVA Post Physical Intervention Policy

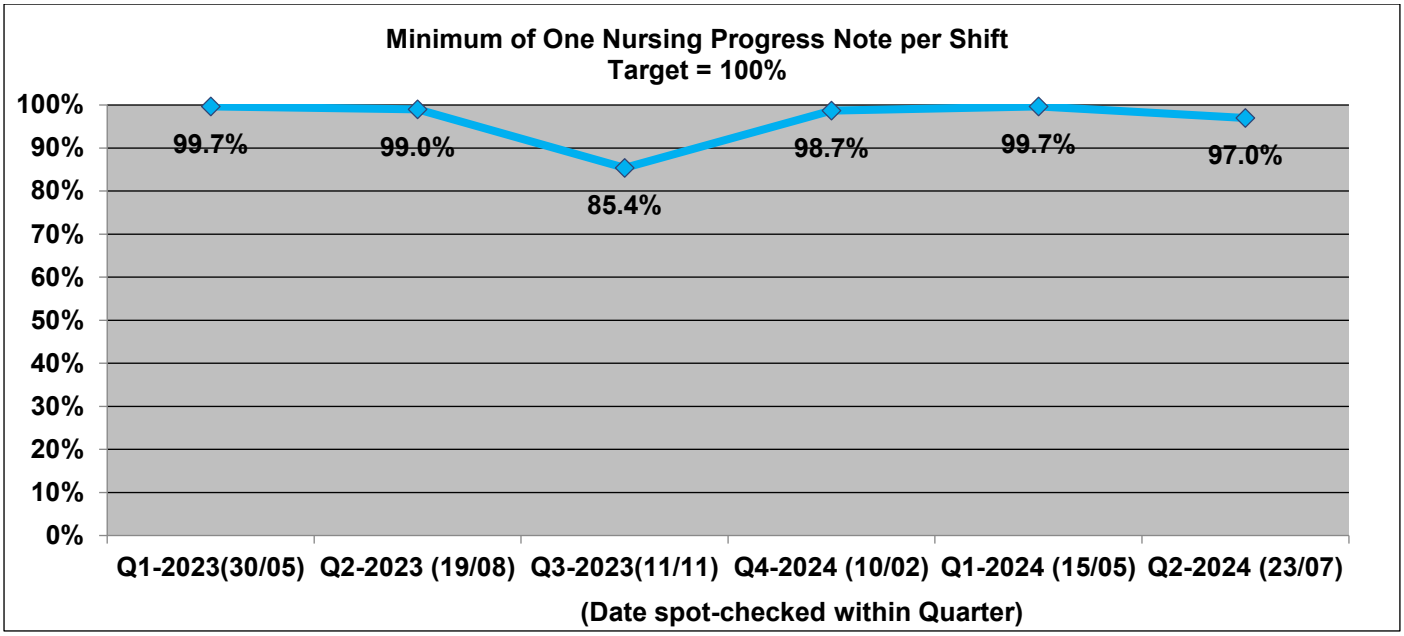
Unvalidated Progress Notes

This quarter's analysis saw a significant decrease on the number of unvalidated entries from 84 to 29. This is a great achievement, given that there will be in excess of 10,000 progress notes entered within a one month period. This gives a percentage of less than 0.3%.



Nurse Progress Notes (one per shift)

As can be seen below, we saw a slight decrease in patients having at least one progress note entered per shift. The spot check took place on 23 July and found that 95% of patients had a progress note entered on the day shift, 100% on back shift and 96% on night shift (giving an overall of 97%). Although this is very high compliance, it should be noted that the day shift percentage is usually a consistent 99-100%.



Clinical Care Policy (First Cycle)
The Clinical Care policy was introduced into practice on 1st May 2024. This replaced the PMVA Observation Policy, and was part of the national 'Observation to Intervention' work. It was agreed that an audit would be undertaken into 7 aspects of the policy to allow the implementation team to know any areas for improvement to ensure successful implementation/change in practice.

Enhanced Care Plan (ECP)

1. Ensure interventions are being entered by all relevant multi-disciplinary team members
2. Ensure daily reviews are being recorded within RiO as directed
3. Ensure weekly reviews are being recorded within RiO as directed
4. Ensure review at 28 days is being recorded within the ECP as directed
5. Ensure ECPs are being closed off by RMOs as directed

Patient Safety Plan (PSP)

6. Ensure weekly reviews are being recorded within RiO as directed
7. Ensure PSPs are being closed off by NICs as directed

There were a few observations noted during the audit. These included:

- There is some confusion regarding when a patient is on an ECP with staffing required in certain aspects and then when levels of staffing reduce in other aspects which could be considered suitable for a PSP. An ECP and PSP should not be in existence at the same time as the overarching ECP has a dedicated area to note any changes in care until the level of risk has reduced enough for the ECP to be closed and a PSP to be created.
- The content, provision and achievement of multidisciplinary interventions varies greatly
- There were 8 instances where 2 forms were live at the same time by error when only 1 form was required. This may have been an ECP and a PSP or 2 PSPs. This does not include any overlap to delay in closing.
- It was noted that there was a lack of clarity regarding what current practice is in place to ensure that daily reviews by medics are conducted over a weekend period following the introduction of an ECP where reviews are required every day for the first 7 days.
- Some forms have sections of information left blank i.e. reason for commencement, risk considerations.

Recommendations from the report were discussed and agreed at the Patient Safety Group in October were:

- A member of clinical staff to review the quality of content of interventions within ECPs and report findings back to Patient Safety Group
- All MDT members to ensure advancement of linked working with interventions to better support patients to progress to general care from ECPs
- RMO and NICs to record daily reviews for the first 7 days within ECPs
- RMO and NICs to record weekly reviews within both ECPs and PSPs
- All RMO's (ECPs) and Nurse in Charge (PSPs) to be aware of their responsibility for closing off forms
- A clear process should be identified by medical staff to ensure cover arrangements are put in place to support completion of daily reviews over a weekend period following the introduction of an ECP
- All other MDT members to make themselves aware of the content of the policy and what is required of them

It should be noted that this is a new policy and a significant change in practice for staff within the State Hospital. An improvement plan is currently being agreed making it clear what actions are required and who will take these forward. The audit will be repeated in 6 months time to ensure improvements are being realised. There are no significant concerns from Clinical Quality at this stage of the implementation as delivery of the improvement plan should result in improvements.

PMVA Post Physical Intervention Policy
The PMVA Post Physical Intervention audit was carried out covering the period May-July 2024. There were a number of improvements required from this audit. One of which is the completion of the National Early Warning Score (NEWS), with 17% compliance. The new version of RiO, that is currently on the test phase, has NEW built into it as a form. It is hoped that staff will start to use this so the information is going straight onto a system.

Other areas for improvement from this audit included:

- Of the 8 injuries recorded within Datix, there were 4 (50%) occasions where the details of the injury matched across DATIX and the PPIA form.
- Of the 50 PPIA forms completed, the incident time on the PPIA form matched with the incident time recorded in Datix on 27 (54%) of occasions
- There were 5 injuries recorded within PPIA forms that were not recorded within the associated Datix and progress notes.
- It was observed that on one occasion, from the incident time recorded in DATIX it was a further 6 hours and 25 minutes before the relevant progress note was validated (Iona 2). There were 3 progress notes that were recorded **before** the time of the incident (2 x Iona 3 and 1 x Lewis 1); the largest time frame being 3 hrs and 44 mins beforehand. There were 2 progress notes detailing incidents that remained unvalidated at the time of the audit (1 x Iona 3 and 1 x Lewis 2).

The full report and findings were discussed at the Patient Safety Group in October with an improvement plan currently being agreed making it clear what actions are required and who will take these forward. A copy of the poster that was sent to all wards can be found in Appendix 1.

There are a number of audits that have taken place on August/September, but have not yet been to the Commissioning Group. These are:

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

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 October 2024 and covers the quarter July-September 2024:

HOSPITAL WIDE VARIANCE ANALYSIS FLASH REPORT - QUARTERLY

Date: July - September 2024

Overview and areas of good practice

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

The quarterly VAT report is split as follows:

Jul-Sep 24	Annual	Intermediate	Total	VAT completion	MDT attendance
Admission	0	3	3	99.6%	79% - decreased from 81% in Q1 24
Arran T & R	5	6	11	96.4%%	62% - decreaseed from 65% in Q1 24
Lewis T & R	5	8	13	100%	64% - decreased from 74% in Q1 24
ID	3	6	9	100%	81% - decreased from 85% in Q1 24
Transition	2	5	7	98.2%	65% - decreased from 69% in Q1 24

- Medical – there was an increase in all Medical interventions due to an increase in VAT completion from 59% last quarter to 91% this quarter.
- Nursing - KW/AW discussing report with patient increased showed the 4th consecutive month of improvement at 90%.

Areas of concern

- Nursing - Key Worker/Associate Worker attendance decreased from 77% in Q1 to 65% in Q2. Patient attendance was at the lowest level in 5 quarters at 53%
- Occupational Therapy continue to be affected by staffing issues and there was a decrease in all interventions over the period– new staff are now in post and taking part in induction training at present

Any challenges with the systems that are being addressed

Medical continue to work towards sustained improvement in VAT form completion.

There were a number of late changes to Case Review dates which impacts all professions

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.

QI Capacity Building

QI Essential Training Cohort 3 commenced training on 28th of August and is running over four half days into November 2024. Fifteen members of staff submitted their interest in attending and eight members took the opportunity to develop their QI knowledge and skill using some of the tools available to support quality improvement projects.

Scottish Improvement Leaders (ScIL) training continues with cohort 46/47. Two members of TSH staff are currently undertaking this programme. They provide regular updates to the QI Forum on the course, with their current focus being on their improvement projects. These projects focus on areas of improvement for TSH and include a project which aims to reduce the time taken to report RIDDORS. ScIL cohort 50 has been recently recruited with three staff members successfully being offered a place. This programme will commence in November 2024.

Building capacity for QI in TSH provides tangible benefits both for individuals and the organisation. Recent ScIL graduates have gone to progress their careers in TSH as a direct result of taking part in the programme. They also now, alongside more experienced QI staff, deliver training locally to TSH staff. The positive pact of QI training can also be demonstrated through the number and variety of QI projects being initiated and lead within TSH. These projects focus on making improvements in how care and services are delivered.

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

Three of the actions identified within the 2024-25 action plan have been completed these were around:*(These actions are completed by other Groups or Committees however are relevant to the Realistic Medicine principles and so form part of the Realistic Medicine Action Plan):*

- Advance Statement being made available at the point of medicine administration was lead by MHPSG
- Development of a new observations policy was lead by Nursing Practice Development
- Review of the Clinical Model, which is reviewed via CMOG

The Realistic Medicine Team are currently focusing at three areas below:

1) Learning into Practice Group continue to meet monthly to develop the establishment of Team Based Quality Reviews (TBQR). Dr Gordon Skilling and Dr Stuart Doig have attended staff business meeting to provide staff groups on the benefits of TBQR's which was positive received. More recently Gordon and Stuart presented a series seminar on Human Factors. Panel members of each of the four services has been identified and training is currently being sourced for later in the year through a Senior Lecturer at the University of Dundee.

2) Use of BRAN (Benefits, Risks, Alternatives and Nothing) questions as part of the Physical Health & Nutritional Care Plan Process has been embedded within Arran Hub. Following the pilot in Arran Hub, where is has been evident that BRAN Questions are being used when staff are discussion patients' physical health and nutritional care plans, it was agreed through the Project Team to scale up and spread into Lewis Hub. An implementation plan has been developed for the introduction of the Physical Health and Nutritional Care Plan within Lewis Hub with staff training being provided by Nursing Practice Development and the Dietetic Service. It is hoped to have the training completed by the end of October 2024 with the launch of the new Physical Health and Nutritional Care Plan process in November 2024.

3) Communicate throughout the hospital is an important part of Realistic Medicine. Recently Realistic Medicine notice board in reception was relaunched to be more visible for staff and provide information both nationally and locally on the principles around Realistic Medicine. The Intranet site is currently being developed to allow staff to have better access to information/literature through collaborative working being made available between the State Hospital and Forth Valley Library Services.

The Clinical Lead and Programme Manger continue to review the Realistic Medicine 2024-25 on a quarterly bases by requesting updates from Leads and support projects as and when required.

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 August to 30 September 2024, 32 guidance documents have been reviewed. There were 22 documents which were considered to be either not relevant to TSH or were overridden by Scottish guidance and 10 documents which are currently under review by their relevant steering group regarding their relevancy and what action should be taken.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required	Decision pending
Mental Welfare Commission (MWC)	5	0	0	5
Healthcare Improvement Scotland (HIS)_	3	0	0	2
Scottish Government	2	0	0	2
National Institute for Health & Care Excellence (NICE)	21	0	0	0
Royal College of Nursing (RCN)	1	0	0	1

There is currently 1 additional evaluation matrix, which has been outstanding for a prolonged period. The evaluation matrix process to review the Scottish Government document regarding substance use is currently underway with an initial meeting by a multi-disciplinary having taken place.

Table 3: Evaluation Matrix Summary

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
Scottish Government	Responding to substance use amongst inpatients on mental health wards – A practical guide for mental health services	MHPSG	Review group met in September to review the content with a 2nd meeting arranged for early October 2024.	April 2024	October 2024

Appendix 1

THE STATE HOSPITAL

NHS SCOTLAND

PMVA Physical Intervention Policy Adherence

DID YOU KNOW ?

- For every instance a secure hold is used, a Post Physical Intervention Form (PPIA) and a DATIX should be completed in RiO by Senior Clinical Cover
- For every occasion a patient is taken to the floor a NEWS should be completed
- Details in the progress notes, DATIX and the PPIA Form should match every time
- Whenever a PRN is administered, a Psychotropic Medication Form should be completed

	Breakdown of locations where secure holds were used	No. of patients	Breakdown of locations for completed PPIA forms	% of PPIA forms completed
Admission				
Arran 1	10	5	8	80%
Lewis 1	3	1	3	100%
Treatment and Recovery				
Arran 2	1	1	0	0%
Arran 3	1	1	1	100%
Lewis 2	4	2	3	75%
Lewis 3	1	1	1	100%
Transition				
Mull 1	N/A	N/A	N/A	N/A
Mull 2	N/A	N/A	N/A	N/A
ID				
Iona 2	5	2	5	100%
Iona 3	34	2	29	85%

Every secure hold, every time.

Have you completed:

- **Progress note**
- **Datix**
- **PPIA Form**

Area of policy requiring greatest improvement

	Observations Required	Observations Recorded within NEWS available within RiO	
Admissions			
Arran 1	9	0	0%
Lewis 1	3	0	0%
Treatment and Recovery			
Arran 2	1	0	0%
Arran 3	1	0	0%
Lewis 2	4	1	25%
Lewis 3	1	0	0%
Transition			
Mull 1	N/A	N/A	N/A
Mull 2	N/A	N/A	N/A
ID			
Iona 2	5	5	100%
Iona 3	32	4	13%

	PRN Administered	Psychotropic Medication Form completed	
Admissions			
Arran 1	5	4	80%
Lewis 1	3	1	50%
Transitions and Recovery			
Arran 2	N/A	N/A	N/A
Arran 3	N/A	N/A	N/A
Lewis 2	1	1	100%
Lewis 3	1	1	100%
Transition			
Mull 1	N/A	N/A	N/A
Mull 2	N/A	N/A	N/A
ID			
Iona 2	5	5	100%
Iona 3	31	23	77%

Every PRN, every time:

Psychotropic Medication Form

Paper No. 24/86

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Board Meeting:	24 October 2024
Agenda Reference:	Item No: 12
Author(s):	Consultant Forensic Psychiatrist & Educational Supervisor
Sponsoring Director:	Medical Director
Title of Report:	Medical Education Report
Purpose of Report:	For Noting

1 SITUATION

The General Medical Council (GMC) Quality Improvement Framework for Undergraduate and Postgraduate Medical Education in the UK sets out expectations for the governance of medical education and training. GMC standards specifically refer to Board governance and it is within this context that this report is being presented to the Board. This report covers the period 1st August 2023 to 31st July 2024.

2 BACKGROUND

Dr Prathima Apurva is Educational Supervisor at The State Hospital (TSH). She is responsible for postgraduate medical training while Dr Natasha Billcliff & Dr Sheila Howitt lead on issues relating to medical undergraduates. The Educational Supervisor reports within the State Hospital to Professor Lindsay Thomson, Medical Director and reports externally to the Training Programme Director for Forensic Psychiatry Higher Training in Scotland, Dr Michelle McGlen, and to local Training Programme Directors for Core Training.

3 ASSESSMENT

3.1 UNDERGRADUATE TRAINING

Teaching Program Placements for Undergraduate Medical Students 2023/24

Student numbers in the last academic year are as follows:

Edinburgh University	100 student placement days with 50 students total.
Glasgow University	9 student placement days with 7 students total
Dundee University	5 student placement days with 1 student total.

All Universities 114 student placement days with 58 students total

These figures represent a significant change from the previous academic year, where 144 student placement days occurred for 40 students. The decrease in total student placement days may possibly be attributed to a change in the methodology for counting these. However, we are encouraged to see a 45% increase in the total number of students achieving placement at TSH.

We continue to offer Edinburgh University students the opportunity of a placement at TSH. This can be arranged via their clinical tutors on an ad hoc basis and is discussed with students on the first day of their psychiatry blocks. Given that this route was previously not leading to students accessing TSH, Dr Thomas (who coordinates the undergraduate teaching at Edinburgh University) advertised the placement with tutors directly. This has led to a new arrangement with NHS borders, who now send students to TSH as part of their placement. For the last two academic years, this has proved a successful arrangement, with students from the Borders having regular placements at TSH.

During this academic year we were approached by the undergraduate education lead for the Royal Edinburgh Hospital and Associated Services with an opportunity to host more students. We considered that we had capacity to do so and as a result of these discussions, we now plan to offer placements to Edinburgh University students placed in Midlothian. For these students, we will be trialing a new method of placement organisation using TuBS (Tutorial Booking System), a system that is routinely used by Edinburgh University students to book tutorials. Students who book through this system will be provided contact details for a TSH medical secretary, who will assist them in organising their placement. We anticipate an increase in student numbers because of this new arrangement.

Our collection rate for student feedback on placements at The State Hospital has been limited over the past academic year. We obtained feedback from only 3 students, all of whom rated their experience as highly enjoyable and useful for their learning. We have reviewed the reasons for our low rate of feedback and realised that it depended on the supervising RMO sending out a feedback form via email to the student, which may not have been a reliable method of soliciting feedback. For the upcoming academic year we have changed this and now the medical secretary in charge of organizing the placement will be the one to send the student the feedback form. This will hopefully lead to a higher rate of feedback in the future.

Forensic Tutorials

The 6 weekly forensic tutorials resumed this year after being cancelled the previous year. They were all delivered remotely via video link. We considered feedback from the lecturers who delivered the tutorial virtually, all of whom advised that remote teaching did not appear to be a productive way of delivering the material. We have therefore corresponded with Dr Thomas who organises the tutorials and for the next academic year we will again deliver tutorials in person in Edinburgh, for each of the 6 blocks of students.

Tutors Meeting

The Tutors and Clinical Teachers meeting for undergraduate students at Edinburgh University was not held this year. Dr Thomas noted that he is in the process of developing new learning outcomes from the General Medical Council and Royal College of Psychiatrists guidance for the undergraduate curriculum and will be recruiting new tutors for the next academic year. We have let him know views from TSH that the tutors meeting would be useful, especially for services not based in Edinburgh, to keep up to date with changes to teaching.

Day Trip

The annual day trip involved large numbers of Edinburgh University students being bussed to TSH for a one-day placement. Following the cessation of this event during COVID, it has proved difficult to reorganise.

Timetables have changed and it has not been possible to find time again in the student blocks where all students can be offered this opportunity. We will continue to discuss this event with Dr Thomas as we felt that it was a useful event that achieved good feedback from the students.

3.2 POST GRADUATE TRAINING

Core Training

Over the past year, we have had six Core Trainees (CTs) on placement at TSH, four from the West of Scotland and two from the East. In common with the growing tendency in recent years, some doctors tend to be part time. We have had 2 part time core trainees and one part time higher trainee in the past year.

Induction Programme

We have a very good induction programme that runs for a few days as the new trainees start. Various departments contribute to this and some of the key aspects include HCR-20 and PANSS training. The induction programme is highly valued by both core and higher trainees. The feedback on this is taken on-board and any adjustments made every 6 months.

First On-Call Rota

We currently have 3 specialty doctors and 3 core trainees. This has been the case for the last few years, which has meant our on-call rota has been fully staffed with 1:6 rota. We undertook rota monitoring exercise with last cohort of core trainees and we had 100% return with clear evidence of our oncall rota being complaint with required standards.

Higher Specialty Trainees

Over the past year we have had five Specialty Trainees (STs) placed with us, for periods of varying length, generally being either three or six months.

Our Specialty Trainees work under the supervision of Consultant Trainers. We are well positioned with regard to our availability of experienced trainers across a variety of specialties, as outlined in Appendix 1.

Specialty Trainees spend part of their weekly timetable undertaking research and special interest activities and overall generally spend less time at the State Hospital than Core Trainees and non-training grade Specialty Doctors. Their role is distinct, represents a progression from Core Training, and maintaining an appropriate distinction in their role from those of other non-Consultant grade Doctors is important as they progress towards readiness for Consultant hood.

Senior Speciality Trainees in their final year of training (ST6) can act up as a Consultant for a maximum period of 12 weeks. This has not occurred during the period relating to this report.

Performance on Scottish and GMC National Training Surveys

We continue to perform well in both surveys and find ourselves within top 2% of training sites. There is generally a good feedback from trainees about their experience with us. Please see Appendix 2.

Teaching Programme

A series of seven lectures is delivered by Consultant Psychiatrists to Trainee Doctors during the first three months of their placement at the State Hospital. The current programme encompasses seven lecture topics, which broadly cover the fundamentals of Forensic Psychiatry and related practice. A system allowing Trainees to deliver feedback on the quality of the lectures delivered has been developed. Trainees are asked to rate the teaching according their agreement with statements on how engaging the lecture was, how well the content met expectations, the helpfulness of the knowledge & skills taught, the relevance of the presentation materials and the overall quality of the presentation. Over the past year 100% of received feedback for the lectures was positive, being in either the 'agree' or 'strongly agree' categories for all items rated.

Monthly Educational Programme

A monthly Educational Forum delivered using a webinar format has continued over the past year, organised by Dr Jana De Villiers. This gives trainee psychiatrists the opportunity to present cases, papers and audit/research, as well as to be educated by other internal and external speakers. This is important for their training and portfolio development and is well received. 6 core trainees and 3 higher trainees utilised the opportunity to present at these,

New to Forensic Programme

A joint venture between NHS Education for Scotland (NES) and the School of Forensic Mental Health (SoFMH) the 'New to Forensic (N2F)' education programme is designed to meet the needs of clinical and non-clinical staff, both new and already working within forensic mental health services. The programme is designed to promote self-directed learning and is multi-disciplinary and multi-agency in approach. The mentee is supported throughout their period of study (recommended six months to one year, depending on previous experience) by a mentor who is an experienced mental health worker. The programme has 15 chapters, which all but one include case scenarios of patients in various settings, from high secure to community psychiatric care.

Over the past year all trainee Psychiatrists arriving on placement at TSH who have not previously done the programme (in some cases doctors have already previously completed the programme elsewhere or on previous placements at TSH and/or are already very experienced in working within forensic settings) have been registered with N2F and provided with the materials to allow them to complete the programme with their Consultant clinical supervisors. TSH Medical Secretary Claire McCrae, who provides administrative support to Dr Apurva, helpfully liaises with staff at the Forensic Network at the point of commencement and it is then the responsibility of the mentee and mentor to ensure the programme is completed. Four trainees have so far been formally signed off as having completed the programme with the Forensic Network over the past year, while the others are currently in the process of concluding same.

State Hospital Visits

Occasional requests for "taster visits" by Foundation Grade Doctors / Core Trainees / non-forensic Specialty Trainees are received on an intermittent basis. These Doctors are curious to find out more about Forensic Psychiatry and, in some cases, they have an interest in pursuing Forensic Psychiatry as a career.

Psychotherapy Training

We have part-time input from a Consultant in Forensic Psychotherapy, Dr Adam Polnay. He provides Balint & Reflective Practice sessions for non-Consultant grade Doctors. He also supports Core and Specialty Trainees identify opportunities for involvement in individual or group psychotherapy activities. Such work forms part of their core psychotherapy training requirements and have continued to be valued by training grade doctors on placement at The State Hospital.

Recruitment & Trends in Working Patterns

Less than full time (LTFT) working patterns have remained popular with trainee psychiatrists over the past year. Recruitment has been strong and there has been a high fill rate in Core and Specialty Trainee posts in Scotland over the past year. This trend, which appeared during the Covid-19 pandemic, appears to be continuing. With the higher availability of training grade doctors on the rotations which send us doctors on placement, and the successful recruitment of a third non-training grade Specialty Doctor at The State Hospital, we are now on a more positive footing with regard to our non-consultant grade medical workforce than we have been in a number of years.

Representation at External Committees Relevant to Medical Education

Over the past year, Dr Apurva has represented The State Hospital at the following:

- West of Scotland Specialty Training Committee (STC)
- National Forensic Psychiatry Specialty Training Committee (STC)
- Bi-annual NHS Education for Scotland Annual Review of Competence Progression (ARCPs)

4 RECOMMENDATION

The Board is invited to note what has been a very positive year for The State Hospital with regard to medical education. We have continued to provide extensive high quality undergraduate and postgraduate medical training via a well-trained and experienced Consultant workforce. Particular strengths have included remaining on top 5% of training schemes nationally. Our recruitment and fill rate is strong and we are able to enter the forthcoming year on a positive footing.

Dr Prathima Apurva
Consultant Forensic Psychiatrist & Educational Supervisor

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	This is an annual report to the Board on issues relevant to medical education at The State Hospital.
Workforce Implications	Nil
Financial Implications	Nil
Route to Board Which groups were involved in contributing to the paper and recommendations?	Prepared by individuals and informed by their involvement in various medical education committees.
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	Nil
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)	There are no identified impacts.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ✓ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

APPENDIX 1 – Recognition of Trainers

Consultant Psychiatrist	NES Clinical Supervisor Course or equivalent	NES Educational Supervisor Course or equivalent	Named Medical Trainer Role	Forensic, Intellectual Disabilities+ or Psychotherapy++ Higher Specialty Trainer	Recognised Trainer via Recognition of Trainers (RoT) section of Scottish Online Appraisal Resource (SOAR)
Consultant Forensic Psychiatrist	Yes				Yes
Consultant Forensic Psychiatrist	Yes				Yes
Consultant Forensic Psychiatrist	Yes		Undergraduate Supervisor	Yes	Yes
Consultant ID Psychiatrist	CEP* Level 2			Yes+	Yes
Consultant Forensic Psychiatrist	CEP* Level 2		Undergraduate Supervisor		Yes
Consultant Forensic Psychiatrist	Yes	Yes		Yes	Yes
Educational Supervisor	Yes	Yes	Postgraduate Supervisor	Yes	Yes
Consultant Forensic Psychiatrist	CEP* Level 2			Yes++	Yes
Consultant Psychiatrist in Psychotherapy	CEP* Level 3		Psychotherapy Tutor (Lothian)	Yes++	Yes
Consultant Forensic Psychiatrist	Yes			Yes	Yes
Medical Director	Fellow HEA**	Yes		Yes	Yes

Appendix 2 Performance on Scottish and GMC National Training Surveys

TSH is very much in the top 2% in the NTS High Performers list for both change in scores and significantly high scores for that specialty. Very positive data.

2.2 Departments in the top 2% for that Specialty

2.2.1 Site: State Hospital - D101H, Forensic psychiatry

Identified by: NTS All Trainee High Performers list (significant change in scores and significantly high for specialty)

GMC NTS (Trainee)

Level	Adequate Experience	Clinical Supervision	Clinical Supervision out of hours	Educational Governance	Educational Supervision	Facilities	Feedback	Handover	Induction	Local Teaching	Overall Satisfaction	Regional Teaching	Reporting systems	Rota Design	Study Leave	Supportive environment	Teamwork	Workload	N
All Trainee	W▲	W—		L▲	W▲	G▲	W▲		W—	W—	W▲	L▲	G▲		W—	W▲	G▲	W—	4
ST	W▲	W▲		G▲	W▲	G	G		G▲	G▲	W▲	G▲			W—	W▲	G▲	W▲	3

Scottish Training Survey

Level	Clinical Supervision	Discrimination	Educational Environment & Teaching	Equality & Inclusivity	Handover	Induction	Team Culture	Wellbeing Support	Workload	Catering Facilities	Rest Facilities	Travel	N
All Trainees													2
All Trainees	W—				W	W	W—		W—				(9 aggregated)
ST													2
ST	W—				W	W	W—		W—				(8 aggregated)

GMC Trainer Survey

Specialty	Appraisal	Educational Governance	Handover	Professional development	Resources to Train	Rota Issues	Support for Training	Supportive environment	Time to Train	Response rate
Forensic psychiatry	W	W	W	L	L	W	W	W	W	38%

DME Comment Required: e.g. Do outliers relate to a known issue or good practice? If not, can they be explained? What is the good practice in place? Can it be shared? What are the actions in place to resolve known issues?

Key to survey results

Scottish Training Survey (STS)

Key	
R	Low Outlier - well below the national benchmark group average
G	High Outlier – performing well for this indicator
P	Potential Low Outlier - slightly below the national benchmark group average
L	Potential High Outlier - slightly above the national benchmark group average
W	Near Average
▲	Significantly better result than last year**
▼	Significantly worse result than last year**
—	No significant change from last year*
	No data available
	No Data

** A significant change in the mean score is indicated by these arrows rather than a change in outcome.

GMC National Training Survey (NTS)

Key	
R	Result is below the national mean and in the bottom quartile nationally
G	Result is above the national mean and in the top quartile nationally
P	Result is in the bottom quartile but not outside 95% confidence limits of the mean
L	Result is in the top quartile but not outside 95% confidence limits of the mean
W	Results is in the inter-quartile range
▲	Better result than last year
▼	Worse result than last year
—	Same result as last year
	No flag / no result available for last year

No Aggregated data is available this year

- The information used to create the STS Triage lists is from Scotland only. The NTS triage lists are based on UK data.
- If criteria is met from any of the following lists (bottom 2%), they will be noted on the triage list; NTS All Trainee list, NTS Level of trainee list, STS All Trainee List, STS Level of trainee List and NTS Trainer Survey Data List. The criteria used for the triage list are: Number of red flags, significant change in scores, significantly low scores for Specialty, excess triple red flags, aggregated low scores for Specialty and number of aggregated red flags (if applicable).
- If criteria is met from any of the following lists, they will be noted on the High Performers list (top 2%); NTS All Trainee list, NTS Level of trainee list, STS All Trainee list, STS Level of trainee list and NTS Trainer survey data list. The Criterion for the High Performers list are: Triple green flags, significant change in scores, number of green flags, persistent high score, high scores for specialty
- A site can be on both the High Performers and Triage lists because of different scores for the different criterion being in the top or bottom 2%. Two departments with similar results can have different outcomes because of the 2% threshold, as they may be just either side of the threshold meaning one is on the main part of the DME report.
- Please note the number of trainees may not always tally due to the inclusion of programme trainees within the data. For example, Dermatology trainees in a post may actually be part of the Medicine Programme.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2024
Agenda Reference:	Item No: 13
Sponsoring Director:	Medical Director
Author(s):	PA to Medical & Associate Medical Directors
Title of Report:	Medical Appraisal and Revalidation Annual Report
Purpose of Report:	For Noting

1 SITUATION

It is a requirement of NHS Education for Scotland that an annual report on Medical Appraisal and Revalidation is placed before the Board.

2 BACKGROUND

Revalidation is the process by which doctors demonstrate to the General Medical Council (GMC) that they are up to date and fit to practise, and comply with the relevant professional standards. The information doctors provide for revalidation is drawn by doctors from their actual practice, from feedback from patients and colleagues, and from participation in continued professional development (CPD). This information feeds into doctors' annual appraisals. The outputs of appraisal lead to a single recommendation to the GMC from the Responsible Officer in their healthcare organisation, normally every five years, about the doctor's suitability for revalidation.

Within the State Hospital, an agreed data set for annual appraisals is collated centrally by the Appraisal and Revalidation Administrator (this is the PA to the Medical & Associate Medical Director). This includes Clinical Effectiveness Data, Pharmacy Audits, CPA / Restricted Patient and Medical Record Keeping Audits.

3 ASSESSMENT

- The Revalidation and Appraisal Committee meet twice yearly in May and November.

- Revalidation Policy
  The Revalidation and Appraisal Policy was approved by the Senior Management Team on 3 August 2016 and is available on the Intranet under HR Connect. The Policy was reviewed at the Revalidation and Appraisal meeting on 7 November 2023.

- Responsible Officer
  Professor Thomson has undertaken Responsible Officer training and attends Responsible Officer Network meetings.

- Revalidation System
  Revalidation system has been used for 12 Consultants and 3 speciality doctors in 2023-24. This includes one doctor on secondment to Scottish Government. One Consultant is appraised and revalidated through the Chief Medical Officer system.

- Appraisals
  From 1 April 2023 to 31 March 2024, of the 15 medical staff within The State Hospital revalidation system, 13 were appraised during this period, one was a new consultant who had just completed the training scheme and one was off on maternity leave.

- Revalidation
  All revalidations are up to date.

- Multi-source feedback
  Multi-source feedback using the SOAR system is now being submitted by medical staff at appraisal meetings. This is required once per 5 year cycle.

- CARE Questionnaire
  The CARE questionnaire was issued to patients in July 2024 for all Consultants. Questionnaires for Specialty Doctors and Consultant Psychotherapist will be issued in early 2025.

- SOAR Appointment System
  SOAR appointment system was introduced to avoid delays in annual appraisals. A doctor will be invited to an appraisal appointment at mutually agreed times on three occasions. Standard letter to doctors not engaging in the process in terms of attending an appointment or submitting paperwork has been prepared. This has never been used to date.

- Case based discussions are included in the appraisal process. There is a monthly allocated slot open to Trainees, Specialty Doctors or Consultants where cases can be discussed by the medical staff group.

- Medical Appraisal Revalidation Quality Assurance Review 2023-24 (MARQA)

  We submitted the Medical Appraisal and Revalidation data return to NES. Their review panel met on Wednesday 19 June 2024 and were fully satisfied with the information and achievement rates that our report outlined, especially given the current workforce pressure. This has reassured the panel that the appraisal and revalidation is operating successfully within the State Hospital.

  Looking ahead to next year, the panel informed us that they will be gradually returning to a fuller review, in particular more details in the governance submission will be requested and examples of good practice will be invited for wider sharing amongst designated bodies.

  The report is available on the Medical Appraisal Scotland Website :
  https://www.appraisal.nes.scot.nhs.uk/our-work/marqa-reports/

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Consultants	Last Date for Recommending Revalidation	Date of Revalidation	CARE Questionnaire Return	Form 4 Completed	Appraisal 01/04/19-31/03/20	Appraisal 01/04/20-31/03/21	Appraisal 01/04/21-31/03/22	Appraisal 01/04/22 – 31/03/23	Appraisal 01/04/23 – 31/03/24	AMP Training		Last date to register for refresher training	Refresher training
										Forensic	Core & Capacity		
	18/11/2028	29/09/23	July 2024	Yes	28/08/2020	20/07/2021	10/03/2022	15/03/23	15/03/24	01/02/19	29/05/21	Jan 24	17/11/23
	15/10/2026	16/10/2021	July 2024	Yes	24/09/2019	01/10/2020	26/10/2021	31/10/22	30/11/23	31/08/22	21/06/18	Jan 2028	17/01/23
	01/09/2026	02/09/2021	July 2024	Yes	04/02/2020	31/08/2020	01/06/2021	25/10/22	03/10/23	01/02/19	29/05/21	Jan 29	25/01/24
	12/02/2025	04/04/20	July 2024	Yes	28/01/2020	01/06/2021	16/03/2022	17/01/23	29/01/24	25/11/19	21/06/18	Oct 27	11/10/22
	01/08/2026	31/05/2021	July 2024	Yes	15/03/2019	30/03/2021	26/01/2022	24/0223	On mat leave	01/02/19	31/10/19	Jan 24	07/08/24
	26/12/2027	02/05/2022	July 2024	Yes	05/11/2019	27/11/2020	04/10/2021	28/11/22	16/11/23	20/09/21	29/05/21	Aug 26	
	27/03/2029	11/10/2023	July 2024	Yes	28/02/2019	02/02/2021	08/03/2022	06/02.23	07/03/24	01/02/19	29/05/21	Jan 28	17/11/23
	20/12/2026	24/05/2021	July 2024	Yes	12/12/2019	23/11/2020	25/10/2021	29/09/22	12/10/23	01/02/19	29/05/21	Jan 28	17/11/23
	28/07/2026	31/05/2021	July 2024	Yes	20/01/2020	16/02/21	11/02/22	30/01/23	25/01/24	01/03/23	29/05/21	April 29	01/03/24
	20/03/2025	11/12/2019	July 2024	Yes		05/10/2020	12/11/2021	10/02/23	05/02/24	05/01/23	09/12/19	Jan 28	05/01/23
	17/08/28		July 2024						*	22/07/20		July 25	
	08/01/28		July 2024						23/06/23 (Tayside)	30/10/18		Nov 28	17/11/23
Specialty Doctors													
	02/02/2027	24/01/2022					05/10/2021 19/10/2021	18/10/22	24/10/23	6-8/7/21		June 26	
	13/10/2024							06/09/22	12/10/23	Not eligible until 2023			
	29/07/28								18/01/24				
Appraised by Other Organisations													
	13/12/2028	25/10/2023	July 2024	Yes	30/04/2019	15/10/2020	12/10/2021	23/11/22	15/11/23		29/05/21	April 26	
Retired Consultants													

4 RECOMMENDATION

The Board is invited to note the content of the Report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	N/A
Workforce Implications	Revalidation and appraisal are requirements to work as a doctor and essential to ensuring our continued medical workforce.
Financial Implications	Nil
Route To Board Which groups were involved in contributing to the paper and recommendations.	HIS requirement. Report will be shared with MAC.
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	Captures feedback on stakeholder experience and provides opportunity to improve this
Equality Impact Assessment	EQIA Screened – no identified 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).	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 24/88

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2024
Agenda Reference:	Item No 14
Sponsoring Director:	Director of Workforce
Author(s):	HR Advisor
Title of Report:	Staff Governance Paper
Purpose of Report:	For Noting

1 SITUATION

This report provides an update on overall workforce performance to 30 September 2024.

Information and analysis is provided to the Workforce Governance Group, the Operational Management Team and Corporate Management Team. Information is also provided on a 6 weekly basis to the Partnership Forum.

2 BACKGROUND

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

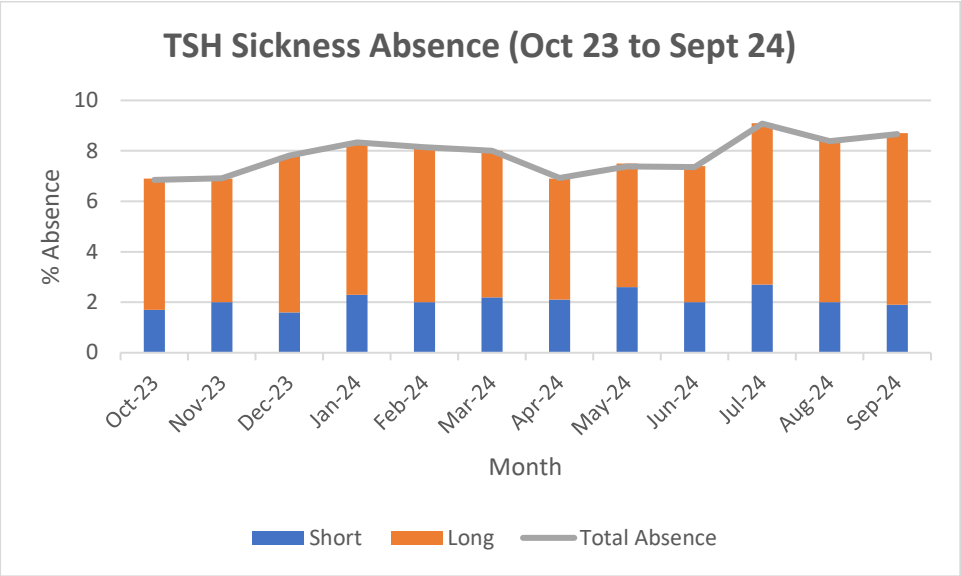
The Tableau dashboards are updated on a daily basis with attendance information using information from the SSTS system, meaning that the information available is live and as accurate and up to date as the information input by managers.

The information is provided to the end of September 2024, including the national figures for sickness absence for completion of the rolling year 23/24.

3 ASSESSMENT

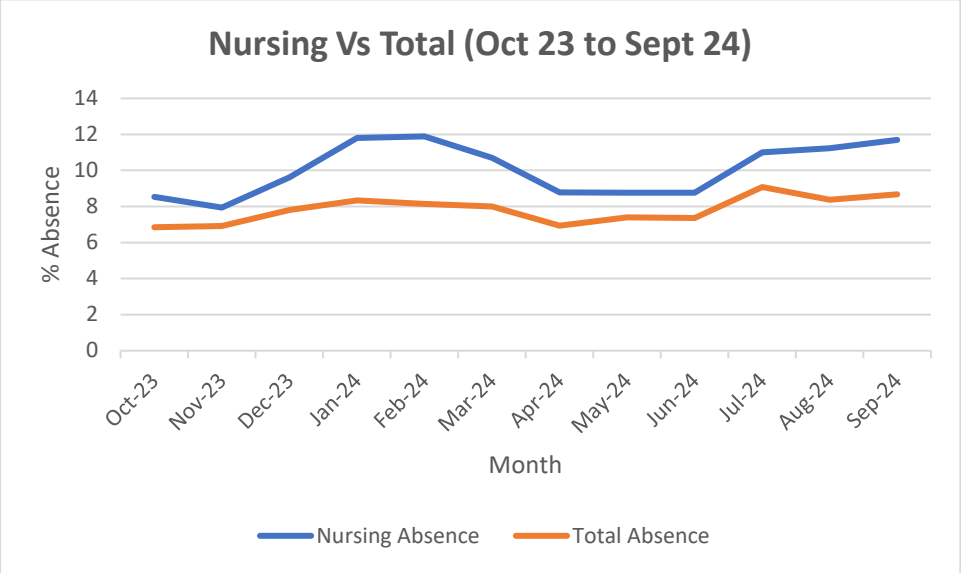
(a) ATTENDANCE MANAGEMENT

(i) TSH Sickness Absence (Oct 23 to Sept 24)



Small increase of 0.2% to 8.67% in September 2024.

(ii) Nursing Sickness Absence (Oct 23 to Sept 24)



Small increase of 0.46% to 11.70%, with long term absence just under 9%.

(iii) ATTENDANCE MANAGEMENT OBSERVATIONS

Patterns/Trends:	Slight increase in total absence (small decrease in short, small increase in long term). Spike in Nursing (long term) is main contributory factor.
Areas of Concern:	Mull Ward 2 (19.48%), Lewis Ward 3 (13.58%), Arran Ward 2(12.23%), Estates (11.96%)
Reasons:	*Key reasons for long-term absence were Anxiety/Stress/depression/other psychiatric illnesses, Injury/fracture, Gastro-intestinal problems and other musculoskeletal problems.* *Key reasons for short-term absence, were cold/ cough/ flu, Anxiety/Stress/depression/other psychiatric illnesses, Gastro-intestinal problems and back problems.*
Activity:	*At the time of reporting, for the month of September, 12 staff were invited to a Stage 1 meeting and 4 invited to a Stage 2 meeting and 1 Stage 3 meeting was reconvened.* *Of the 180 people who have been on a Stage 1 in the past 12 months, 83 remain on an active monitoring period. 69 of which are on a Stage 1, 13 on Stage 2 and 1 on Stage 3.* Meeting with CEO, Director of Nursing and Director of Workforce took place to review long term absence position, which highlighted the majority of cases in process and largest pressure for long term sick is between 0 and 3 months. Follow up meeting in November, which will also review short term sickness position.
Benchmarking:	Rowanbank: TBC Orchard Grove:

b) **RECRUITMENT**

TIME TO HIRE	97 days (KPI of 75 days)	Small number of vacancies
SUMMARY OF VACANCIES:	15.8 wte Band 5 Registered Nurse vacancies pending recruitment and qualification	8.6 wte RN's planned for induction in October and 5 OU students qualifying. **Current Vacancy at mid October: 2.2wte**
EMPLOYABILITY:	MA vacancy out to advert and further vacancy proposed in January.	
	Two supernumerary placements advertised, fully funded by Scot Gov and in partnership with South Lanarkshire Council.	

c) **SUPERNUMARY STAFFING**

OT & EXCESS	51.05 WTE	Down from 57.16 WTE
NURSING	33.34 WTE	Down from 37.17 WTE
SSR	9.90 WTE	Down from 11.82 WTE

d) EMPLOYEE RELATIONS

(i) LIVE ER CASES

Ongoing ER Case Work					
	<1 month	1-3 months	3-6 months	6+ months	Total
Capability - formal	0	0	0	0	0
Conduct - formal	1	1	2	2	6
Bullying & Harassment - formal	0	0	0	0	0
Grievance - formal	0	0	0	0	0
Whistleblowing	0	0	0	0	0

No other formal cases instigated in month of September.

e) LEAVERS

Leavers

- *7 employees ended their employment in September 2024: YTD total is 30.*
- *Turnover YTD is 3.95% compared to last year which was 4.69%*

Exit Interviews

- *Exit interviews continue to be offered to all staff on leaving the organisation at the time of resignation letter received to HR.*
- *Exit Interviews completed April to September totals 11 out of 30.*

Exit Interview Process has been written and is available from HR Connect outlining how organisational themes and learning will be shared as well as immediate feedback to Directors as happens at present.

f) **JOB EVALUATION**

Update at end September 2024

- In September there was one significant change Job Description received and two carried over from August.
- Three outcomes were given.

Status

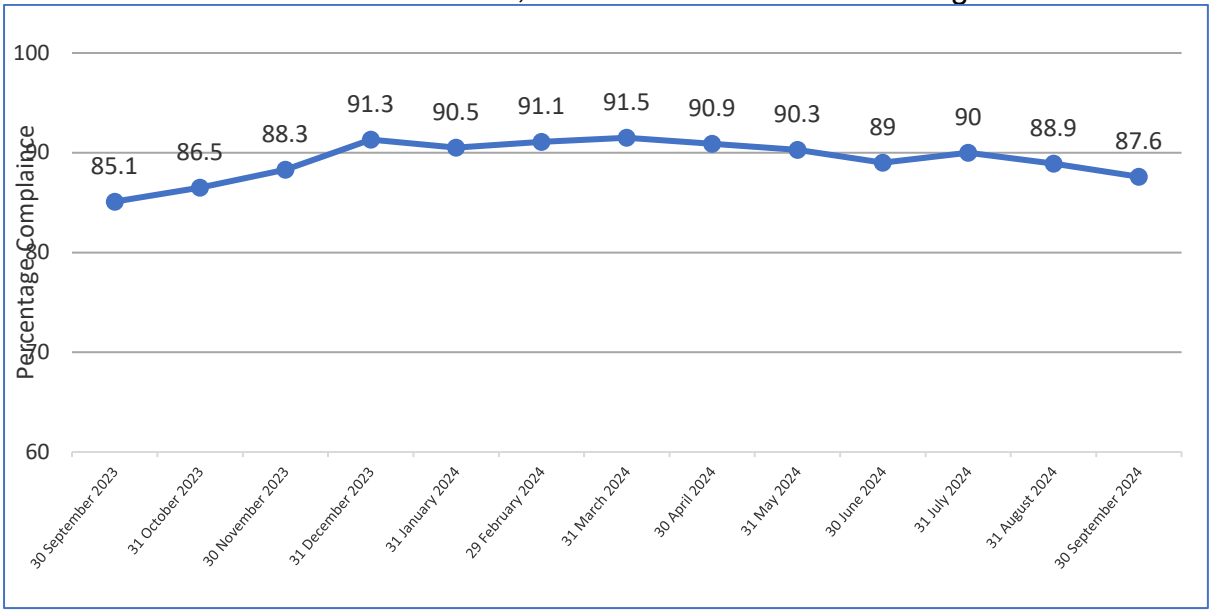
- At end of September, there are no outstanding posts.
- The STAC - Job Evaluation Annual Performance Report 2023/24 was presented to the Partnership Forum at their September meeting and approved. The agreed report to be submitted to STAC before the national deadline.

Job Evaluation Steering Group

The group continue to meet bi-monthly taking forward any issues raised via the JE Practitioners involved in panels and quality checking.

G) PDPR COMPLIANCE

A small decrease in month to 87.6%, but still above the national target of 80%.



MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	N/A no proposal – update report Supports delivery of Staff Governance Standards and Workforce Plan
Workforce Implications	N/A
Financial Implications	N/A
Route to Meeting Which groups were involved in contributing to the paper and recommendations.	Report is presented at Staff Governance, Partnership Forum, WGG, CMT
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	There are no identified impacts.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2024
Agenda Reference:	Item No: 15
Sponsoring Director:	Chief Executive
Author(s):	Head of Corporate Governance
Title of Report:	Board Improvement Plan
Purpose of Report:	For Noting

1. SITUATION

The NHSScotland Blueprint for Good Governance outlines a model for effective corporate governance to deliver good governance in healthcare. The Blueprint describes the functions and enablers of good governance, as well as definitions of the delivery systems and evaluation mechanisms required for continuous improvement. Through this NHS Boards should take a consistent and systematic approach to assessing their governance arrangements with a view to identifying any emerging issues or concerns.

2. BACKGROUND

Along with all NHS Boards, the State Hospital completed a self-assessment questionnaire in 2023, which focused on effectiveness against the Blueprint model. A Board Development Session followed this in March 2024, led by the Board Development Team from NHS Education for Scotland. This session informed the development of the Board Improvement Plan, which was then approved by the Board at its meeting on 25 April 2024, and submitted to Scottish Government.

The Board agreed that a review of progress should be completed in October 2024, followed by an annual review in April 2025.

3. ASSESSMENT

The self-assessment survey and follow up session reflected a positive position for the Board, with recognition of key areas of strength especially around setting the direction, leadership of strategic plans, monitoring performance and scrutiny of evidence.

The plan highlighted key areas where further progress can be made, and this report provides a six monthly update in this regard.

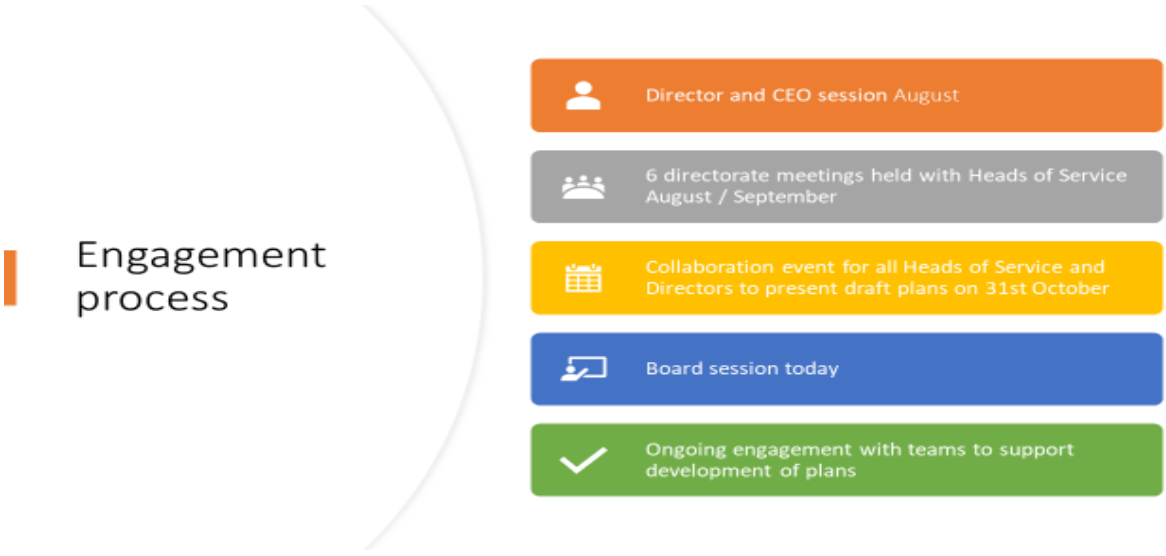
Risk Management
The Board receives dedicated reporting relating to Risk and Resilience at each meeting, and this covers a range of key areas including the financial position as well as bed capacity within the State Hospital and across the wider forensic estate. This ensures that any key risks for the organisation are prioritised on the agenda and that issues, which may arise, can be escalated for consideration.

The Board has recognised that substantial progress has been made in respect of managing risk, and awareness of risk appetite. This is to be developed further as part of the improvement plan, linking the Corporate Risk Register to the Corporate Objectives. The Risk Team is working with each directorate to review their existing risks, beginning with Nursing and Operations and Security, Resilience and Estates. The aim is to complete this refreshed approach by February 2025.

A further development is the Tactical Risk, Resilience and Operational Security Group, which is being established as a sub group of the Corproate Management Team (CMT) and has a commencement date projected for December 2024.

Engaging Stakeholders
In terms of stakeholder engagement, the plan includes development of a stakeholder map to help give clarity in this area, defining stakeholders, and how TSH engages in different forums. In the past six months, this has been taken forward through the approach to planning as well as the development of a local Carer Strategy, and this will support taking forward a stakeholder mapping exercise.

Developing of the Medium Term Plan is aligned with the organisational development workstream, and linked to workforce planning. This is an inclusive and wide-ranging approach to stakeholder engagement, and the Board had an opportunity to consider progress in this respect at the development session held on 3 October 2024.



Additionally, there has been key focus on the development of a local Carer Strategy, as outlined by the Carers (Scotland) Act 2016. This has included how this role is defined and how best to support patients' relatives and friends, who may play a role in their lives. For a high secure setting, this has required a tailored approach to identify carers, and ask how they identify themselves through a survey process. With increased engagement seen, this has provided a helpful baseline of information that can then be used to inform the strategy.

Work has also continued to implement the Triangle of Care to seek quality improvement in this area, as well as offering a welcoming approach to carers through visiting facilities through the Family

Centre and ward visits. The Board considered the good progress made at the development session on 3 October 2024, and noted that the finalised strategy is due to be completed in December 2024.

Influencing Culture
Within the plan, there is a stated aim to raise awareness of the whistleblowing standards, and support staff to raise concerns. Over the past six months, there has been a review the approach taken to the Whistleblowing Standards.

There is now a section on HR Connect to advise staff on how to access support and raise concerns, and linking to the policy. There was a communications campaign for Speak Up Week, with a focus on raising awareness throughout all staff groups. There will be a link to external confidential contact support through NHS Lanarkshire, as well as revised training for internal confidential contacts. It is planned to move management of the process to Corporate Governance, and to consider the change in Executive Lead at the end of this financial year as well as promoting the role of the Non-Executive Whistleblowing Champion.

Running alongside this approach, the Organisational Development Lead is taking forward a deep dive into the organisation's 'health' status with a view to producing recommendations as part of the Organisational Development and Workforce Plan. A dedicated staff bulletin was issued week beginning 15 October 2024, as well as a stand set up within the Wellbeing Centre, about the approach being taken. A Seminar Series focused on this area on 18 September 2024.

The overall approach is to focus on the areas that matter to employees of the organisation and to target specific development approaches.

Diversity, Skills and Experience
The plan focuses on succession planning as a key area of risk, and the need to take steps to build resilience. Work is progressing through the Workforce Governance Group to link into the national NHSScotland Succession Planning approach, and this is scheduled to come to the Staff Governance Committee at its next meeting in November 2024. A key area is the need for tailored internal approaches to be reviewed for senior specialised roles, and the potential to link to personal development reviews.

The Workforce Governance Group has also taken a refreshed approach to its own role, and a new delivery sub-group has been established. The focus is on supporting workforce initiatives, and identifying any key risks to delivery.

For the Board itself, there should be a review of the skills matrix of the Non-Executive Cohort, with a view to future recruitment so that this can be used to help inform any future recruitment to the Board. The State Hospital is participating in the Aspiring Chairs programme both as a host Board, and in supporting individual participation.

The Assurance Framework
There are a range of workstreams underway in this regard, most particularly to benchmark the State Hospital to other forensic settings within NHSScotland and through the Forensic Network, as well as to the three high secure hospitals within NHS England. The Board regularly received updates in this respect e.g. attendance management, security approaches, and complaint management.

The NHS England Clinical Secure Practice Forum brings together representatives from the four UK high secure hospitals, and the State Hospital attends this meeting on a quarterly basis. This provides an opportunity to collaborate on matters related to security. For instance, a Prevention and Management of Violence and Aggression guidance document produced through the four hospitals. In addition, the NHS England High Secure Collaborative brings together clinical representatives from the four UK high secure hospitals, with a focus on clinical matters.

Evaluation

The plan sets out the intention to better promoting the work of TSH e.g. with the wider public and through collaborative workstreams.

There is continued participation in national networks for Medical Directors (SAMD) Nurse Directors (SEND) as well as Finance Director (DoFs) providing platforms through which a focus on forensics can be platformed. The TSH Chief Executive is the Board Chief Executive (BCE) lead for mental health, as well as chairing Healthcare in Custody through which the work of TSH is promoted.

Formal collaborative relationship are formalised through a range of service level agreements for example, Occupational Health Services, Payroll, Pharmacy and Social Work services.

It is worth highlighting the close and beneficial working relationship between the State Hospital and the Forensic Network in particular. Of note, the network is leading the development of Transgender Guidance, as well as Guidance for Transfers from Custodial Settings to Forensic Mental Health Services. The Board are aware of the role the network plays in terms of conflict resolution, to decide the appropriate patient pathway within medium or high secure settings.

There is increased focus on relationships with external agencies, and hosting visits to the hospital including Scottish Prison Service.

The Communications Strategy supports public awareness of the State Hospital, and this has been led in a variety of ways including promoting patient and carer stories on the website, providing an accessible way to show how care is delivered within the hospital, especially rehabilitative pathways. There has also been stronger linkage through the recruitment strategy, and use of social media.

4. RECOMMENDATION

The Board is asked to note progress to date, and provide any further input if required. Further, that an annual assessment will be presented to the Board at its meeting in April 2025.

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP / Corporate Objectives	To embed continuous improvement of governance arrangements as part of the Blueprint of Good Governance
Workforce Implications	No issues identified in terms of staff resourcing
Financial Implications	There are no direct financial impacts related to progressing this plan
Route to Board Which groups were involved in contributing to the paper and recommendations.	As per national guidance, and the Board has ownership directly. The CMT reviewed this as per of their agenda prior to the plan coming to the Board.
Risk Assessment (Outline any significant risks and associated mitigation)	This is a continuous improvement mechanism, and should not present additional risks to the Board.
Assessment of Impact on Stakeholder Experience	Stakeholder engagement is a key part of the plan, and will be reviewed as part of the proposed governance arrangements
Equality Impact Assessment	This is not required as part of this workstream
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 is not relevant to this workstream
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

Appendix A

Priority Area	Blueprint Function	High level Action	Interdependency	Lead	Timeline	Status	intended good governance outcome
Functions	Risk Management	Review the Board risk appetite in light of current financial and operational pressures. Ensure that this is agreed and the risk management approach is embedded across the organisation, including through the development of local risk registers, and linking Corporate Risk Register to Corporate Objectives.	Standing committees	Director of Security, Resilience and Estates	Feb-25	Underway with regular updates to Board and Standing Committees. To continue to develop across each directorate locally, and bring together in CRR.	Intent is to link risk, performance and governance in more streamlined way for clarity and for continual assurance reporting going forward.
Functions	Engaging Stakeholders	Produce a stakeholder map to define who our stakeholders and the purpose of our engagement. Review our Anchor strategy as a mechanism to develop community engagement and help with visibility and impact.	External agrencies e.g. MWC, patients and carer groups, government, elected representatives and wider public	Director of Nursng and Operations/Head of Planning, Performance & Quality/OD	Feb-25	This is new workstream - stakeholder map leads to be agreed then developed, building on exisitng workstreams. Anchor Plan agreed and baseline metrics in place.	To define TSH stakeholders more clearly and the links to each, and to develop targetted engagement alongside planning espacially in relation to change programs.
Functions	Influencing culture	Raise awareness of Whistleblowing Champion to improve levels of psychological safety and support staff to raise concerns.	INWO, Scottish Government	Director of Workforce (to be reviewed?)	Aug-24	TSH to reposnd to INWO advice in respect of executive leadership of whistleblowing i.e. not an HR function. Need for Exec lead to work with HRD to develop planning for staff suport	To support staff to understand how to raise concerns through business as usual mechanisms and policies, and also how to raise cocerns through wihsitleblowing. To impact culture so that this is seen positive way of speaking up through range of mechanisms
Enablers	Diversity, Skills, and Experience	Include succession planning through Staff Governance Committee	Link to communications planning, and public perceptions	Director of Workforce	May-24	Build on work initiate in Workforce Governance Group - add to next SGC agenda as starting point, and to scope issues and key risks. Strategy and action	Nees to bring reporting to SGC to help define key areas of risk, and give assurance on action plan to mitigate the future risks and help develop staff locally to support retention.
Delivery	The Assurance Framework	Explore further benchmarking opportunities and tools, keeping the Board updated.	NHS England High Secure , Forensic Netwrok,	All Directors through CMT	Oct-24	Covers range of areas and underway across directorates- single lead to be agreed for more coherence : e.g. attendance management, digital inclusion, security ,	To stregthen assurance on range of metrics in more meaningful way, and in the right context given the Board's sepcialist role. To gelp gain learning and seek improvement across range of metrics.
Evaluation	Evaluation	Better promote our work to national Boards through raising our profile, host visitors and bespoke work. Opportunity to observe Board meetings in other areas to see how they function and identify any areas of learning.	National Boards Collaborative forums e.g. CEO, DoFs, Planning Leads	All Directors through CMT	Nov-24	Covers range of areas - single lead to be agreed to give more structured and coherence : e.g. finance, procurement, SLAs , healthcare in custory, forensic network , infirmaton governance , PMVA	To promote and share sepcialised expertise within the Baord, as well as ways of seeking learning and new ways of working

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2024
Agenda Reference:	Item No: 16
Sponsoring Director:	Chief Executive Officer
Author(s):	Head of Communications
Title of Report:	Communications Annual Report 2023/24
Purpose of Report:	For Noting

1. SITUATION

The Head of Communications is required to produce a Communications Annual Report. This report covers performance from 1 April 2023 to 31 March 2024 in support of the Communications Strategy 2020/25. This update is provided as at April 2024.

2. BACKGROUND

All communications activity supports the Board in the delivery of its core objectives and legal obligations. The establishment of a Communications Annual Report is therefore an important assurance process in considering the effectiveness of State Hospital internal and external communications.

Given the nature and organisational arrangements of the Board, patients are uniquely viewed as internal communication stakeholders in addition to Non-Executive Directors, Volunteers, the Chaplaincy Team, Advocacy, and staff. Carers, the public, and the media are included within external communication arrangements.

The two services predominately delivering internal and external communications within the State Hospital are the Communications Service and the Person Centred Improvement Service (PCIS). These two services work very closely together with the PCIS having specific responsibility for patient, carer, and volunteer communication. Combined key result areas include Stakeholder Communications (Internal and External including staff, patients, carers, and volunteers), Public Relations (Relationship Management), Crisis Management, Public Affairs (Media and Political) and Marketing Communications.

This annual report covers the work of the Communications Service. Communication activity with patients, carers, and volunteers during 2023/24 is captured in the PCIS 12-month update reports.

Additionally, stakeholder stories presenting feedback from patients, carers, and volunteers directly to the Board continues bi-monthly.

3. ASSESSMENT

The Communications Service performed to a high standard, delivering a wide ranging and comprehensive communications service to stakeholders.

Staffing

The challenges of staff recruitment, development and training at the same time as progressing paused tasks and meeting organisational objectives both strategically and operationally, has been significant. Despite this, the Communications Service was integral all year in amplifying and / or localising national messaging, and State Hospital business as usual.

There is no doubt that the ongoing functioning and future proofing of the Communications Service has benefitted from investment of a PR & Digital Communications Officer in year. The PR & Media Communications Officer moved onto pastures new. The possibility of this post being replaced by a Communications Assistant is being explored.

Additionally, in year, all mandatory training was up to date, staff objectives were developed and reviewed, staff appraisals were undertaken at the correct time, and Personal Development Plans (PDP) were in place.

Key Achievements

Achievements worthy of a special mention include coverage of good news stores in local and national newspapers as well as on radio, progressing all outstanding tasks such as review and update of circa 135 publications, communications campaigns internally and on social media to raise the profile of AHPs, and the communications poster campaign that helped reduce sickness absence as part of the Task & Finish group, and the revamp of social media content to ensure it was State Hospital related and educational.

Performance – Target and Objectives

The Communications Service consistently performs to a high standard, delivering a wide ranging and comprehensive communications service to stakeholders. Additionally, others responsible for delivering effective communications continued to achieve agreed objectives.

All core Communications tasks including key performance indicators, quality assurance objectives and quality improvement objectives were delivered. All legislative requirements were met, and all financial targets / savings were achieved.

These achievements were made while adhering to the core values and ways of working that the Board sponsors and are promoted across NHSScotland.

Service Delivery

During the year, the backlog of outstanding tasks was addressed. Furthermore, the advancement of service delivery in terms of exploring more modern methods of communication was explored to add variety and ensure existing methods do not become dated.

During the year, all Communications strategies and policies were up to date, and effective, as was all supporting documentation with planned reviews in place for those documents nearing end of life.

Focus continues on developing the service and enabling the best and most effective use of resources. Embedded within this is building capacity for the future with an emphasis on appropriate resilience, succession planning and growth.

Risk & Resilience

The Memorandum of Understanding (MoU) with the NHS Golden Jubilee (established 2018) in respect of senior communications cover arrangements within each organisation remains in place at the request of the Golden Jubilee.

The Communications Risk Register outlining local cover arrangements in the absence of the Head of Communications is now obsolete due to the appointment of additional Communications staffing.

4. RECOMMENDATION

The Board is asked to note the update.

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP / Corporate Objectives	The Annual Report supports the State Hospital's Communications Strategy. The strategy supports legal obligations, local and national strategic objectives, quality assurance and quality improvement objectives, NHS values and behaviours, openness and transparency, professional standards, and best practice in PR and Communications.
Workforce Implications	Service delivery is dependent on the Service being at full establishment.
Financial Implications	Any additional costs resulting from the re-evaluation of the PR & Digital Communications Officer role will need to be covered by the Communications Service. As a result, we are unlikely to proceed with recruiting for the vacant Band 5 PR & Media Communications Officer position. Instead, we will explore the recruitment a part-time Band 4 Communications Assistant.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Sponsorship and governance route: Head of Communications and the Chief Executive.
Risk Assessment (Outline any significant risks and associated mitigation)	Previous risk associated with a single person resource now mitigated.
Assessment of Impact on Stakeholder Experience	Promoting key messages and a positive image of the Hospital leads to improved public understanding of the State Hospital, mental illness, and helps to tackle associated stigma.
Equality Impact Assessment	Numerous EQIAs are in place to support the Communications Strategy and associated activity.
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 Head of Communications works closely with the PCIS to support an inclusive approach to ensuring patients who experience significant barriers to communication are enabled to contribute meaningfully to all aspects of care and treatment.
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. Numerous DPIAs are in place to support the Communications Strategy and associated activity.

COMMUNICATIONS SERVICE ANNUAL REPORT 2023/24

'ENABLING RESILIENCE AND GROWTH'

1. CORE PURPOSE

Communication is at the heart of everything we do. Within the State Hospital, the core purpose relates to all aspects of communications both internally and externally – from consultancy / advice and guidance to the provision of electronic communications, audio-visual production including video, dealing with the media, social media, the production of corporate publications, and stakeholder engagement. Specifically, the Head of Communications acts as a communications link between the Hospital and stakeholders including staff, the local community, general public, professional bodies, and local and national government, and drives forward improvements in communication. This enables the influencing and shaping of communication planning and strategy at all levels, ensuring good communications practice is firmly embedded in everyday service development, delivery, and change.

Given the nature and organisational arrangements of the Board, patients are uniquely viewed as internal communication stakeholders in addition to Non-Executive Directors, Volunteers, the Chaplaincy Team, Patients' Advocacy Service, and staff. Carers, the public and the media are included within external communication arrangements, which differs from the Communications function of other Boards. The State Hospital's public (patients) are with us for an average of 6.5 years, and some very much longer, and therefore are classed as internal stakeholders. The public are potential patients of territorial Boards and are viewed by them as external stakeholders. These Boards will therefore undertake direct engagement with their public in relation to health, wellbeing and services provided.

The two services predominately delivering internal and external communications within the State Hospital are the Communications Service and the Person Centred Improvement Service (PCIS). These two services work very closely together with the PCIS having specific responsibility for patient, carer, and volunteer communication. Combined key results areas include Stakeholder Communications (Internal and External including staff, patients, carers, and volunteers), Public Relations (Relationship Management), Crisis Management, Public Affairs (Media and Political) and Marketing Communications.

This annual report covers the work of the Communications Service from 1 April 2023 to 31 March 2024. Communication activity with patients, carers, and volunteers during 2023/24 is captured in the PCIS 12-month update reports. Additionally, stakeholder stories presenting feedback from patients, carers, and volunteers directly to the Board continues bi-monthly.

Trust and confidence of our stakeholders can only be achieved through maintaining the highest levels of transparency. The work of the Communications Service and PCIS help drive our reputation locally, nationally, and globally through different channels by communicating with all stakeholders in a timely, accurate and consistent fashion. This in turn generates confidence, which ultimately supports the Board's vision and corporate objectives.

Within Communications, we believe that our values are the bedrock of our culture, guiding how we work with one another and our stakeholders.

2. LOCAL AND NATIONAL DRIVERS

Communications is delivered in line with the State Hospital's Communications Strategy 2020/25, which meets the legal obligations contained within:

- State Hospital Annual Operating Plan (AOP) 2023/24.
- National Staff Governance Standard (4th edition), June 2012.
- NHSScotland Healthcare Quality Strategy, May 2010.
- NHSScotland 2020 Workforce Vision (*Everyone Matters*), June 2013.
- Healthcare Improvement Scotland (HIS) – 'What Matters To You?' August 2016.
- Human Rights Act 1998.
- Public Interest Disclosure Act 1998.
- Freedom of Information (Scotland) Act 2002.
- Equality Act 2010.
- Public Services Reform (Scotland) Act 2010.
- Patient Rights (Scotland) Act 2011.
- Mental Health (Care and Treatment) (Scotland) Act 2003 / 2015.
- Carers (Scotland) Act 2016.
- Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016.
- General Data Protection Regulations (GDPR) 2018.
- Duty of Candour Procedure (Scotland) Regulations 2018.
- Fairer Scotland Duty 2018.

3. COLLABORATIVE WORKING

A key aspect of the Communications Service is the requirement for effective and regular collaborative working across all directorate structures and teams. Being independent from other functions, services, or directorates, ensures effective broader organisational confidence, dialogue and connection is maintained. This is something that has been achieved over many years. Within the State Hospital environment, it is important for staff to be able to see a function that not only serves all staff and disciplines equally but is positioned correctly to do this through a joined up internal network of strong lines and links in all directions with communications in the centre.

Collaborative working with the Scottish Government Mental Health Team, Scottish Government Communications colleagues, Health Board Communications peers, the Mental Welfare Commission, and other partners is well established.

4. STAFFING / RESOURCES AND INVESTMENT FOR THE FUTURE

The Communications Service has an establishment of three posts:

- Head of Communications
- PR & Digital Communications Officer
- PR & Media Communications Officer

The PR & Media Communications Officer moved onto pastures new in November 2023 having been in post for a year. In December 2023, the post was re-advertised, and interviews were undertaken, but no appointment was made.

Due to the current financial climate there is now a need to be more cautious about spend and an increased requirement to make savings. A Communications Assistant post is being explored in place of the higher banded PR & Media Communications Officer post. This would achieve the necessary savings and would also meet service requirements.

5. KEY PERFORMANCE INDICATORS (KPIs)

Established KPIs relate to the core Communications Service as detailed below:

No	KPI	Source	Timescale	Status / Outcome
01	To produce a Communications Annual Report for presenting to the Board.	Board	Annually	**Continues to be met**
02	To produce the Board's Annual Report.	Board	By 31 October each year	**Continues to be met**
03	To produce at least 44 weekly bulletins for staff.	CEO	Annually	**Complete** Fifty-one were produced.
04	To produce at least 40 special bulletins as a support to staff.	CEO	Annually	**Complete** Forty-nine were produced.
05	To produce Staff Newsletter 'Vision' twice a year as a minimum.	CEO	Annually	**Complete** Six editions were produced: three regular editions and three Wellbeing special editions.
06	To deliver on 100% of all appropriate requests for Talks to the Community.	General Public	Annually	**Complete** No talks were delivered.
07	To respond promptly to all Media Enquiries.	Media	Annually	**Complete** This was achieved for the 11 enquiries received.
08	Complete the 'Well Informed' section of the Staff Governance Self-Assessment Monitoring Tool.	Staff Governance Standard	Annually	**Complete** Achieved and evidenced by way of the 'Well Informed' section of the State Hospital's Staff Governance Standard Monitoring Return.
09	To ensure attendance at four of the six State Hospital Board Meetings.	Board	Annually	**Continues to be met**

No	KPI	Source	Timescale	Status / Outcome
10	Ensure Board business is published on the Website including Board Schedule of Meetings, Public Notices, Agendas, Minutes, and Papers.	Board	Ongoing	**Continues to be met** Additionally, after each Board Meeting a review of all Board papers takes place to identify information / communication for the staff bulletin, staff newsletter 'Vision,' Intranet, Website, Media, and Social Media as appropriate.
11	To attend 90% of NHSScotland Strategic Communications Network Meetings.	NHSScotland	Annually	**Continues to be met** These meeting were all held via Teams.
12	To ensure representation at the annual NHSScotland Event.	NHSScotland	Annually in June	**Continues to be met as appropriate** The event in June 2023 was a virtual event which we did not attend.
13	Annual re-design of Weekly Staff Bulletin and Special Bulletin.	Chair	By end March annually	**Continues to be met**

The table below details activity in 2023/24 not covered by KPIs:

No	Workstream	Lead	Outcome	Key Result Area
01	Media Releases / Statements	Head of Comms	Three Media Releases and two Media Statements were produced.	Media Relations
02	Media Features	Head of Comms	One Media Feature (radio) was undertaken for World Mental Health Day with Good Morning Scotland.	Media Relations
03	Media Leaks	Head of Comms	Previously we only submitted a Datix for Media Leaks. In 2023/24 a Datix was raised for all Media Enquiries and coverage whether this was related to the Media Enquiry or not.	Media Relations
04	FOI Enquiries	FOI Lead	The number of FOI Enquiries is captured within the Information Governance Annual Report.	Public Relations
05	Academic Published Articles	Research & Development Manager	The Research Committee Annual Report 2023/24 notes all published journal articles and the delivery of presentations.	Public Relations
06	Leadership Walkrounds	-	These were paused during the year. A "Once for Scotland" approach to Leadership Walkrounds is being explored.	Staff Relations

6. QUALITY ASSURANCE (QA) OBJECTIVES

The table below details progress against QA objectives set for 2023/24:

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
		Internal Communications			
01	Provide professional advice and direction to the Board, line managers and all teams.	Comms Strategy	Head of Comms	Ongoing	**Continues to be met** This enables the influencing and shaping of communication planning and strategy at all levels, ensuring good communications practice is firmly embedded in everyday service development, delivery, and change.
02	Review Communications Risk Register.	Risk Management	Head of Comms	Every three months	**Complete** The Register focused on resilience. Now obsolete with the appointment of staffing.
03	Ensure effective communication with relevant stakeholders to share updates relating to strategic priorities including sickness absence and nursing resource utilisation.	Chief Executive / Service Strategy / Directors' Objectives	All Directors	Ongoing	**Continues to be met**
04	Review the State Hospital's Corporate Document Standards in support of good corporate governance.	Comms Strategy	Head of Comms	-	**New for 2023/24** **Complete** Standards reviewed, updated and relaunched on 11 September 2023.
05	Review and update of State Hospital publications / information sheets.	Comms Strategy	Comms	-	**New for 2023/24** **Complete** The Publications Database was redeveloped in year and all publications / banner stands were reviewed.
06	Review and update of State Hospital Banner Stands following rebrand.	Head of Comms	Comms	-	**Awaiting rebranding**

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
			Internal Communications (cont'd)		
07	Produce bulletins, newsletters, publications, and other communications to advise staff of what is happening in the Hospital and the wider NHS.	Comms Strategy	Comms	Ongoing	**Continues to be met**
			External Communications		
08	Through effective communications, foster public and political confidence in the care and services provided to protect and enhance understanding of the Hospital.	Comms Strategy	Comms	Ongoing	**Continues to be met**
09	Report Communication incidents / leaks to the Media via Datix.	Comms Strategy	Comms	Ongoing	**Continues to be met** During the year it was agreed a Datix be submitted for every Media Enquiry, and all mentions of the State Hospital in the press / online.
10	Board meetings, dates, public notices, agendas, minutes, and papers to be advertised / published on the website.	Board	Comms	Ongoing	**Continues to be met**
11	Inform Non-Executives and other identified staff of major events which are likely to attract Media interest.	Board	Head of Comms	Ongoing	**Continues to be met**
12	Keep the Scottish Government up to date on all matters relating to media activity and any correspondence with patients and families and / or carers which may require government officials and / or Ministers to become involved.	Annual Review	Head of Comms	Ongoing	**Continues to be met**
13	Ensure information is provided in an accessible format as required.	Comms Strategy	Comms	Ongoing	**Continues to be met**

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
		External Communications (cont'd)			
14	Undertake first annual review and update of the content on the redeveloped Website and produce statistical report via Google Analytics.	Comms Strategy	PR & Digital Comms Officer	Annually	**New for 2023/24** **Complete and will continue quarterly** Content was reviewed quarterly during the year Google Analytics report for 2023/24 has been produced. A Website Maintenance & Development Plan has been produced to aid review.
15	Undertake an annual review and update of the content on the ONELAN screens.	Comms Strategy	PR & Digital Comms Officer	Annually	**Continues to be met** Content is accurate and up to date.
16	Undertake annual reviews and updates of the State Hospital's Speakers' Directory and general presentation slides.	Comms Strategy	Head of Comms	Annually	**Complete** This update includes feedback from community talks.
17	Review and update the State Hospital Wikipedia page.	Head of Comms	PR & Media Comms Officer	-	**New for 2023/24** **Complete** Wikipedia did not allow us to update this despite trying on several occasions.
18	Bi-annual review of Media Training requirements for Directors and other identified staff.	Comms Strategy	Chief Executive / Head of Comms	December 2024	**On track** Requirement being explored with a view to delivering in house at the end of 2024.
19	Familiarisation with 'Dealing with the Media' Guidance for State Hospital Spokespeople.	Comms Strategy	On-Call Directors / CEO	Ongoing	**Continues to be met** Note - This should be read in conjunction with the State Hospital's approved 'Media Lines for On-Call Directors' which have been prepared to assist Directors in responding to media enquiries.

No	QA Objective	Source	Lead	Timescale	Status / New Timescale
			External Communications (cont'd)		
20	Review role of Communications in an Incident.	Head of Comms	Head of Risk & Resilience / Comms	Feb 2023	**Complete** Communications role and all pre-prepared Contingency Planning Media Statements were reviewed.
21	Maximise key messages about the Hospital's work, role and the services provided thus raising awareness of the Hospital's image, profile, and potential with external audiences locally, nationally, and internationally.	Comms Strategy	Comms	Ongoing	**Continues to be met** During the year, we drove this through our social media channels as a means of educating stakeholders.
			Strategy / Policy		
22	Conduct an interim review and update (if required) of the Communications Strategy, policies, and procedures.	Comms Strategy	Head of Comms	Annually	**Continues to be met** Media Policy updated February 2023 to reflect first staffing appointment in October 2023.
23	Regular review and update of the Pandemic Influenza Communications Strategy.	Infection Control Committee	Senior Nurse for Infection Control / Head of Comms	April 2025	**Continues to be met** Interim review took place in May 2023 signed off by the Infection Control Committee (ICC). Next review is due April 2025.
24	Undertake Equality Impact Assessments for Communications.	Equality Act	Head of Comms	As required	**Continues to be met** All communication strategies and policies are supported by an Equality Impact Assessment which is reviewed at the time of policy review. Communications Strategy (EQIA approved January 2022), Pandemic Influenza Communications Strategy (EQIA approved July 2018 and will be reviewed in April 2025 with the strategy), Media Policy (EQIA approved March 2022), and External Website Maintenance & Development Policy (EQIA approved March 2022).

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			Strategy / Policy (cont'd)		
25	Following handover of Intranet from eHealth to Comms, review and update Intranet Maintenance & Development Policy and associated Equality Impact Assessment (EQIA) to reflect changeover.	Comms Strategy / Equality Act	Head of Comms	-	**New for 2024/25** This will be undertaken when Sharepoint Online gets the national green light to proceed.
26	Undertake Data Protection Impact Assessments (DPIAs) for Communications.	GDPR	Head of Comms	-	**Continues to be met** Four DPIAs have been developed: Communications Strategy (DPIA approved March 2019), Media Policy (DPIA approved March 2022), the Use of Social Media (DPIA updated November 2021), and Website Maintenance & Development Policy (DPIA approved March 2022).

7. QUALITY IMPROVEMENT (QI) OBJECTIVES

The following table shows performance against QI objectives set for 2023/24:

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			Internal Communications		
01	Build capacity for workload ensuring full complement of staff is in place.	Board	Head of Comms	-	**New for 2024/25** Explore appointment of Communications Assistant in lieu of PR & Media Communications Officer moving on. This lower banded post enables the required savings for 2024/25 and future years to be met.
02	Redevelop the Intranet. The current Sharepoint site (now at end of life) will be replaced with the new 'Sharepoint Online' version which is being led nationally for all Boards by National Services Scotland (NSS).	National	Comms / eHealth	Ongoing	**New for 2023/24** The project is at an early stage nationally pending resources, governance approvals and other necessary requirements ensure successful implementation across NHSScotland. A State Hospital Intranet Upgrade Action Plan was produced to support the transition locally, and a staff engagement exercise commenced.
03	Redevelop the State Hospital Photo Library.	Head of Comms	PR & Digital Comms Officer	-	**New for 2023/24** **Complete**
04	Continue to undertake staff engagement exercises to support corporate objectives.	Comms Strategy	Project Lead / Designated Individual	Ongoing	**Continues to be met** Latest engagement exercise during the year related to the Intranet – move from old to new site.
05	Continued support for the new Clinical Model post implementation.	Clinical Model Oversight Board	Project Lead / Comms	-	**New for 2023/24** **Continues to be met as appropriate**

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			Internal Communications (cont'd)		
06	Support the Hospital's implementation of e-Rostering (now Allocate Optima)	Director of Workforce	Head of Comms	-	**New for 2023/24** **Complete** Communications in partnership with Learning & Development developed a rostering user guide for staff. Staff bulletins were also produced to support the project.
07	Support / promote iMatter.	National	OD Manager / OD & Learning Advisor / Head of Comms	Annually	**Continues to be met**
08	Promote the work of Healthy Working Lives (HWL).	Values & Behaviours Group	OD Manager / PR & Media Comms Officer	Ongoing	**Continues to be met** Achieved through the staff bulletin and the production of resources.
09	Support the 'Excellence Awards' and staff 'Long Service Awards.'	Values & Behaviours Group	OD / Comms	Annually	**Continues to be met** Communications is a member of the working group responsible for organising and managing these events.
10	Support the What Matters To You (WMTY) Day.	PCIS	PCIL / Comms	Annually in June	**Continues to be met**
11	Support ad-hoc key events via dedicated staff bulletins / Vision / campaigns as appropriate.	Project Lead	Project Lead / Comms	Ongoing	**Continues to be met** For example, visits and recruitment fayres.
12	Review and further develop Communications Guides.	Head of Comms	Comms	-	**Continues to be met** During the year, 15 new guides were developed, and a formal Guides Database was developed to support the review process.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			Internal Communications (cont'd)		
13	Review and further develop Standard Operating Procedures (SOPs)	Head of Comms	Comms	-	**New for 2023/24** **Complete** During the year, four new SOPs were developed, and a formal SOPs Database was developed to support the review process.
14	Develop a Departmental Induction Pack for new staff to Communications.	Head of Comms	Head of Comms	-	**New for 2023/24** **Complete**
15	Annual redesign of the Weekly Staff Bulletin and Special Bulletin.	Board	Comms	Annually	**Continues to be met** New design launched 1 April each year.
16	Explore Microsoft Sway for staff communications.	Head of Comms	PR & Digital Comms Officer	-	**New for 2023/24** **Ongoing** Initial exploration undertaken in 2023/24 however Microsoft 365 new applications may take preference. These need to be explored when Sharepoint Online is implemented, so paused for now.
17	Develop Asset Registers for Communications.	GDPR	Head of Comms	Dec 2024	**New for 2024/25** On track.
			External Communications		
18	Ensure research is shared through the Website.	Medical Director	Research & Development Manager / Head of Comms	March 2023	**Continues to be met** The website has a dedicated page for sharing Journal articles.
19	Explore opportunity for the State Hospital to put a case forward for a State Hospital variant of the NHSScotland logo that more clearly identifies the State Hospital as an NHSScotland organisation	Corporate Management Team (CMT)	Head of Comms	-	**New for 2022/23 and still ongoing** Business case submitted January 2023. In December 2023 Business Case was updated at Scottish Government request and resubmitted. We continue to be patient.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
	External Communications (cont'd)				
20	Produce suitable content for the Hospital's Social Media channels to maintain an effective presence.	Directors / HODs / Project Leads / Comms	Comms	Ongoing	**Continues to be met** A Social Media Planner was developed in 2023/24 to ensure a mix of current news and educational posts.
21	Ensure recruitment advertising promotes a positive image of the Hospital as a great place to work.	HR Directorate	Comms	Ongoing	**Continues to be met** Each post is advertised numerous times on Social Media prior to the closing date.
22	Raising the profile of the Hospital by promoting it as a great place to receive care, and important for all who live in, work in, and visit as well as a major employer for the local community.	Comms Strategy	Comms	Ongoing	**Continues to be met** In the main, this is achieved through the media, social media, the website, and recruitment initiatives.
23	Explore social media for businesses and ensure two-factor authentication is enabled.	eHealth	Infrastructure Operations & IT Security Manager	-	**New for 2023/24** **Partly complete** Two-factor authentication was enabled for Twitter in 2023/24. A solution for Facebook is still being explored.
24	Explore Twitter Blue Tick / Verified for Businesses.	eHealth	PR & Media Comms Officer	-	**New for 2023/24** **Complete** Alongside other Boards w were not granted the Blue Tick status as we do not meet the requirements.
25	Explore Linktree as a means of driving traffic between social media platforms and increasing engagement.	Comms Strategy	PR & Media Comms Officer	-	**New for 2023/24** **Complete** A Linktree Account was created in August 2023.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			External Communications (cont'd)		
26	Update of State Hospital Nursing video on YouTube.	Comms Strategy	PR & Media Comms Officer / Comms	By July 2023	**New for 2023/24** **Complete** Nursing video identified as a priority for update. This was done in November 2023.
27	Review of all State Hospital videos on the State Hospital YouTube channel with a new to updating or removing.	Comms Strategy	Comms	By March 2025	**New for 2024/25** **On track**
28	Undertake Video Training and practice sessions to enhance familiarisation.	Comms Strategy	PR & Media Comms Officer and Head of Comms	-	**New for 2023/24** **Complete** Training was undertaken in February 2024. In 2024/25 familiarisation training will continue until individuals are proficient.
29	Produce a series of short educational videos that can be placed on the State Hospital website, YouTube, and other social media channels.	Comms Strategy	Comms	By March 2025	**New for 2024/25** **On track**
30	Produce key messages / facts including information on items that can be easily misunderstood or can cause concern, e.g., patient outings, patients with autism, misinformation etc.	Comms Strategy	Comms	By March 2025	**New for 2024/25** **On track** This will be done collaboratively with the Intellectual Disability (ID) Service.
31	Issue Media Releases surrounding good news stories, ensuring the safety and security of patients, staff and visitors is not compromised.	Comms Strategy	Comms	-	**Continues to be met**
32	Invite the Media into the Hospital as and when appropriate to help promote positive Media coverage and reduce historic sensationalised, controversial coverage often featured around our patients.	Comms Strategy	PR & Digital Comms Officer / Comms	-	**Consideration continues to be given** No requirement for 2023/24.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			External Communications (cont'd)		
33	Continue to invite visitors to the Hospital to learn about our work. Visitors include MSPs, Health Board Chairs and senior officials as well as other stakeholders.	Board	CEO / Directors	Ongoing	**Continues to be met** Visits are captured in the Chief Executive's Report to the Board and are covered in the staff newsletter 'Vision' as appropriate.
34	Host visit from NHS Lanarkshire Comms staffing as part of their development.	Jackie McColl, Deputy Director of Comms	Head of Comms / Comms	-	**New for 2023/24** **Complete** Visit by Communications staff from NHS Lanarkshire took place in May 2023.
35	Strengthen relationships with the local media.	Comms Strategy	PR & Digital Comms Officer	-	**New for 2023/24** **Complete** Relationships were strengthened with local papers and radio.
36	Develop Intellectual Disability Q&A that could be attached to media responses and utilised via Social Media platforms.	Comms Strategy	PR & Digital Comms Officer	-	**New for 2023/24** **Complete** Q&A developed for BBC documentary in August 2022 continues to be utilised as appropriate on social media.
37	Produce narrative that covers process from admission to discharge, making reference to reason for admission to the State Hospital.	Comms Strategy	PR & Digital Comms Officer + ID Service RMO	By March 2025	**New for 2024/25** **On track**
38	Create narrative around detention / restriction orders and review process / rights to appeal.	Comms Strategy	PR & Digital Comms Officer + ID Service RMO	By March 2025	**New for 2024/25** **On track**
39	Consider approaching print media and agree a series of features with them – if trust can be established.	Comms Strategy	PR & Digital Comms Officer	By March 2025	**New for 2024/25** **On track**

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			External Communications (cont'd)		
40	Actively place features in psychiatric and nursing healthcare journals.	Comms Strategy	PR & Digital Comms Officer	Ongoing	**New for 2023/24** **Continues to be met** Attempts were made during the year however content was not accepted unless it was paid for.
41	Further strengthen relationships with the local media through media releases.	Comms Strategy	PR & Digital Comms Officer	Ongoing	**New for 2023/24** **Continues to be met** A number of good news stories were covered in local media during the year and relationships were strengthened.
42	Explore a media monitoring service with an external company.	Chief Executive	PR & Media Comms Officer	-	**New for 2023/24** **Complete** This was explored and proved costly. We have gone with the free PressReader service which we check daily.
43	Redesign of Board Meeting Public Notice so it is more eye-catching / engaging.	Head of Comms	PR & Media Comms Officer	-	**New for 2023/24** **Complete**
44	Review Memorandum of Understanding (MoU) with another National Board as a means of strengthening resilience within both Boards.	National Boards Collaborative	Head of Comms / Chief Executive	Ongoing	**Continues to be met** MoU with the NHS Golden Jubilee reviewed and updated in February 2024. Next review 2026.
45	Maintain links with other agencies and forensic services through the Forensic Network.	Comms Strategy	CEO / Medical Director / Other Professions	Ongoing	**Continues to be met**
46	Improve communications with partners about the Hospital's work, aims and successes and look for opportunities to work collaboratively.	Comms Strategy	Head of Comms	Ongoing	**Continues to be met** Good relationships maintained with Scottish Government, Mental Welfare Commission and NHS Boards.

No	QI Objective	Source	Lead	Timescale	Status / New Timescale
			Collaborative Working		
47	Be actively involved in the National Board Review Groups and work supporting the National Collaborative.	National Boards Collaborative	Head of Comms for Comms strand	As required	**Continues to be met** This was paused in 2023/24.
48	Support the NHSScotland Event.	Scottish Government	Head of Comms	Annually	**Continues to be met** Support is provided via promotion and role of Poster Co-ordinator / management of abstract submissions.
49	Develop the leadership needs of NHSScotland Communications professionals: Directors of Comms and Comms Heads of Service.	Strategic Comms Group	Strategic Comms Leadership Sub Group	Ongoing	**Paused** This work has been paused since the beginning of the Covid-19 pandemic.

8. EVALUATION OF EFFECTIVENESS

All core Communications objectives, corporate objectives, and legislative requirements were met in 2023/24. The following are examples of positive outcomes evidencing effectiveness achieved during the year.

8.1 Internal Communications

- The appointment of the PR & Digital Communications Officer in May 2023 quickly made a valuable contribution to the team.

- The extensive development of Communications Guides, Standard Operating Procedures (SOPs) and the Communications Induction Handbook in year has strengthened governance and effectiveness in terms of service delivery.

- The 2023 iMatter Survey saw a response rate of 72%. The Board's Employee Engagement Index (EEI) was 75 (both scores were the same as last year, 2022).

- Workshops / events / training promoted via the Staff Bulletin were well attended evidencing that staff read the bulletin, and the bulletin remains an effective means of promoting these activities.

- The staff bulletin and staff newsletter 'Vision' continue to keep staff and volunteers updated on all the latest news internally and externally. Staff requests for dedicated staff bulletins continued to be high, as were staff contributions to weekly staff bulletins and Vision. We explored SWAY as a new method of communication.

- Despite the need for redevelopment, the Intranet continued to play a vital role, creating a virtual environment where staff could stay informed, connect, communicate, and share. The Communications Service page on the Intranet was reviewed and updated in year.

- Communications launched an Intranet Staff Engagement Exercise in respect of migration from the current, to the developing, Sharepoint Online Intranet site. An Intranet Upgrade Action Plan was developed to ensure smooth transition when we get the go ahead.

- Email system remained effective for issuing urgent communications or those that are not included in the staff bulletin, e.g. weather warnings, grounds access time changes, and items sought or no longer required, works on site, programme downtimes, public holiday staffing, lost property etc. The 'All User Email Request' icon on the Intranet continues to be effective.

- Feedback arising from the policy consultation process (housed on the Intranet and advertised through the staff bulletin and email system) evidenced that staff took the time to read formal communications, respond and contribute to policy improvement.

- Requests for printed materials continued, evidencing fit for purpose and in demand. The new Publications Databases captures circa 80 information sheets, 19 banner stands, and circa 35 departmental initiatives. These were all reviewed and updated in year.

- Communications support was given to various projects and disciplines throughout the year including the Seminar Series, staff wellbeing initiatives, Allied Health Professions (AHP) promotional campaign, iMatter, Speak Up, Clinical Model, Allocate Optima (eRostering), Health and Care (Staffing) (Scotland) Act 2019 (HCSA), new Personal Attack Alarm (PAA) roll out, implementation of CCTV, Attendance Management, Sharepoint Online, Daytime Confinement (DTC) and Recruitment.

- Communications staff are key members of numerous groups including the Freedom of Information Committee, Climate Change & Sustainability Group, HR & Wellbeing Group (which was paused during the year), Healthy Working Lives Group, Staff Recognition Steering Group (Excellence Awards and Long Service Awards), eHealth Sub Group, Business Classification Scheme (BCS) Project Team, HCSA Project Team, eRostering Project Team (now changed to Allocate Optima), Daytime Confinement (DTC) workstream, and the Task & Finish Group. Communications also attended all meetings of the Organisational Management Team (OMT), Corporate Management Team (CMT), and the Board.

8.2 External Communications

- The website continues to meet the needs of our stakeholders. Quarterly checks were undertaken during the year to ensure content on main pages was reflected in the FOI section. This cross-referencing will continue as good practice going forward. Our Website Maintenance & Development Action Plan ensures content is relevant and up-to-date.

- We are delighted to report that two positive stories were published in local newspapers: State Hospital Shortlisted for National Award and the retirement of our long serving Housekeeping Supervisor. Additionally, two positive features were placed in national media: State Hospital Shortlisted for National Award (Daily Record – September 2023), and World Mental Health Day (Sunday Post – 6 October 2023) with associated slot on BBC Radio Scotland (Medical Director – 10 October 2023).

- Through the effective management of media enquiries, we were able to protect the Hospital's reputation by either (1) preventing what could have been a potential news story or (2) by lessening the impact of a negative story through rebutting inaccuracies and providing information to ensure fair and balanced coverage. All media enquiries were shared with the Board, Scottish Government colleagues, and the Mental Welfare Commission (MWC) in support of knowledge exchange, collaborative working, and consistent messaging.

- Media Lines for On-Call Directors were reviewed and further developed during the year.

- Social Media posts were redesigned during the year and content revamped to educate stakeholders about the Hospital and the service it provides. Around three to four posts were placed each week.

- General enquiries continue to be received through the general State Hospital mailbox (tsh.info@nhs.scot) evidencing that this is not only effective but is a popular resource. Enquiries are daily and can relate to vacancies and placements, requests for psychiatric reports, media enquiries, requests for information, and mental health support.

- Provision of State Hospital promotional items were sought after during the year as these continue to be popular for recruitment events / fayres and in support of infection control awareness.

- Talks to the local community took place evidencing continued interest in the State Hospital.

- Hosting of visits to the Hospital ensures a wider audience learns about our work and enables the opportunity of sharing best practice and networking. Details of these visits are included in the Chief Executive's Report to each Board meeting.

- At each Board Meeting, the Chair provides feedback from the NHSScotland Chairs' Meeting. This ensures the Board is aware of what is happening nationally and includes updates on targets and priorities. The Chief Executive reciprocates this in terms of national Chief Executive Officer (CEO) meetings.

9. SUMMARY / CONCLUSION

Staffing

The challenges of staff recruitment, development and training at the same time as progressing paused tasks and meeting organisational objectives both strategically and operationally, has been significant. Despite this, the Communications Service was integral all year in amplifying and / or localising national messaging, and State Hospital business as usual.

There is no doubt that the ongoing functioning and future proofing of the Communications Service has benefitted from investment of a PR & Digital Communications Officer in year. The PR & Media Communications Officer moved onto pastures new. The possibility of this post being replaced by a Communications Assistant is being explored.

Additionally, in year, all mandatory training was up to date, staff objectives were developed and reviewed, staff appraisals were undertaken at the correct time, and Personal Development Plans (PDP) were in place.

Key Achievements

Achievements worthy of a special mention include coverage of good news stores in local and national newspapers as well as on radio, progressing all outstanding tasks such as review and update of circa 135 publications, communications campaigns internally and on social media to raise the profile of AHPs, and the communications poster campaign that helped reduce sickness absence as part of the Task & Finish group, and the revamp of social media content to ensure it was State Hospital related and educational.

Performance – Target and Objectives

The Communications Service consistently performs to a high standard, delivering a wide ranging and comprehensive communications service to stakeholders. Additionally, others responsible for delivering effective communications continued to achieve agreed objectives.

All core Communications tasks including key performance indicators, quality assurance objectives and quality improvement objectives were delivered. All legislative requirements were met, and all financial targets / savings were achieved.

These achievements were made while adhering to the core values and ways of working that the Board sponsors and are promoted across NHSScotland.

Service Delivery

During the year, the backlog of outstanding tasks was addressed. Furthermore, the advancement of service delivery in terms of exploring more modern methods of communication was explored to add variety and ensure existing methods do not become dated.

During the year, all Communications strategies and policies were up to date, and effective, as was all supporting documentation with planned reviews in place for those documents nearing end of life.

Focus continues on developing the service and enabling the best and most effective use of resources. Embedded within this is building capacity for the future with an emphasis on appropriate resilience, succession planning and growth.

10. LOOK BACK

Areas of focus for 2023/24 and 2024/25 as identified in last year's annual report are shown below together with an update:

- Produce a Communications Service Induction Handbook for new Communications staff and develop the two new roles within the Communications Service to ensure cohesion and effectiveness – Complete.
- Implement Sharepoint online (new Intranet) – In progress.
- Establish an effective media monitoring service – Complete.
- Raise the profile of the State Hospital by strengthening and further developing media / social media activity, electronic communications, educational materials, and the production of audio-visual materials – Complete and ongoing.
- Review all Hospital-wide Publications and Banner Stands – Complete.

- Redevelop the Publications Database, Media Database and Photo Library - Complete.
- Develop a Communications Information Asset Register – On track for 2024/25.
- Review the State Hospital's Corporate Document Standards – Complete.
- Review DPIAs – On track for 2024/25.
- Review the Communications Risk Register every three months – Complete and now obsolete.
- Support new Hospital priorities such as the implementation of eRostering (i.e. Allocate Optima) and Clinical Model pre and post implementation – Complete.
- Complete State Hospital Rebranding – In progress.

11. LOOK FORWARD

Areas of focus in 2024/25 include:

- Implement Sharepoint online (new Intranet).
- Develop audio-visual materials – in particular, video.
- Develop a Communications Information Asset Register.
- Review DPIAs.
- Complete the State Hospital Rebranding.
- Recruit to ensure staffing establishment of three is maintained.

Caroline McCarron Chart.PR MICPR
Head of Communications
12 April 2024

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2024
Agenda Reference:	Item No: 17
Sponsoring Director:	Finance and eHealth Director
Author(s):	Information Governance and Data Security Officer
Title of Report:	Information Governance Annual Report
Purpose of Report:	For Noting

1 SITUATION

In order for the Board to have an overview of the work carried out by Information Governance, an annual report is provided for consideration. The Annual Report highlights the activities during 2023/24.

2 BACKGROUND

The Information Governance Group, chaired by the Senior Risk Information Owner (SIRO) is responsible for progression of attainment levels in relation to Information Governance Standards – reporting to the Finance, eHealth and Audit Group.

The Caldicott Guardian principles are integrated within the initiatives and standards required by NHS QIS for Information Governance and attainment levels are recorded via the Information Governance Toolkit.

The Committee has, over the course of the year continued to work to improve Information Governance standards and practices across the Hospital.

3 ASSESSMENT

The report highlights the main areas of activity and issues from 2023/24.

Key areas of work addressed include:

- Information Governance Standards (DPCT);
- Information Governance.Risk Assessments;
- Information Governance Training, including national events;
- Category 1 or 2 investigations, as required;
- Personal Data Breaches;
- Electronic Patient Records;
- Information Governance Walkrounds;
- FairWarning;
- Records Management;
- Freedom of Information;
- Subject Access Requests;
- MetaCompliance;
- ICO Audit, NIS Audit support.

Actions for the next twelve months include the on-going implementation of the ICO audit action plan, the continuance of all of the above aspects under an increasing national scrutiny and focus, plus addition work in the following areas:

- Records Management plan resubmission;
- Introduction of Business Classification Standards;
- Redaction software introduction;
- Introduction of a Specialist Information Governance training;
- Maintenance of training compliance.

4 RECOMMENDATION

The Board is asked to **note** the progress outlined in the attached report for the year 2023/24 and the key plans for the coming period.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	The Report follows good practice and also links in with national Information Governance developments and requirements
Workforce Implications	Not applicable
Financial Implications	No financial implications
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Information Governance Group
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None
Equality Impact Assessment	No identified 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).	No identified implications
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

INFORMATION GOVERNANCE ANNUAL REPORT

APRIL 2023 – MARCH 2024

(Including Health Records)

Lead Author	Director of Finance and eHealth / Senior Information Risk Owner
Contributing Authors	Records Services Manager
	Information Governance and Data Security Officer
	Associate Medical Director / Caldicott Guardian
Approval Group	The State Hospitals Board for Scotland
Effective Date	April 2024
Review Date	April 2025
Responsible Officer	Director of Finance and eHealth / Senior Information Risk Owner

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1 INTRODUCTION AND HIGHLIGHTS OF THE YEAR

The Information Governance Group, chaired by the Senior Risk Information Owner (SIRO) is responsible for progression of attainment levels in relation to Information Governance Standards.

These are recorded and monitored through the Data Protection Compliance Toolkit (DPCT). The Caldicott Guardian principles are fully integrated within the initiatives and standards required for Information Governance

The Group through its quarterly meetings has received and scrutinised regular reports all areas of governance, including the following – RiO audits, records management, risk assessments, training, Freedom of Information (FOI), data protection and Information Governance incidents and outcomes – as well as reviewing those items on the Corporate Risk Register relevant to the Group's remit.

In addition, there has been a focus on monitoring the progress of the 12 follow-up actions arising from the 2022 audit by The Information Commissioner's Office (ICO) – which had received an overall rating of "High" ("a high level of assurance that processes and procedures are in place and are delivering data protection compliance"). The audit focussed on organisational structure, policies and procedures, training for specialist IG roles, transparency, contracts with contractors and data breaches – and all actions are complete or on schedule.

During 2023/24, Information Governance support and assistance was also provided to the team responsible for preparing the Hospital's submission to the Network & Information Systems (NIS) Audit – which was completed in December 2023 and resulted in a compliance rating of 76%, "showing strength across the organisation and a high level of performance".

We have also continued to adhere to recommendations included in the Scottish Government's "NHSScotland Information Assurance Strategy CEL 26 (2011)" document and the regular schedule of Information Governance walkrounds within the Hospital has continued, including non-patient areas. In addition, the group has continued to focus on other key areas of priority such as the electronic patient record (EPR) system and outcomes of the FairWarning system – together with any ad hoc issues such as record retention and email scams.

This report is submitted on an annual basis to the Board, through the State Hospital's internal governance and approval structure.

The Committee has, over the course of the year continued to work to improve Information Governance standards and practices across the Hospital. We encourage staff to adopt good Information Governance standards through a number of measures undertaken by the group, and to complete mandatory online Information Governance learning modules.

2 INFORMATION GOVERNANCE GROUP

2.1 Information Governance Group membership

Director of Finance and eHealth (Chair)
Associate Medical Director/Caldicott Guardian
Head of e-Health
Head of Procurement
Clinical Admin Representative
Information Governance and Data Security Officer
Senior Information Analyst & Information Technology Security Officer
Lead Nurse
Health Records Manager
Psychology Representative
Security Information Analyst
Finance Representative
Social Work Representative
Human Resources Representative
Health Centre Representative
Pharmacist Representative
AHP Representative
Risk Management Representative
Business Manager Corporate Services
Forensic Network Representative
Information Asset Owners

2.2 Role of the group

The group has a wide reaching remit, being responsible for all matters in respect of Information Governance within the Hospital as the title suggests. The membership of the group is purposely broad. This allows the group to be representative of staff groups and departments from across the hospital.

2.3 Aims and objectives

- Ensure compliance and development of Information Governance overall as monitored by the DPCT.
- Address issues arising in the hospital in relation to Data Protection.
- Address issues arising in the hospital in relation to Records Management including structure, filing, storage, and archiving.
- Address Caldicott issues including monitoring DATIX reports and ensuring relevant training for staff.
- Provide a forum for the various staff groups within the hospital to raise any Information Governance issues and to receive feedback from Information Governance on such matters.
- To monitor requests made in relation to Freedom of Information and Data Subject Rights Requests.

2.4 Meeting frequency

The group meets on a quarterly basis to discuss any issues as outlined above, however the terms of reference include the option to hold ad-hoc meetings should the group require to meet outwith the quarterly cycle. Following agreement from the wider group, a small subgroup – the Information Governance DPCT Group – meets 6 monthly in order to concentrate on the assessment of the current attainment levels and supporting evidence required for the DPCT. In addition, another small subgroup also meets 6 monthly to review the Information Governance risk register (see para. 3.2).

2.5 Strategy and work plan

As noted in previous reports, the Caldicott principles have now been integrated within the initiatives and standards developed by NHS QIS for Information Governance. The Information Governance Toolkit and Data Protection Compliance Toolkit (DPCT) are completed twice yearly in order to monitor the performance of the hospital in relation to Information Governance.

The schedule of work for the subgroup is compiled in such a way as to allow the group to review progress with DPCT. This monitoring allows the group to develop an action plan of work to be undertaken by the group members. In addition, meetings are used to address the issues that may arise such as filing, relevant training, confidentiality issues etc..

2.6 Management arrangements

The Information Governance Group reports annually to the State Hospitals Board for Scotland through the Information Governance Group Report. The Information Governance Group also reports to the Corporate Management Team as relevant.

3 KEY PIECES OF WORK UNDERTAKEN BY THE GROUP DURING THE YEAR

3.1 Information Governance Standards

The Information Governance standards was retired at the end of 2021 and was replaced with the Data Protection Compliance Toolkit (DPCT). It has been developed from ICO's accountability framework, which supports the foundations of an effective privacy management programme.

The toolkit is divided into 10 categories, within each category there are a set of statement and questions that are rated on a 1 – 4 scale

Level	DPCT Status
1	Expectations not met
2	Expectations partially met
3	Expectations met without review cycle
4	Expectations fully with review cycle

Category	Level 1	Level 2	Level 3	Level 4	Status
1. Leadership and Oversight	0%	42%	58%	0%	**Level 3**
2. Policies and Procedures	6%	47%	47%	0%	**Level 2**
3. Training and Awareness	5%	14%	81%	0%	**Level 3**
4. Individuals' Rights	20%	34%	46%	0%	**Level 2**
5. Transparency	31%	50%	19%	0%	**Level 2**
6. Records of Processing and Lawful Basis	25%	50%	25%	0%	**Level 2**
7. Contracts and Data Sharing	7%	39%	54%	0%	**Level 3**
8. Risks and DPIAs	3%	45%	52%	0%	**Level 3**
9. Records Management and Security	13%	44%	41%	2%	**Level 2**
10. Breach Response and Reporting	16%	76%	8%	0%	**Level 2**
Overall Rating (2024)	**13%**	**45%**	**41%**	**1%**	**Level 2**
Previous Rating (2023)	15%	49%	36%	0%	Level 2
Change	**-2%**	**-4%**	**+5%**	**+1%**	**=**

Whilst the DPCT shows a range of attainment, this year's position was due to the implementation of a new method of monitoring compliance.

Work continues in conjunction with the recommendations from ICO's audit to improve the organisations compliance status.

There has been a slight improvement noted in the scoring of the DPCT monitoring areas. Some of this is in part to a change that has been made to the way the meetings of the Group are held – rather than having full membership expected to attend all meetings, two meetings are arranged annually to have a full oversight review of the DPCT, with meetings in between with targeted attendance to focus on specific areas.

3.2 Information Governance Risk Assessments

Information Governance risks assessments are undertaken by a subgroup of the IGG – the IG Risk Assessment Group – comprising of staff from IG, IT Security, Risk Management and eHealth as well as the Caldicott Guardian. Unfortunately there has been fewer meetings than had been planned due to other workload impacting on time and resources. The Group last met in February 2024 and further meeting is planned for August 2024.

At this time there were four open Information Governance risk assessments on the risk register covering a variety of risks (e.g. failure to communicate a change in access requests to eHealth in a timely manner). All four risks are currently at or below their target risk rating of medium. A review of Datix incidents from the previous 6 months flagged up the requirement for reminders to be sent to staff re the importance of checking email addresses prior to sending. No new risk assessments were felt to be required at that time.

On each occasion that the Information Governance risk assessments have been updated steps have been taken to minimise the risks highlighted (e.g. procedures to ensure identifiable information is sent recorded delivery; procedures re mobile devices; risks associated with staff leaving the organisation).

The Risk Assessment Group is currently working through registered risks to update them to reflect new technologies and working practices such as Teams and remote working. Reports are now provided to the group on all relevant incidents recorded through Datix and the DPO register of personal data breaches. The Group has changed its working methodology to be proactive rather than reassessing out of date risks and this is proving to be beneficial.

3.3 Information Governance Training

The majority of Information Governance training for staff is delivered online via LearnPro. All modules remain mandatory for all staff. Monitoring of completion rates by staff is undertaken by the Training & Professional Development Manager, with oversight by the IGG.

The completion of the modules can be seen in the table below.

Information Governance module completion				
Module	**Mar 2021**	**Mar 2022**	**Mar 2023**	**Mar 2024**
IG: Essentials (Target >85%)	78%	76%	95%	85%
IG: Series (Target >80%)	-	-	-	87%
Confidentiality	98%	98%	98%	-
Data Protection	98%	97%	98%	-
Records Management	98%	98%	98%	-

The changes have been made to the reporting of the Confidentiality, Data Protection and Records Management modules following their review and update last year. These modules are known collectively known as the IG: Series.

3.4 Category 1 & 2 Investigations

There were no Category 1 investigations relating to Information Governance during the year.

There was one Category 2 investigation which related to an external email address being included in an internal email distribution group that lead to confidential patient information being inadvertently disclosed to a third party.

The investigation recommended that;

- Email Distribution groups have only one owner.
- Regular checks are made to ensure group memberships continue to be appropriate
- Raise staff awareness about checking email addresses added to distribution groups.
- Raise awareness of other secure methods of data transfer, such as secure file transfer or direct upload to digital systems like RiO.

3.5 Personal Data Breaches

Under the UK GDPR there is a requirement to record personal data breaches. In cases where there is a high risk to the individuals involved, these breaches must be reported to the Information Commissioner's Office no later than 72 hours from discovery. The State Hospital uses Datix to record potential breaches of personal data.

Reported Personal Data Breaches				
	2020/21	2021/22	2022/23	2023/24
Reported Breaches	19	56	35	24
Required ICO Notification	0	0	0	0

There were 24 recorded personal data breaches in 2023/24 that were attributable to The State Hospital, which is a reduction over last year.

Area	Percentage
Internal Email Disclosures	29%
Information Disclosed Externally	25%
Others	17%
Information Disclosed Internally (non-email)	13%
Leak to the Media	8%
Incorrect Information	4%
Information Unavailable When Needed	4%

The majority of recorded breaches related to our communication platforms (email and physical post).

We continue to encourage staff as to the importance of displaying high standards in relation to Information Governance. Guidance notes are circulated through the Staff Bulletin and Information Governance Walkrounds provide an opportunity for informal contact with staff to give guidance on Information Governance matters

No breaches required notification to the Information Commissioner's Office (ICO).

3.6 Electronic Patient Records

Members of the IGG were actively involved in the ongoing development of the EPR (RiO) – and the project-specific EPR Group continues to meet regularly. RiO 22 went live on 08 March 2022 with a successful transition period. Following this we have moved quickly to introduce BAU process for ongoing development of RiO. A multidisciplinary project approval group (Rio Oversight and Development (ROAD) Group) has been established that reports to the eHealth Sub Group. Included within the approval process is appropriate information governance scrutiny.

Regular audits are carried out on various areas within Rio, with documentation and guidance updated as required. Issues are discussed at the Information Governance Group, or the ROAD Group.

A robust system is in place for Requests for Change to RiO – this may involve a quick assessment and authorisation by the system owner, or a more thorough review by members of the team including IG checks and workability.

Further work has been carried out to integrate links between RiO and the medication prescribing system (HEPMA) – a link for users from RiO to HEPMA is under development. A substantial piece of work for the RiO project team over the last period has been the development of Grounds Access processes embedded in RiO. These went live in June 2024. Since then the feedback in relation to this development has been extremely positive, with feedback that the new system has substantially improved the timescales from application to granting.

3.7 Information Governance Walkrounds

Having been introduced in 2015 as a recommendation following the publication of the NHS Scotland Information Assurance Strategy CEL 26 (2011) the Information Governance Walkrounds have built on the success of the previous years. The unannounced walkrounds occur a random throughout the year and encompass all areas of the organisation were personal information is used.

At the start of this year a new system of recording was introduced to promote more consistency during walkrounds.

Grade	Description
Excellent	No issues found
Very Good	1 – 3 minor issues found
Good	4 – 8 minor issues and/or 1 significant issue found
Improvements needed	9 - 14 minor issues and/or 2 significant issues found
Action Plan required	more than 15 minor issues, more than 2 significant issues and/or 1+ suspected breaches of legislation

The staff members involved in walkrounds noted the good standards of Information Governance that have been apparent in visited areas.

Of the eleven areas inspected during the year, nine were graded good or better, with the majority being ‘Very Good’. Two areas required improvement, however all issues were promptly resolved after communication with the relevant staff members and managers.

The walkrounds compliment the Records Management plan and general information governance goals by providing an informal opportunity for staff to raise questions or seek guidance on specific aspects of their work as well as raising general awareness of information governance considerations.

3.8 FairWarning

The group receives exception reports on the levels of FairWarning alerts raised and a subgroup is tasked with maintaining appropriate alerts and thresholds to provide a proportionate audit of access to personal information.

In the main FairWarning alerting rates remained consistent with previous years taking in to account changes in the patient population over the year. However, there has been a notable increase in the number of alerts relating to high numbers of staff accessing a single patient's record in one day. Whilst all the alerts were appropriately closed, if the trend continues the subgroup may need to review the cause of this increase in alerts.

This is the eighth consecutive year in which no incidences of inappropriate access have been alerted via FairWarning.

The group continues to be satisfactorily assured that there are no areas of concern regarding inappropriate access.

Whilst the focus of FairWarning is to detect potential inappropriate access to patient records, the sustained absence of such actions from any area of the organisation should be seen as a very positive statement about the professional conduct of staff.

3.9 Records Management

This year has again been extremely busy but positive for the Health Records Department. The addition in staffing resources has meant that day-to-day workload is mostly manageable and there has been some advances made in the wider Records Management workload.

The State Hospitals Board for Scotland submitted its Records Management Plan (RMP) to the Keeper of the Records in December 2016. The Plan was agreed and accepted by the Keeper with some elements graded as amber, and having work outstanding. A Plan Update Review (PUR) was carried out and submitted to National Records of Scotland (NRS) in October 2021. A positive response to this was received in December 2021, recognising the work that has now been carried out in areas such as the creation of a Corporate Records Policy and a formal Information Asset Register. As there have been noted improvements in Records Management within the organisation, it has been agreed with the NRS team that a full resubmission of the RMP will be completed in December 2024. A project group consisting of staff from around the organisation is working on this..

The move to a separate service (Records Services Department) is well underway, with a more formal split from eHealth taking place. This is allowing the department to function more independently and become involved in projects and work around the hospital, liaising with staff from various departments to promote RM in all areas. Staff are becoming more confident in dealing with corporate records as well as maintaining day to day oversight of clinical records.

The Records Management Group has met and is responsible for oversight of the resubmission of the RMP. A sub-group of the IGG is also being formed with responsibility for the oversight of clinical records – this was set to meet for the first time in Summer 2023, however due to lack of clinical input, this was not achieved. A further attempt will be made in Autumn 2024. A Quality Improvement project to reduce data held in shared drive space, and also to being using a Business Classification Scheme had begun, although due to resource issues this is now being taken forward as part of the RMP and Information Asset Register work rather than a QI project.

The current Health Records Policy and Corporate Records Policy are going to be merged to form an overarching Records Management Policy in Summer 2024. A formal Retention and Destruction Policy was agreed in September 2023, and work is ongoing with regard to formal guidance on version control and naming conventions..

Appraisal of patient records for permanent preservation or destruction has continued, with more records having been destroyed. Referral files have also been appraised as part of this process.

Work is ongoing to gather metadata on items for permanent preservation with the National Records of Scotland.

Work is being undertaken in relation the to the Hospital's Information Asset Register. This includes staff recording data as well as assisting staff to complete the process of registering systems and data held, whilst offering advice and encouragement to incorporate records management methodology. A formal records survey has been restarted however this has been slow to move forward due to resource issues. More time will be put into this in Summer 2024 in line with the RMP resubmission.

Work relating to M365 is still ongoing with the Records Service Manager being involved in national groups to ensure good RM is included in all areas and to ensure the organisation is aware of what is taking place outwith our own organisation. There is also national work to update the Records Management Code of Practice ongoing which the Health Records/Records Services Manager has contributed to. Information and updates from this work is shared regularly with internal colleagues.

As 2023 celebrated the 75th birthday of the NHS, the department put on a display of historical artefacts and information relating to changes in how The State Hospital has developed throughout the years in the Wellbeing Centre. This was positively received, with many staff coming along to view photographs and other memorabilia. As this generated interest, it has been agreed that departmental staff will provide an introduction to TSH at staff inductions, to give new colleagues an idea of the history of the Hospital.

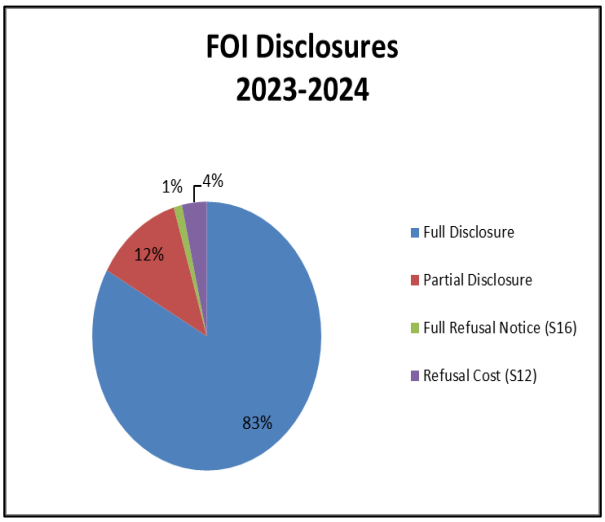
3.10 Freedom of Information

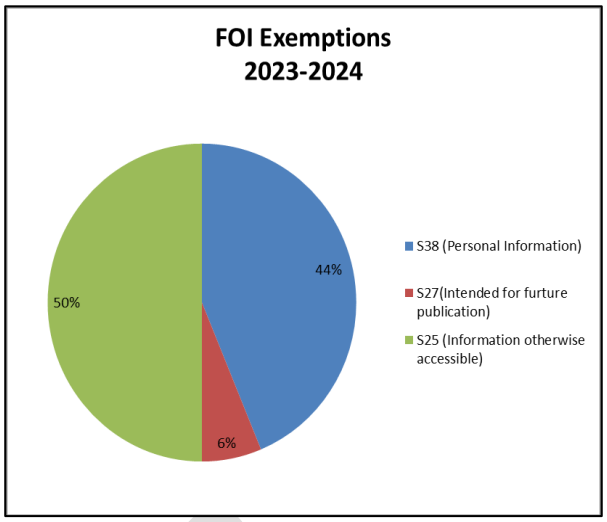
The group is kept informed of all Freedom of Information (FOI) requests and of the timescales achieved in responding to these. Requests have mainly come from the general public (64%), with the charities, lobby or campaigning groups (14%) the second largest requestors. The numbers of requests were up 66% over last year.

Number of Freedom of Information Requests					
	2019/20	2020/21	2021/22	2022/23	2023/24
Requests made	224	262	172	145	242
Completion rate within timescales	100%	89%	99%	91%	95%

This year has seen another drop in requests for reviews, with all the reviews finding that The State Hospital's original response was an appropriate response, which required no modification.

Number of Freedom of Information Reviews					
	2019/20	2020/21	2021/22	2022/23	2023/24
Requests for review made	0	3	4	2	1
Upheld without modification	0	3	4	2	1
Upheld with modification	0	0	0	0	0
Substituted a different decision	0	0	0	0	0
Reached a decision where no decision had been reached	0	0	0	0	0





Where the organisation held information, it provided a full response to applicants for the majority of requests (83%).

Three exemptions were used to withhold or decline to publish information. In most cases (50%) this was because the requests related to information that the applicant could reasonably obtained without making a FOI request.

3.10.1 Freedom of Information Self-Assessment

The FOI Committee drive a continuing improvement cycle based on the Scottish Information Commissioner's self-assessment toolkit.

The toolkit comprises of six modules each reviewing a particular area of our FOI obligations providing a four-point scale of performance (Unsatisfactory, adequate, good and excellent) that reviews the year's performance. Modules 5 & 6 were introduced by the Commissioner in 2021/22.

Ratings	Meaning
Excellent	Greatly exceeds the requirements of FOI
Good	Exceeds the requirements of FOI
Adequate	Meets the requirements of FOI
Unsatisfactory	Below the requirements of FOI

Public authorities, such as The State Hospital, are expected to deliver an 'adequate' service, taking in to account their local setting.

Standards and Criteria	2020/21	2021/22	2022/23	2023/24
1. Responding on time	Good	Good	Good	Excellent
2. Searching for, locating and retrieving information	Good	Good	Good	Good
3. Advice and assistance	Adequate	Adequate	Good	Good
4. Publishing information	Adequate	Adequate	Adequate	Adequate
5. Conduct of Reviews	N/A	Good	Good	Good
6. Monitoring and managing FOI performance Standards and Criteria	N/A	Good	Good	Good
Overall	Adequate	Adequate	Adequate	Good

The assessment shows that the management of FOI with the organisation now exceeds the requirements of the Freedom of Information (Scotland) Act.

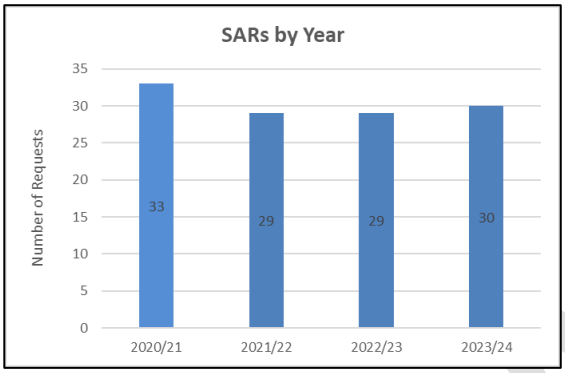
The overall rating is usually determined by the lowest score over the six sections, however the assessment allows for local circumstances to be considered when calculating the rating.

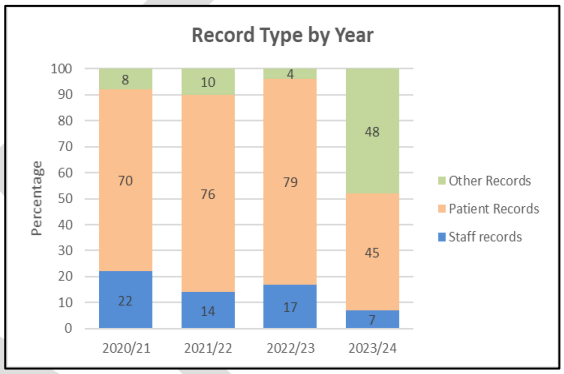
The criteria for scoring the fourth module about publishing information makes assumptions about FOI stakeholders which cannot be applied to our patients due to nature of a high security environment.

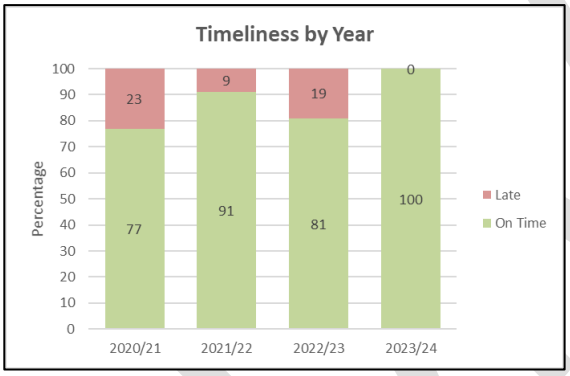
As such, provided that the rating for this section is not 'Unsatisfactory', it will be disregarded when calculating the overall ratings going forward.

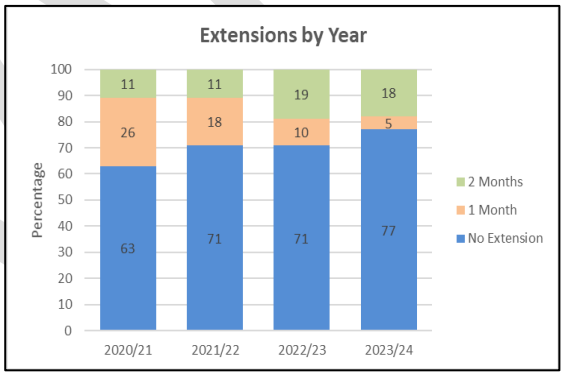
3.11 Subject Access Requests

Subject access requests continue at expected numbers, although there has been a notable change in who makes requests. Previously the majority of requests came from our current patients, however the majority of requests (48%) this year were received from discharged patients.









3.12 MetaCompliance / MyCompliance

MetaCompliance is a policy management system which is designed to ensure that key policies are communicated to all members of staff in order to ensure they obtain, read and understand their content. It also provides evidence of communication to line management and can identify individual staff members as having read and understood key policies.

MetaCompliance is supported by the complimentary system MyCompliance which provides a way to acknowledge policies prior to MetaCompliance enforcing a response.

Over the last year the number of policies delivered by MetaCompliance has remained at 61. Most "All Staff" policies achieve around 94% awareness and agreement within three months of release. Whereas "Clinical" policies achieve around 92% awareness and agreement within the same timeframe.

The MetaCompliance system was replaced by a cloud based MyCompliance platform at the end of the year. The new platform continues to enforce selected policies, however the number of these has been reduced to lessen the impact of locking staff out of their PC's until they agree to

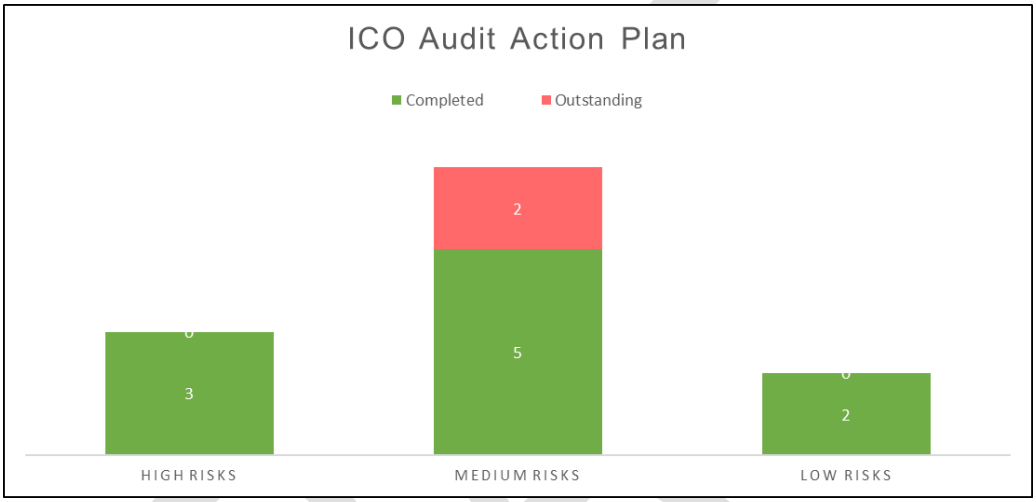
a policy. A self-service portal provides staff a convenient way to agree policies and quarterly management reports will start to be provided in the second quarter of 2024.

4 INFORMATION COMMISONER'S OFFICE AUDIT

The Information Commissioner's Office (ICO) audited the State Hospital to assess the risk of non-compliance with data protection legislation, the utilisation of ICO guidance and good practice notes and the effectiveness of data protection activities.

The audit was conducted in November 2022 with the organisation being awarded a high assurance rating.

The audit identified some areas were the state hospital could improve their compliance and following consultation with ICO a 12 point action plan was agreed to be completed over the next two years.



The organisation has now completed 83% of the action plan and only has two outstanding items. These relate to refresher training for Information Asset Owners and Information Asset Administrators as well as ensuring that there are resilience arrangements for their roles.

Training is planned in the second and third quarters of 2024/25.

5 IDENTIFIED ISSUES AND POTENTIAL SOLUTIONS

We have continued to try to improve attendance at the IGG meetings as full attendance at this group can sometimes be difficult to achieve – although continuing to have remote Teams meetings has encouraged a strong turnout. We encourage attendance by making the remit of the group relevant to staff members' roles, incorporating user feedback on eHealth matters into the agenda for the group. The attendance by deputies in the event of diary pressures is also now in place with a stronger emphasis for all members to encourage attendance.

Microsoft 365 (M365) implementation continues to be subject to a number of national delays. The groups tasked with delivering M365 have recruited more staff and it is hope that this will improve the speed of implementation nationally.

Staff who have duties that involve information governance tasks, such as subject access redaction should be suitably trained. A major training program will be delivered in 2024/25 to ensure that staff have appropriate training to support them in their roles.

Resourcing is always an issue, particularly when dealing with time limitations on statutory duties such as the supply of Subject Access Requests. Proposed solutions to assist in reducing the impact of this are being introduced, including the introduction of new software to assist with redaction and formal contingency plans with assistance from other departments if required.

6 FUTURE AREAS OF WORK AND POTENTIAL SERVICE DEVELOPMENTS

Work/ Service Development	Timescale
Records Management Plan to be resubmitted	December 2024
Introduction of national Business Classification Schedule in shared drive areas	December 2024
Utilisation of software assisted redaction for subject access requests for clinical records	July 2024
Specialist Information Governance training program	April 2025
Maintain 80% completion for the IG: Essentials learning module.	Ongoing
Maintain 85% completion for the IG: Series learning module.	Ongoing

7 NEXT REVIEW DATE

April 2025

Paper No. 24/93

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2024
Agenda Reference:	Item 19
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Director of Finance and eHealth
Title of Report:	Network & Information Systems Review
Purpose of Report:	For Noting

1 SITUATION

The State Hospital (TSH) was subject to a compliance progress review of Network & Information Systems by Cyber Security Scotland in October 2023, following the previous review in October 2022.

2 BACKGROUND

In 2020 the Scottish Health Competent Authority commissioned a three-year programme of audits and reviews of health boards to evaluate compliance with the Network & Information Systems (NIS) regulations. The initial audit programme was completed and unless incident reports or significant system changes in a health board merit a more frequent audit exercise, audits are conducted every third year – with the next for the State Hospital due in 2026. In intervening years, including 2024, Compliance Reviews are being undertaken – to which this report relates - the primary objective of the review being to assess progress on implementing the recommendations from the previous full audit and note progress on the control requirements.

3 ASSESSMENT AND OUTCOMES

3.1 2023 OUTCOME

A considerable amount of evidence was submitted up front to the reviewers – each piece of evidence requested for the review being "mapped" and cross-referenced to one or more controls set out. The documentary evidence was then reviewed and assessed for compliance.

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

The overall assessment was a rating of 76% - a significant improvement on 2022, "showing strength across the organisation and a high level of performance" and which saw us described as

"a strongly-performing board with a clear commitment to the NIS audit programme".
(All 17 categories were rated above the 60% compliance level, with 9 being 80% or better, and two at 100%. It was interesting to note that, had our submission been rated against the same framework as in 2022, then our Board's compliance rating would have been 86%.)

The report was particularly praising of the "involvement and support of the Chief Executive and SLT to the NIS audit" – seen as a "critical factor in this achievement" and "an approach that is to be commended and exemplar to other boards." The raised level of awareness and commitment from all levels was a key factor in the review.

During the outcomes meeting with the Board, one of the areas also highlighted by the reviewer was the strength of TSH training – noting that the inclusion of a training plan was the first they had seen from their reviews – and something now being addressed by other boards.

3.2 NEXT STAGES

The NIS lead and team have been reviewing the areas for development, addressing these where possible for this year's interim review in the second half of October.

Being the first year of the three-year cycle towards the next full review in 2026, this year's evidence submission is relatively small - being down to other pieces of work still being developed such as business continuity and disaster recovery desktop exercises, and further securing our digital infrastructure by removing/replacing legacy systems.

The aim is for our overall interim compliance score to increase above 80% and, for the category of business continuity / disaster recovery testing policies and procedures which was noted as a priority for development, to improve on that area towards a compliant rating. (This is a development area common with most other Boards and it is being taken forward jointly between the NIS and Risk teams).

The relevant actions continue to be tracked by the monitoring group

4 RECOMMENDATION

The Board is to note the report.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2024
Agenda Reference:	Item No: 20
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 17th October 2024; The next Project Oversight Board is scheduled for 21st November 2024. At the meeting of 17th October 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 26th November 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 61 has been accepted. A verbal update on progress since the time of writing will be available to the Board.

The installation of technology is complete. Remaining works are final elements of commissioning, a quantity of minor works, Site Acceptance Testing of the installation and the production of documentation. Difficulties in addressing CCTV issues remain the primary cause of recent programme delays and a verbal update will be provided.

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 continue to be affected by changes in the project timescale. The project currently has a potential overspend (exclusive of VAT) of approximately £783k. This has increased by approximately £60k since the August 2024 report to the Board. The main components of this increase are Project Advisor costs and Staff costs, both now projected to the end of December in order to provide a contingency.

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

Project Start Date:	April 2020
Planned Completion Date:	November 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 14/10/24:	£9,574,965
Total costs to date (exc. VAT & retention) at 14/10/24:	£9,431,130
Total costs to end of project (Exc. VAT & retention)	£ 143,834

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 13/10/24 is:

Securitas	£ 7.274m
Thomson Gray	£ 1.138m
Doig & Smith	£ 0.008m
HVM	£ 0.192m
Staff Costs	£ 0.925m
Income	-£ 0.106m
Total	**£ 9.431m**

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.

THE STATE HOSPITALS BOARD FOR SCOTLAND

AUDIT AND RISK COMMITTEE **ARC(M) 24/03**

Minutes of the meeting of the Audit and Risk Committee held on Thursday 20 June 2024.

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

Chair:	
Vice Board Chair	David McConnell
Present:	
Employee Director	Allan Connor
Executive Director	Stuart Currie
Non-Executive Director	Pam Radage
In Attendance:	
External Auditor, KPMG	John Blewett
Internal Auditor, RSMUK	Victoria Gould
Internal Auditor, RSMUK	Assam Hussain
Chief Executive	Gary Jenkins
Director of Finance and eHealth	Robin McNaught
Head of Corporate Planning, Performance & Quality	Monica Merson
Board Chair	Brian Moore
Head of Corporate Governance	Margaret Smith
Director of Security, Estates, and Resilience	David Walker
External Audit Director KPMG	Michael Wilkie

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting, and there were no apologies to be noted.

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 approved the Minutes of the previous meeting held on 21 March 2024.

The Committee:

a) Approved the minutes held on 21 March 2024.

4 MATTERS ARISING – ROLLING ACTION LIST UPDATE

The Committee received the action list and noted progress on the action from the last meeting, noting that the action to bring the annual reports from governance committee into a common format was completed therefore, this action is now closed.

Mr McConnell clarified in respect of the action relating to the scheme of delegation, and it was confirmed that this had been approved by the Board at its last meeting.

The Committee:

1. Noted the updated action list.

RISK AND RESILIENCE

5 CORPORATE RISK REGISTER

Mr Walker presented the Corporate Risk Register to the Committee highlighting that there were currently no risks out of date and no changes to the risk register updates. He noted the three high graded risks ND30, ND70 and FD90 and advised that updates in relation to these were provided within the report.

Mr Walker acknowledged that the development of the Corporate Risk Register had been slower than hoped due to work pressures in relation to the number of CAT1 and CAT2 adverse event reviews recently commissioned. He highlighted that work was still being undertaken to complete the Nursing Directorate review and once this was completed a review of the Security Directorate would take place around August / September. Mr Walker added that there was also work underway on the DATIX system to transfer all risks onto this system which will allow for a more informed picture of our risk profile.

Ms Radage asked, in relation to the In-Phase system that is being introduced, if the transfer of risks onto the DATIX system is a nationally driven project and what benefits would be seen from this system. Mr Walker explained that this was a module within the current DATIX system and that the Risk Team would investigate the In-Phase system to determine whether or not this will be beneficial for the State Hospital (TSH) in terms of assessing risk.

The Committee:

1. Endorsed the Corporate Risk Register as presented to be an accurate statement of risk.

6 RISK and RESILIENCE ANNUAL REPORT 2023/24

Mr Walker presented the Risk and Resilience Annual Report 2023/24 noting that there had been some excellent work done by a small department. He noted that changes have been made to the structure of the department within the last year with the addition of a Health and Safety Advisor and a Resilience Officer. Also highlighted were areas of good practice, noting the good work around the development of the Corporate Risk Register and Local Risk Registers, which was now embedded into the remit of the Organisational Management Team.

Mr Walker also noted that work had continued to build and maintain relationships with partner organisations; Police, Fire Service, Ambulance and South Lanarkshire Council. This helped to ensure that TSH resilience plans were fit for purpose. He drew attention in particular to the various workstreams in which, although challenges had been identified, this had led to exploring possible solutions.

Mr Moore acknowledged the excellent work undertaken by the department over the year adding that this offers strong assurance of the resilience of the organisation and asked if feedback had been received in relation to work undertaken along with Police Scotland to deliver Mental Health Awareness training to police negotiating teams.

Mr Walker advised that the provision of this training had been ongoing for a number of years, alongside Police Scotland supporting the training of TSH negotiators. However, TSH did now provide input to Police Scotland's training course on Mental Health Awareness, which has been very well received. Mr Walker added that Police Scotland had helped with the process of introducing the role of Critical Incident Communicator within TSH, and that a number of staff had completed negotiator training.

Mr Jenkins thanked the department for their hard work and acknowledged the benefit of the structural changes that have taken place, and thanked Mr Walker for his positive leadership of the team.

Mr McConnell asked if the rise in RIDDOR figures was due to random fluctuations or if there were underlying reasons for this and for some detail on the position and progress of Local Risk Registers. Mr Walker clarified that the rise in RIDDOR numbers were due to existing risks, and provided assurance that Local Risk Registers were being managed by the Risk and Resilience Team. Heads of Department had responsibility to review local risks regularly, with clear procedures embedded should there be any changes to risks which required to be escalated.

The Committee:

1. Noted the Risk and Resilience Annual Report 2023/2024.

INTERNAL AUDIT

7 INTERNAL AUDIT REPORTS

a) Complaints

Ms Gould of RSMUK presented the Complaints Management Internal Audit Report and provided the Committee with an overview. She explained that the Complaints Management Audit had not been due to take place until 2024/25 however, due to the need to re-phase the Security Project Audit it had been agreed to bring the Complaints Audit forward. The report was based on the year 2023/2024 and the audit focused on recent changes within complaints handling. Ms Gould highlighted that the report was very positive and gave substantial assurance to the organisation, with four low graded actions that have been agreed with management.

Ms Smith noted her appreciation of the audit outcome given that complaints management could be a challenging and complex area of service, and underlined the changes that have been made recently were embedding in well which and improving delivery of the service.

Mr Currie acknowledged the positive report and asked what procedures are in place to maintain the standard of the complaints process and to lend resilience in this area, given the small complaints handling team. Ms Radage also acknowledged the positive report and asked for feedback around any other means available to patients to provide feedback. Mr Jenkins noted the positive report and added that patients also had a wider safety net through the Patients' Advocacy Service as well as the Tribunal Service. He added that patients have the opportunity through the Patient Partnership Group to provide regular feedback and to suggest where improvements could be made. He noted that recent changes made, which include regular meetings with patients by the complaints service, were positive and agreed that resilience within the team was important to ensure that the high standard of the service could be maintained.

Mr McConnell asked for clarity surrounding the action point in relation to complaint reporting being discussed within the Clinical Governance Committee meetings. Ms Gould noted that, while mindful of the constraints of confidentiality, the minutes of the Clinical Governance Committee meeting should reflect when discussions and scrutiny of data surrounding complaints had taken place.

b) New Clinical Model

Mr Hussain of RSMUK presented the Internal Audit Report on the New Clinical Model, and explained that the purpose of this report was to look at the implementation of the Clinical Model and how the hospital was monitoring the effectiveness of this change; and highlighted that the report gave reasonable assurance with one medium priority action.

Mr Hussain noted that the review found that there had been clear planning processes when developing the Clinical Model, with comprehensive reporting in place across the hospital's

governance structure throughout the development and implementation phases of the project. He advised that TSH had demonstrated thoroughness in ensuring all key stakeholders were involved and engaged throughout the project. In particular, he noted that management of the project implementation stage had been excellent, led by Ms Merson. He added there were clear reporting lines on roles and responsibilities of each group and a lot of time was spent on contingency planning and prior to handover. Mr Hussain informed the meeting that the medium priority action was around individual service KPI's which would help to assess and evaluate the implementation of the new model. Further, Mr Hussian noted one point for consideration would be to avoid duplication within the terms of reference in future project planning.

Mr Jenkins offered thanks to Mr Hussain and colleagues for the report and agreed around the point of duplication. Ms Merson also thanked Mr Hussain and RSMUK and welcomed this report and advice around clarity of terms of reference and noted the action point related to KPI's.

Mr McConnell also thanked Mr Hussain for the report and the helpful comments and for the assurance this provides.

The Committee:

1. Noted Complaint Audit Report 2023/2024, and commended the work by the team, giving a rating of substantial assurance.
2. Noted New Clinical Model Report, thanking the key teams and staff more widely for their work in this important area.

8 INTERNAL AUIDT

a) Audit Progress Report

Mr Hussain presented the Audit Progress Report and reiterated the point that the Complaints Audit had been completed which had been substituted in place of the Security Audit, which would now take place around October 2024. Mr Hussain added that the Physical Health Audit Review would commence on 15 July 2024 and all remaining reviews have been scheduled.

b) Action Tracking Report

Ms Gould presented the Action Tracking report noting that the action arising from the Clinical Observations Audit had been closed as has the actions surrounding the Patient Monies Audit. Ms Gould noted that although one of the ESG actions had been closed the report does contain updates to other ESG actions that are in progress. Ms Gould ended the update by reiterating that it is a positive report and welcomed the timely update responses by management.

Mr McConnell welcomed the updates.

The Committee:

1. Noted the Audit Progress Report.
2. Noted the Action Tracking Report.

9 INTERNAL AUDIT REPORT 2023/24

Mr Hussain presented the Internal Audit Report 2023/24 and highlighted the key points. Mr Hussain advised the report provided a positive opinion and shows the organisation has an adequate and effective framework for governance, risk management and internal control. Mr Hussain also highlighted the breakdown of the review and directed members to the summary contained within appendix B for further information and details of further enhancements that could be made to ensure the framework remained adequate and effective.

Mr McConnell welcomed the report and the assurances given.
The Committee:

1. Noted the Internal Audit Report 2023/24.

ANNUAL REPORTS FROM GOVERNANCE COMMITTEES

10 GOVERNANCE COMMITTEE ANNUAL REPORTS

a) AUDIT and RISK COMMITTEE ANNUAL REPORT 2023/24

Mr McConnell summarised the Audit and Risk Committee Annual Report for 2023/24 explaining that this contained background information in relation to work undertaken by the Committee as well as member attendance and expressed thanks to members for their attendance at these meetings. Mr McConnell added this report contained recommendations, for the most part relating to financial statements which have been made throughout the year and flagged areas for improvement as well as areas of best practice. Mr McConnell concluded by adding that the report showed that the Committee had carried out their remit for the year and that effective governance arrangements have been in place throughout the year.

b) CLINICAL GOVERNANCE COMMITTEE ANNUAL REPORT 2023/24

Mr McConnell summarised the Clinical Governance Committee Annual 2023/24 to members advising that the report covers the various key reports and work undertaken by the Clinical Governance Committee throughout the year, highlighting that the Committee had fulfilled their remit for the year and that there is an appropriate level of governance from the committee in accordance with their remit.

Mr Currie commented that the report was well written with the format allowing for ease of understanding. Ms Radage echoed the point made by Mr Currie and added that it was lengthier than the other annual reporting submitted. Ms Smith advised that although there has been work undertaken to streamline and standardise all Committee reports, historically the Clinical Governance Committee report has always contained a lot of information however, there may still be some work to be done to condense the report further. Mr Jenkins and Mr McConnell agreed with the points made.

c) STAFF GOVERNANCE COMMITTEE ANNUAL REPORT 2023/24

Mr McConnell highlighted the Staff Governance Committee Annual Report 2023/24 with Ms Radage adding that the report sets out the number of areas that have moved forward but noted that focus will remain on areas of challenge such as sickness absence. She confirmed that this report had been reviewed and agreed within the Committee, and that it did demonstrate that its remit had been fulfilled throughout the year. There was agreement with this across the committee.

d) REMUNERATION COMMITTEE ANNUAL REPORT 2023/24

Mr McConnell summarised the content of the Remuneration Committee Annual Report 2023/24 noting that it provides appropriate assurances and demonstrated that the Committee had fulfilled its remit throughout the year.

The Committee:

1. Approved the Audit and Risk Committee Annual Report 2023/24 to be submitted to the Board.
2. Approved the Clinical Governance Committee Annual Report 2023/24 to be submitted to the Board.
3. Approved the Staff Governance Committee Annual Report 2023/24 to be submitted to the Board.

4. Approved the Remuneration Committee Annual Report 2023/24 to be submitted to the Board.

11 NATIONAL SINGLE INSTANCE (NSI) & NSS SERVICE AUDITS

Mr McNaught presented the National Single Instance (NSI) and NSS Service Audits and highlighted the NSS Audit noting that there is no significant control issues raised for IT services and any issues raised in past years had now been confirmed as being cleared. Mr McNaught added that no control weaknesses in relation to TSH were noted within the audit on the NIS finance system.

Mr McConnell welcomed the report and the fact that there are no significant matters arising that would impact TSH.

The Committee:

1. Noted the National Single Instance (NSI) and NSS Service Audits.

12 EXTERNAL AUDIT ANNUAL REPORT TO THE BOARD AND THE AUDITOR GENERAL FOR SCOTLAND 23/24

Mr Wilkie presented the External Audit Annual Report to the Board and the Auditor General for Scotland 2023/24 and provided some context in relation to areas audited and the rationale for this. Mr Wilkie stated that the intent was to issue an unmodified audit opinion on the Financial Statements and indicated that the report concluded positively across its key areas, and highlighted that within the report there were details of audit recommendations for this year and also a follow up of prior year recommendations.

Mr McConnell noted the proposed clear audit certificate, however he asked for clarity around one unadjusted item referenced within the report and asked for specific assurance that there were no immediate implications in relation to audit work still to be completed. Mr McNaught confirmed that this related to an item left within the asset register that had been fully written off which had no net impact.

Mr Wilkie highlighted that an updated version of the report would be provided as there had been some changes made, as highlighted in the summary, and added that it was important to note that there were no areas of concern to highlight to the Board.

Mr Currie raised a point in relation to financial sustainability, and the risk in relying on non-recurring savings each year. Mr Wilkie advised that whilst the Board did have a higher proportion of non-recurring savings in the current year as well as in 2024/25, the plan was to focus on operational efficiency and look more towards recurring savings where possible.
Mr Wilkie referred to the Management Representation Letter explaining that these are standard confirmations that the Auditors are required to obtain from persons charged with governance and highlighted the contents of this statement to the meeting.

Mr McConnell thanked Mr Wilkie and Mr Blewett for work throughout the year.

The Committee:

1. Noted the External Audit Annual Report to the Board and the Auditor General for Scotland and that it would be submitted to the Board later on the same day.

13 STATUTORY ANNUAL ACCOUNTS 2023/24

Mr McNaught presented the Statutory Annual Accounts 2023/24 and explained that this was provided to help members navigate through the Annual Accounts and highlighted which pages pertain to each area of the Annual Accounts. Mr McNaught noted that there have been minor changes from previous years in the format of the Annual Report and added that the accounts are reviewed and audited by KPMG and directed members to the draft unqualified audit opinion given by KPMG on page 32-35. Mr McNaught ended by expressing thanks to the Finance Team and NSS staff for their diligent work on the year end process.

Mr McConnell expressed thanks to Mr McNaught and the Finance team for preparing the report, noting the positive position detailed within and asked if the Governance Statement was now complete.

Mr McNaught confirmed that once the grading in relation to the Clinical Model Audit is reflected in the Governance Statement and other minor wording changes have been made, that it would then be complete.

Mr Jenkins also expressed thanks to Mr McNaught, the Finance team and colleagues at NSS.

The Committee:

1. Acknowledged that the above points would be reflected in the accounts for signing and agreed to recommend the Statutory Annual Accounts for 2023/24 to the Board for final approval.
2. Noted their thanks to Robin McNaught and the Finance Team and both the internal and external auditors.

14 ANNUAL AUDIT COMMITTEE ASSURANCE STATEMENT TO THE BOARD

The Committee received the Annual Audit Committee Assurance Statement to the Board for 2023/24. Mr McNaught advised that this paper was for the Audit Committee to present to the Board, at its meeting today, to give specific assurance that the Performance Report, Accountability Report and the accounts themselves could to be signed with the Audit Committee's and external auditors' approval within their remit, and on the basis of assurance from the annual reports received from the governance committees.

Mr McConnell noted that this paper brought together all of the assurance documents presented at this meeting of the Committee, including the annual reports of each of the governance committees.

Members noted that the assurance statement would inform the Board in its collective decision for:

- Approval and signing of the performance report
- Approval and signing of the accountability report
- The approval and the adoption of the Annual Accounts which have been separately presented to this Committee and the Board for consideration

Members approved the Annual Audit Assurance Statement for 2023/24 for submission to the Board.

The Committee:

1. Approved the annual Audit and Risk Committee Assurance Statement for 2023/24 for submission to the Board.

15 PATIENT FUNDS ACCOUNTS 2023/24

Mr McNaught presented the Patients Fund Accounts and explained that patients' funds were the balances of money held by TSH on behalf of patients. Mr McNaught added that due to the nature of these accounts an annual independent audit was carried out. This has received an unqualified opinion from Wylie & Bisset. Mr McNaught further explained that accounts for March 2024 were presented to show a summary of the collective patients' income and spending as managed through the hospital patient account. Mr McNaught asked the Committee to recommend to the Board that the he and the Chief Executive were given approval to sign the summary income and expenditure statement.

The Committee:

1. Approved the Patient Funds Account Report 2023/24 to be submitted to the Board for its approval.

16 AUDIT FOR SCOTLAND NATIONAL REPORTS

Mr McNaught presented the Audit for Scotland National Report to members detailing NHS Scotland performance and highlighting the key areas and action points contained within the report The key areas to be addressed are financial pressures, savings, staffing and capital spend. Of the action points Mr McNaught noted that there were eight actions for Scottish Government and two for Scottish Government and Boards together. Of relevance to TSH, was the action to focus on a value based health and care action plan, and continued emphasis on good governance.

There was discussion on the issues highlighted, and how solutions would be identified across NHSScotland. Mr Jenkins concurred with the points made by Mr McNaught and assured members that any points raised within these reports would be reflected on as appropriate.

The Committee:

1. Noted the Audit for Scotland National Reports.

FOR INFORMATION

17 FINANCIAL POSITION UPDATE 2024/25

Mr McNaught presented the Financial Position Update for 2024/25 and explained that the report presented the indicative draft financial position to month two, adding that this showed a small adverse variance at this date, with a year-end break-even position anticipated. Mr McNaught assured the Committee that meetings were held monthly with each directorate to address plans required to achieve and maintain breakeven.

Mr McNaught noted that the main areas of pressure were noted in sections 3.3 and 3.4 of the report and added that these represented known pressures and as such priority will be given to the capital demands for 2024/25, which would result in some intended capital spend for this year being carried over into next year to ensure key priorities were addressed. Mr McNaught ended by adding that at the most recent finance meeting with the Scottish Government, they had been content with the current TSH position and forecast for 2024/25, and had agreed to budgets and increased savings targets.

Mr Currie expressed the significance of financial position reports to help to identify trends at the earliest possible stage and asked about the consequences of delaying capital spend budgets. Mr McNaught advised that the current position remains that any capital spend requirements were to be managed within recurring funding. Mr Jenkins highlighted that within the report, it was noted that there was a commitment from the Scottish Government to fund Agenda for Change aspects however, no funding had been released as yet.

The Committee:

1. Noted the Financial Position Update 2024/2025.

18 WAIVERS OF SFI TENDERING REQUIREMENTS REPORT

Mr McNaught presented the Waivers of SFI Tendering Requirements Report explaining the process required for the formal tendering processing and outlining the reasons when this cannot be adhered to, noting that instances of this happening had fallen slightly in the year to March 2024. Mr McNaught assured members that each instance was closely reviewed to ensure that the use of a waiver was appropriate.

Mr McNaught noted in relation to fluctuations, that these were related to Security, Estates and IT licensing, maintenance and service support which had agreements that ran for two to three years. Mr McNaught ended by adding that there were no items for which this process was not followed when it should. Mr Jenkins assured the Committee that where the tender process was waivered, extensive discussion took place to ensure compliance and place this within the context of requirements which were bespoke to TSH environment.

The Committee:

1. Noted the Waivers of SFI Tendering Requirements Reports.

19 LOSSES AND SPECIAL PAYMENTS 2023/24

Mr McNaught presented he Losses and Special Payments Report 2023/24 and highlighted the key points. He noted that one payment arose from an agreement made towards the end of last year and was finalised and issued in June, and therefore would appear in the 2024/25 statement. He noted the reduction overall from the previous year, and that there were no significant elements that required highlighting to the Committee.

The Committee:

1. Noted the Losses and Special Payment Summary.

20 a) FRAUD UPDATE and b) FRAUD ACTION PLAN

Mr McNaught presented the Fraud Update and Fraud Action Plan to members and explained that these reports provide an update on the progress with counter-fraud matters as dictated by the Scottish Government. Mr McNaught noted that Counter Fraud Services (CFS) alerts issued since the last report were referred to in the paper. He advised that these were being reviewed and circulated as appropriate within TSH adding that all newly reported approaches would continue to be noted.

Mr McNaught highlighted there were no matters arising within the last quarter which required review, and that the Fraud Action Plan was in place and agreed with CFS, with a meeting recently held with them to review the TSH annual return.

The Committee:

1. Noted the Fraud Update and Fraud Action Plan.

21 CYBER CRIME UPDATE

Mr McNaught presented and summarised the Cyber Crime Update which provided an update of the overall ongoing cyber risk position and highlighted two recent areas of risk. Mr McNaught explained that one area of risk, the NHS Dumfries and Galloway cyber-attack was still an ongoing investigation and that TSH had provided support to any affected TSH staff, and ensured appropriate steps had been taken to engage with the Information Commissioner's Office (ICO) who have recently confirmed they were satisfied with the action taken by TSH.

In relation to the second risk, Mr McNaught noted that an issue with a laptop used by a security contractor was under investigation, with action put in place promptly to ensure that no devices which could be of risk were brought on site.

Mr McNaught added that there have been no other national nor local specific security risks raised in the last quarter and assured members that TSH continued to have strong awareness of current risks and to be alert to these as and when they arise. He also noted that cyber security training continued to be undertaken.

Mr Currie referenced the cyber-attack on NHS Dumfries and Galloway and asked if there had been discussion around what learning points had been made to mitigate this happening again. Mr McNaught advised that this would be picked up, going forward. Mr McNaught added that when engaging with external suppliers, assurances were sought on cyber security and this would continue to be factored in for future Service Level Agreements.

The Committee:

1. Noted the Cyber Crime Update.

22 CLIMATE EMERGENCY AND SUSTAINABILITY UPDATE

Mr Walker presented the Climate Emergency and Sustainability Update, highlighting the key areas of the report and summarised the remit of the group.

Mr McConnell welcomed the report and stated that it was particularly useful to see planned work that is due and that the Internal Audit ESG recommendations had been included for context and completeness.

The Committee:

1. Noted Climate Emergency and Sustainability Update.

23 SECURITY, RESLILIENCE, HEALTH & SAFETY OVERSIGHT GROUP

Mr Walker presented the Security, Resilience, Health & Safety Oversight Group report and asked the Committee to note work undertaken by the group.

The Committee:

1. Noted the Security, Resilience, Health & Safety Oversight Group.

24 FINANCE, eHEALTH AND AUDIT GROUP UPDATE

Mr McNaught summarised the update from the Finance and eHealth group highlighting that the report noted the activity of the group and that it was conducting its business as per the terms of reference and that there were no matters which require escalation to the Audit and Risk Committee.

The Committee:

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

25 FRAMEWORK DOCUMENT FOR NHS BOARDS

Ms Smith explained to the Committee that the Framework Document had been developed for NHS Territorial Boards and was brought forward to the meeting for noting, adding that TSH had in place its own framework document.

The Committee:

1. Noted the Framework Document for NHS Boards.

26 ANY RELEVANT ISSUES ARISING

No issues were raised.

27 ANY OTHER BUSINESS

Mr McConnell expressed thanks to Mr Walker for the help and support given to the Committee, in the context of his upcoming retirement.

No other business was raised.

28 DATE AND TIME OF NEXT MEETING

The next meeting will take place on Thursday 26 September 2024 at 9.30am via MS Teams.

The meeting ended at 12 noon.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	24 October 2024
Agenda Reference:	Item No: 21
Title of Report:	Audit and Risk Committee – Highlight Report
Purpose of Report:	For Noting

This report provides the Board with an update on the key points arising from the Audit and Risk Committee meeting that took place on 26 September 2024.

1	Internal Audit	The Committee received progress reporting on audit activity for the current year, including a review of the outstanding actions from previous audit reporting. The Committee reviewed progress on implementation of the plan for the coming year, including the dates for planned audits to commence. One finalised audit was received relating to Consultant Discretionary Points, with an outcome of partial assurance. The Committee discussed the findings and learnings to be taken from the audit, focused on the implementation of policy and governance arrangements. It was noted that this had relevance for the Staff Governance Committee.
2	External Audit	The External Auditors advised progress on work relating to the audit for the current financial year, and this was noted by the Committee.
3	Corporate Risk Register	The Committee received a report on the position on the Corporate Risk Register, highlighting the three risk rated as high, and risk distribution. There were no new risks to be considered. Progress of work to develop the register further was also reviewed, with updates to come back to the Committee.
4	Finance	The Committee received an update on the financial position noting that the expectation of a breakeven position for 2024/25 within the context of the challenging financial landscape. It was underlined that there are increasing pressures in seeking to make the savings requirement.
5	Counter Fraud	The Committee received a quarterly summary of six alerts received from Counter Fraud Services (CFS) and noted that no allegations of fraud relating to TSH had been received in the last quarter.
6	Cyber Crime Report	The Committee received an update including on the lessons learned following the cyber attack experienced by NHS Dumfries and Galloway this year, as well as an email phishing exercise led

		within TSH.
8	Anchors Strategy	The Committee received reporting outlining recent local and national progression of the Anchors strategy and approach. This was in relation to workforce, local procurement and use and disposal of land and assets for the benefit of the community, following the submission of baseline stat to Scottish Government in April 2024. Reporting was received positively given the limitations for TSH as a small national board.
9	Policy Update	The Committee received assurance reporting on the management of policy reviews, led through the Policy Approval Group. The Committee were pleased by the continued good progress in this area, which had previously been an area of concern.
10	Procurement Annual Report	The Committee noted the 2023/24 Annual Report for Procurement, summarising activity. Reporting was based on the current strategy, as well as future planned activity. The range of activity, and skills provided to the organisation were noted, and the Committee were pleased to note the contribution made to support key directorate workstreams.
11	Legal Claims Annual Report	Reporting provided a summary of the claims activity for the financial year 2023/24, against comparative data for previous years. It was noted that no new claims were received during this period.
12	Climate Change and Sustainability	An update was received to outline the work progressed within TSH in support of the NHS Climate Emergency & Sustainability Strategy 2022-2026. The Committee noted excellent progress in this area, and the oversight taken by the Climate Change and Sustainability Group.
13	Committee Effectiveness	The Committee formally reviewed its effectiveness, In line with the Audit Handbook, with all members of the Committee having completed a survey in this respect. This item brought detailed discussion, with insights on the impartiality of the committee within the context of a small board. There was consideration of the interactions between, and roles played by both internal and external audit. It was agreed that the committee contributes effectively to the overall control environment of the organisation, and that this was a helpful review exercise in this regard.
14	Workplan 2025	The Committee received and agreed its workplan for 2025, agreeing that it was a comprehensive plan, and acknowledging that it would be kept under review throughout this period.

RECOMMENDATION

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

MONITORING FORM

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