THE STATE HOSPITALS BOARD FOR SCOTLAND
BOARD MEETING

THURSDAY 19 DECEMBER 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 24 October 2024	For Approval	TSH(M)24/09
4.	**Matters Arising:** **Rolling Actions List: Updates**	For Noting	Paper No. 24/99
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
7.	**Patient Story: The Patient Partnership Group – Reflections on 2024**	For Noting	Presentation
8.	**Patients' Advocacy Service** Introduced by the Director of Nursing and Operations	For Noting	Paper No. 24/100
10.10am	**RISK AND RESILIENCE**		
9.	**Corporate Risk Register** Report by the Acting Director of Security, Estates & Resilience	For Decision	Paper No. 24/101
10.	**Clinical Model – Resourcing** Report by the Director of Nursing and Operations	For Decision	Paper No. 24/102
11.	**Finance Report – to 30 November 2024** Report by the Director of Finance & eHealth	For Noting	Paper No. 24/103
12.	**Bed Capacity Report:** **The State Hospital and Forensic Network** Report by the Medical Director	For Noting	Paper No. 24/104
10.45am	**CLINICAL GOVERNANCE**		
13.	**Carers Strategy** Report by the Director of Nursing and Operations	For Decision	Paper No. 24/105
14.	**Quality Assurance and Quality Improvement** Report by the Head of Planning, Performance and	For Noting	Paper No. 24/106

	Quality		
15.	**Clinical Governance Committee:** Approved Minutes of meeting held August 2024	For Noting	CGC(M) 24_03
	Report of meeting held 14 November 2024		Paper No. 24/107
11.15am	**BREAK**		
11.25am	**STAFF GOVERNANCE**		
16.	**Staff Governance Report** Report by the Director of Workforce	For Noting	Paper No. 24/108
17.	**Whistleblowing Q2 Report** Report by the Director of Workforce	For Noting	Paper No. 24/109
18.	**Staff Governance Committee:** Approved Minutes of meeting held August 2024	For Noting	SGC(M) 24_03
	Report of meeting held 21 November 2024		Paper No. 24/110
11.45am	**CORPORATE GOVERNANCE**		
19.	**Climate Emergency and Sustainability Annual Report 2023/24** Report by the Acting Director of Security, Resilience and Estates	For Decision	Paper No. 24/111
20.	**Whole System Infrastructure Reporting: Do Minimum Business Continuity Option** Report by the Acting Director of Security, Resilience and Estates	For Decision	Presentation
21.	**Board Workplan and Reporting Framework** Report by the Head of Corporate Governance	For Decision	Paper No. 24/112
22.	**Performance Reporting – Quarter 2** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 24/113
23.	**eHealth Annual Report** Report by the Director of Finance and eHealth	For Noting	Paper No. 24/92 *(Deferred from October 2024)*
24.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 24/114
25.	**Annual Review 2023/24** Report by the Head of Corporate Governance	For Noting	Paper No. 24/115
26.	**Any Other Business**		Verbal
27.	**Date of next meeting:** 9.30am on 27 February 2025		Verbal
28.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal

29. Close of Session Verbal

Estimated end at 12.40pm

THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 24/09**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 24 October 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	Cathy Fallon
Director of Nursing and Operations	Karen McCaffrey
Vice Chair	David McConnell
Non-Executive Director	Pam Radage
Medical Director	Lindsay Thomson

In attendance:

Risk Team Leader	Stewart Dick [Item 7]
Acting Director of Security, Estates & Resilience	Allan Hardy
Information Governance and Data Security Officer	Ken Lawton [Item 17]
Head of Communications	Caroline McCarron
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 apologies for the meeting from Mr Gary Jenkins (Chief Executive) and Mr Robin McNaught (Finance and eHealth Director) and Mr Stuart Currie and Ms Shalinay Raghavan (Non-Executive Directors).

Mr Moore noted that Item 18 on the agenda would be deferred to the next meeting in December due to unavoidable circumstances, which meant that the Head of eHealth could not be available to present the report.

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 22 August 2024 was noted to be an accurate record of the meeting subject to minor amendment in terms of the record of attendance.

The Board:

1. Approved the minute of the meeting held on 22 August 2024.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

In reference to Item 9 on the Rolling Action List, it was noted work was progressing in relation to potential additional options for visitor travel to the hospital. This was being coordinated in conjunction with the Carers' Strategy that was currently under development, and would come back to the Board.

The Board also noted that a process had been agreed for walkrounds, including Non-Executive Director involvement and that dates would be confirmed shortly in this respect.

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 the most recent NHS Board Chairs meeting, which had been attended by Ms Rosemary Agnew in her capacity as Independent National Whistleblowing Officer and Ms Liz Humphries as Chair of the Whistleblowing Network. Of particular relevance to the State Hospital (TSH) was the importance of independent, accredited investigators as well as embedding the national guidance at a local level. There was further discussion and reflection by NHS Board Chairs on how to capture and promote cultural awareness, and Mr Moore commented on the work ongoing within TSH and the link to Organisational Development, as well as the potential to learn from other NHS Boards in this area. He also noted that an update had been presented to the Staff Governance Committee in August on the preparations for Speak Up Week. The event had promoted awareness across the organisation, and Mr Moore offered thanks to all staff involved.

Mr Moore also advised that NHS Board Chairs had discussed the level of assurance provided by the Network and Information System (NIS) Audit process, in terms of cyber security risks. It was important to recognise that NIS was one line of defence only, that there was a need for additional measures to address the risk posed of potential cyber-attack, and this was the approach being taken by TSH.

At the end of September, NHS Board Chairs held an away day with the Cabinet Secretary for Health and Social Care in attendance. Mr Moore had taken the opportunity to enquire about progress on establishing the new Forensic Mental Health Board for Scotland. Further follow up had been arranged with both the Cabinet Secretary and with the Minister for Social Care, Mental Wellbeing and Sport. NHS Board Chairs had also received a presentation on the shared lessons to be taken from the Board Goverance the self assessment exercise undertaken, and the further development of Board Improvement Plans as part of the Blueprint for Good Governance.

Mr Moore noted that there had been a Board Development Day on 3 December, which had covered some important areas and had supported constructive discussion. Of note were the presentations on the Carers' Strategy, the work progressing on development of the Medium Term Plan, and also consideration of the resourcing model to support the Clinical Model. Today's meeting included an update on how the model was embedding after the first 12 months.

He noted that it had been a considerable pleasure to attend the Sports Awards Ceremony at the conclusion of Sports Week. Mr Moore thanked all patients and staff who had been involved in the event, which had been very positive in nature.

Mr Moore also highlighted the success of Climate Week in the hospital, and noted the involvement of Ms Fallon in this regard. Ms Fallon provided an update of her activities, especially the range of staff she had met as part of the event. This had included Security and Estates colleagues, as well as Procurement, each of whom had been knowledgeable and helpful in providing background to the initiative underway, or planned. She had also met nursing colleagues (from students to senior nursing staff) and their enthusiasm had been very evident. She thought that it had been beneficial to be able to meet with staff in this way, with a clear purpose and role as a Non-Executive, and provided the

opportunity for helpful discussion. Mr Moore agreed with this, underlining the importance of open access in this way. It may be worth considering a "champion" role within the staff cohort to align with the existing Executive and Non-Executive roles.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

In the absence of Mr Jenkins, Ms McCaffrey provided an update to the Board. She began by echoing the Chair's reflections on Sports Week, and that patients and staff had been enthusiastic to see Board Members at the event, and the crucial impact this had.

She then advised that Mr Jenkins had attended the inaugural meeting of the new NHS Leadership Group, which had replaced the Board Chief Executive (BCE) Strategic Meeting. Discussion at this meeting had included the Lord Darzi Review (in respect of NHS England) and its potential influence on Scotland. The group also addressed the work of the Planning & Delivery Board on vascular and oncology services, and national care planning. She advised that Mr Jenkins had also attended a meeting of the Mental Health & Wellbeing Strategic Leadership Board, which focused on the implementation and monitoring of the Mental Health & Wellbeing Delivery Plan.

Ms McCaffrey confirmed that there was no further update available at this time regarding the terms of reference for the Forensic Governance Advisory Group. In relation to the development of a female high secure service within TSH, funding for the initial feasibility study had not been accepted by Scottish Government at this time and that further work was progressing in this regard. She also confirmed that a meeting was scheduled with Scottish Government to review the Quarter 2 financial return. Alongside this, there were a number of future engagements planned including a meeting with the Minister for Social Care, Mental Wellbeing and Sport and the Lord Advocate for Scotland, on 4 November. The Minister would then be attending the hospital in person to lead the Annual Review for 2023/24 on 18 November 2024. A meeting was planned with the Cabinet Secretary for Health and Social Care on 25 November, as indicated by the Chair's update.

Ms McCaffrey also noted that the Board would receive an update today in relation to the Security Refresh Project, which was expected to be completed by the end of November. Lastly, that a development session planned with Directors and Heads of Service on 31 October, to help shape the Medium Term Plan.

Mr Moore thanked Ms McCaffrey for this update and noted the significance of the new NHS Leadership Group, which may have significant impact on the planning and governance framework for NHSScotland as a whole.

The Board:

1. Noted the update from the Chief Executive.

7 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 24/81) from the Acting Director of Security, Resilience and Estates, which provided an overview of the Corporate Risk Register. Mr Dick joined the meeting for this item, and led the Board through the content of the paper.

He summarised the position, noting that there were no new risks proposed for addition to the register, and that all of the current risks had been reviewed within the scheduled timescales. Mr Dick advised that the Risk Team were meeting with each of the Directors to review and update the risks within each of their remits. He provided a summary of the position in relation to each of the risks within each directorate portfolio, and as reported within the paper. He moved on to highlight the four risks which

were graded as “high”. In relation to MD30 relating to patient obesity, work was planned to review the assessment of this risk more fundamentally, within the wider context of what meaningful actions could be taken in this regard. For ND70, the Board were aware that a detailed review of resourcing was underway which would impact the assessment of this risk – reporting was due to the next Board meeting. He noted that for FD90 in relation to the financial risk faced, this was expected to remain at its current grading, as this would depend on the wider national context for NHSScotland as a whole. Lastly, SD57 relating to Significant Adverse Event Reviews (SAERs) had been moved to a grading of “high” due to the delays in completion of reviews and outstanding actions. There has been pressure within the Risk Team given the number of review required concurrently. Mr Dick concluded his update by outlining the work planned to continue the development of the register. Mr Hardy added that as part of this, there was a need to better define risk based on the data available, to help evaluate the position. He also commented on the positive work taken forward by the Risk Team over the course of the past year.

Mr Moore also acknowledged the significant progress made over the course of the past two years, especially in the understanding of ownership of risk across the organisation, as well as an improvement in the presentation of reporting.

Mr McConnell referred to risk SD51 relating to the potential of security failure, and asked how the Security Refresh project, and its projected completion, would fit with this risk. Mr Moore also reflected on the need to capture the risk that may exist in the post-handover period. This should be considered in terms of the existing risk as defined, and the possible need to scrutinise any risk that may develop going forward. Ms McCaffrey noted the level of scrutiny currently through the Project Oversight Board, in terms of the product post-handover. On this point, Mr Hardy added that it was planned to recruit a new security manager post to take responsibility for monitoring systems following completion of the project, as well as the continued support from the contractor during the two-year warranty period.

Action – Allan Hardy

Ms McCaffrey welcomed the approach through the Risk Team more generally, with a clearer focus on tangible measures that could be taken to mitigate risks, enabling directorate teams to better scrutinise the risks within their remits.

Ms Fallon asked for further clarification of the position in relation to SAERs, noting the increased level of reviews that were overdue, and what was proposed to improve this. Mr Dick advised that the team were working on a better system for approval of finalised reports, which should expedite matters. For progression of the reviews, there had recently been an increase in resourcing within the team, which could be used to manage the review process. In addition to that, there was liaison with the review leads so ensure that they had an understanding of the require timescale, as well as sufficient support through which the take the reviews forward. He noted that it had been an unusual situation to have six reviews being progressed at the same time.

Ms McCaffrey advised that a more structured approach was being taken to the progression of the actions that came of review, to ensure that these were being completed in good time. Reporting came to the Organisational Management Team on a regular basis. Mr Hardy agreed with this approach and gave assurance that the importance of this was recognised.

Ms Fallon also asked about FD96 in relation to cyber security, and if the full risk assessment could be circulated, as recent events had focused attention on this area, and this was agreed.

Action – Allan Hardy

Ms Radage asked about the risks within the Workforce Directorate, noting that consideration was being given to adding corporate risk related to staff absence, and breaches of the Working Time Directive, especially given the continuing issues experienced with long-term absence. Mr Dick confirmed that this was being actively considered and that an update would return to the Board.

Action – Allan Hardy

Mr Moore summed up for the Board, noting in particular the focus from Health Improvement Scotland

on the need for all NHS Boards to improve performance relating to SAERs. He noted the need to review the cyber security risk as had been discussed as well as the need to re-visit the security risk, and whether there was a need to be more explicit in respect of each. Finally, noting that the workforce risks should be assessed in terms of any need for additions to the register.

The Board:

1. The Board reviewed the current Corporate Risk Register and approved it as an accurate statement of risk.
2. Requested consideration of how the following are assessed: security risk, cyber security risk, and workforce risks.
3. Requested further update in terms to need to improve SAERs performance.

8 FINANCE REPORT TO 30 SEPTEMBER 2024

The Board received a paper (Paper No. 24/82) from the Finance and eHealth Director. In the absence of Mr McNaught, Ms McCaffrey provided an overview of reporting noting that the paper presented the financial position to Month 6 (Quarter 2). There was a small adverse variance at this date, with a year-end break-even position anticipated. Meetings were being held monthly with each directorate to address plans required to achieve and maintain breakeven.

She went on confirm that the most recent monthly finance update meeting with Scottish Government had noted that they were content with the current position and forecast for 2024/25, with agreement of budgets and the increased savings target. The next quarterly review meeting would take place on 11 November. Ms McCaffrey confirmed that the planned savings for the nursing directorate had started to be phased in from Month 4, while all other directorates were scheduled evenly across the full year.

She asked the Board to note that there were anticipated due allocations still outstanding, regarding the Agenda for Change pay award. The allocation for the reduction in shift hours had now been received and had been allocated. Further, that the additional current pressures outlined in reporting had been highlighted to Scottish Government, for their review subject to funding availability. The report also noted the
work underway by nursing leadership, with input and analysis from finance, in order to evaluate the recruitment of nursing staff to mitigate the overtime pressures, within the context of achieving directorate savings at the targeted level.

Finally, Ms McCaffrey confirmed that capital demands for the current year were being prioritised against a much constrained position in terms of lack of availability of any additional funds. The areas of key spend were detailed, and any new requested capital items would be considered against the current plan. Forward capital demands and known pressures would form an element of the new Business Continuity Plan now underway, and which was due to be submitted to Scottish Government by January 2025.

Ms Fallon raised the issue of the additional costs pressures being experienced for outboarding costs and also for a specific care package required for a high risk patient, and the likelihood of a further allocation from Scottish in this respect. She also asked for clarification for the projected spend on Distinction Awards. Mr Moore noted that there should be caution around the availability of additional finding, and that contingency planning may be required. Ms McCaffrey noted that this was being absorbed within the nursing budget presently. Mr McConnell noted that in the previous item for discussion, there had been acknowledgement that the financial risk would be expected to remain high.

It was noted that Mr McNaught would be asked to bring back any further information available in respect of these points, in further reporting.

Action – Mr McNaught

Mr Moore referred to the existing list of planned improvement to the hospital estate, and the points raised by the Mental Welfare Commission following their recent inspection. It would be necessary to

make key decisions on the allocation of funds on this respect.

He also referred to the provision for Open University placements, and that the Staff Governance committee had discussed this in terms of the benefits to the organisation of this. Ms McCaffrey agreed, underlining the importance of encouraging students to come to TSH, and then being able to retain and develop staff through this route.

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.
2. Requested a further update on the possibility of additional funding within year; and some clarification on spend on Distinction Points.

9 BED CAPACITY REPORT

The Board received a paper (Paper No. 24/83) from the Medical Director. The report outlined bed capacity within TSH for the period 1 August to 30 September, and added context in terms of the wider issues across the forensic estate.

Professor Thomson summarised this position detailing the flow of patients across services within TSH, and the continued over occupation within the ID service. She advised that there was one patient who had been admitted through exceptional circumstances. She also advised the Board about correspondence that the Forensic Network had received from Scottish Government on 26 September, asking for specific work to be led on capacity across forensic service providers, with a collaborative approach towards resolution. The first meeting was planned for the beginning of November, with an aim to progress this work within the short timescale requested.

Mr Moore asked about this commission for the Forensic Network, as it appeared to be a pre-cursor to the development of a new Forensic Mental Health Board. Professor Thomson agreed and advised that there had been some specific individual cases wherein the patient journey had highlighted the need for a more linear approach and collaboration across forensic service providers.

Mr Moore indicated the need to have a further update on this workstream as it developed.

The Board:

1. Noted the content of report.

10 CLINICAL MODEL – 12M EVALUATION

The Board received a paper (Paper No. 24/84) from the Medical Director, which provided a 12-month evaluation of the Clinical Model since its commencement in July 2023. Professor Thomson led Board Members through the content of the paper, which included the origins and development of the new model, as well as the arrangements that were put in place for the safe transitioning of patients.

Professor Thomson outlined the progress demonstrated in service leadership, with the related governance structure through the Clinical Model Oversight Group (CMOG). She detailed the evaluation of the internal progression of patients through the services, as had been the original aim, and also highlighted the importance of patient feedback which would be a priority going forward. Professor Thomson summarised the impact of patient activity seen to date, as well as the work progressing to better record the recording of activity across wards and services to help support evaluation. However, there was an early indication of a small increase in activity levels, and the aim was to build on this

further. She also provided some background on incident levels prior to the model being implemented,

and levels of incidents since then. Reporting detailed the impact on incident levels in each service area, as well as the context in respect of each; and this was detailed under the previous model, the transition period, as well as the new model. Professor Thomson then detailed the impact on self-harm by service type by way of the same categories, and the conclusions drawn to date.

She provided assurance to the Board on the Implementation Evaluation Process and Timetable, as a three year, mixed method, multi –informant evaluation of the implementation and utility of the new model. She detailed the work which was ongoing in this respect, and which would be brought back to the Board. Further, on the role of the CMOG in relation to the evaluation measures set out against the aims of the model; as well as ensuring that services were working towards adherence to the agreed clinical guidelines. Lastly, Professor Thomson highlighted the summary of the evaluation undertaken, which presented an overall positive picture to date.

Mr Moore thanked Professor Thomson for the detailed nature of reporting, which did provide assurance on the learning that could be taken at this early stage, as well as the actions in place.

Mr McConnell asked whether patient activity levels had recovered in the post pandemic period i.e. had there been an uptick evidenced at that point and what would be the comparison to the pre-pandemic period. Professor Thomson advised that patient activity levels had not recovered to pre-pandemic levels, and that it would have been expected to see an upturn in levels in any case.

Ms Fallon commented that it was helpful to have multi-source feedback, and that the report was helpful in this respect. She added that she had attended the Patient Partnership Group (PPG) and that patents had been discussing the model, and found the experience of progressing through services to be a positive one generally. Ms Radage also found that reporting provided assurance, and was pleased to hear the positive feedback from the PPG. She asked about the Intellectual Disability (ID) Service, and the increased number of incidents recorded, and the way forward in that respect, as well as the impact on staff. Professor Thomson noted that the change in delivery of the ID service has been a major change as part of the model, and this followed on from the previous safety study conducted in 2018, which had shown a higher level of incidents within the ID Service. The change was made to two wards as a more desirable environment, and currently three wards were open. It would be necessary to take a considered view on any further change. It was acknowledged that this could be an area of challenge, and supportive mechanisms were in place for staff. There was a second staff survey underway which may help in this regard. Ms McCaffrey added that it was important to take a balanced view, and that staff should also get the opportunity to work across different services; whilst providing support for development of skills in specialised areas of care as well. She also reflected that core skills were universal across the piece.

Mr Moore asked if staff were contributing to the surveys at a meaningful level, and Professor Thomson confirmed that this was the case, with response rates of 38% to the initial survey, and 33% to the follow-up. Mr Moore summed up for the Board, noting that this detailed reporting had been helpful to the Board and followed on from a previous update provided as a Board Development Day this year. Moving forward, there should be careful assessment of how further reporting would be managed at Board and Standing Committee level.

<u>The Board:</u>

1. Noted the content of reporting.

11 QUALITY ASSURANCE AND QUALITY IMPR OVEMENT

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 24/85) which provided an update on the progress made in quality assurance and improvement activities, since the date of the last meeting.

Ms Merson provided a summary of the key aspects of reporting noting firstly that the Quality Strategy had been approved by the Board at its last meeting. She noted the four clinical audits, each of which had demonstrated reasonable levels of compliance. She summarised the flash report included in reporting, in respect of hospital wide variance analysis. She also provided an overview of the work being progressed through the QI Forum, and provided some further background on the ways in which the training and support offered to staff in this area, had demonstrated some key benefits for the organisation as a whole, as well as the individuals involved. Ms Merson also highlighted the range of workstreams being taken forward through the Realistic Medicine framework, and the continued progress on the Evidence for Quality matrix.

Ms Fallon spoke positively on the continued development shown through the QI Forum, and the building of capacity in the organisation in this regard. She also asked for clarification on the timing of the progress notes recorded, and the time of the incident itself; and Ms Merson noted that further information would be sought in this regard.

Action – Ms Merson

Mr Moore also noted that there had been a 17% compliance on the completion of the National Early Warning Score (NEWS) and that it was to be expected that significant improvement would be made in this respect. Ms Merson noted that there had been a process issue in this regard. Ms McCaffrey added that learning had been l taken from a recent review, and that her expectation was to see the improvement required in the future.

The Board:

1. Noted the content of the report.

12 MEDICAL EDUCATION REPORT

The Board received a paper (Paper No. 24/86) from the Medical Director, to provide an overview of undergraduate and postgraduate training within TSH for the period 1 August 2023 to 31 July 2024, in accordance with the General Medical Council (GMC) Quality Improvement Framework for Undergraduate and Postgraduate Medical Education.

Professor Thomson provided an overview of the report, detailing the provisions made for both undergraduate and post graduate programmes. Reporting demonstrated that this had been a very positive year for TSH with regard to medical education. The hospital provided high quality training through a well-trained and experience Consultant workforce, and TSH continued to be in the top 5% of training schemes nationally.

The Board:

1. Noted the content of the report.

13 MEDICAL APPRAISAL AND REVALIDATION ANNUAL REPORT

The Board received a paper (Paper No. 24/87) from the Medical Director, representing annual reporting on Medical Appraisal and Revalidation as required by NHS Education for Scotland (NES).

Professor Thomson provided a summary of the key aspects of the report, which gave assurance on the appropriate systems on place in this respect, with all medical appraisals and revalidations up to date. She also noted that the Medical Appraisal Revalidation Quality Assurance Review had been submitted to NES, and that their review panel had been satisfied with the system in operation at TSH. The panel had also advised that there would be a return to a fuller review in the coming year.

Mr Moore thanked Professor Thomson for this report which provided essential assurance.

The Board:

Noted the content of the report.

14 STAFF GOVERNANCE REPORT

The Board received a report from the Director of Workforce (Paper No. 24/88) summarising workforce performance, underpinned by a range of metrics.

Mr Wallace provided a summary of the report, focusing on key elements including attendance management, and the small increase in sickness absence of 0.2% during September, meaning that it rose to 8.67%. This was being managed actively at a senior level, to ensure that all elements of support were in place to help staff return to work. It was helpful to place this figure within the context of sickness absence levels at other forensic setting, with it being indicated that these were higher. He also highlighted the positive position on recruitment – with a small number of vacancies across the organisation and a healthy position within the nursing cohort. He also noted the low turnover of staff, which was also positive, and that although there had been a small drop in PDPR compliance levels, performance remained above the national target.

Mr McConnell noted the increase in sickness absence compared to the same point last year, and the cyclical nature of this. Mr Wallace acknowledged the increase in long-term absence, and the particular challenge of absences in excess of 28 days and up to three months. Ms McCaffrey commented on the potential for a peak following the holiday period which would see increases in respiratory disease including Covid-19. Ms Radage and Ms Fallon echoed this point in terms of the challenge across health and social care settings, and welcomed the low turnover figures.

Mr Moore noted the high levels of absence in some areas and departments of the hospital, and raised the challenge of delivering care and possible impact on service delivery. Mr Wallace commented on the importance of looking at all of the metrics within such areas including iMatter reporting and PDPR compliance, to better understand what additional support mechanisms could be taken forward to help to improve the position.

Mr Moore summed up for the Board, and noted that detailed oversight would continue through the Staff Governance Committee on the key issues raised, particularly the action required in relation to attendance management.

The Board:

1. Noted the content of the report.

15 BOARD IMPROVEMENT PLAN

The Board received a paper (Paper No. 24/89) from the Head of Corporate Governance, which provided a six month update in respect of progress on the implementation of the Board Improvement Plan, as part of the NHSScotland Blueprint for Good Governance workstream.

Ms Smith presented an overview of this for the Board, and highlighted the key areas wherein further progress could be made. This included further development of the framing of the Corporate Risk Register, as well as a re-fresh of existing risk assessments. She outlined the work taken forward in terms of stakeholder engagement most notably through the Carers' Strategy, and that the next stage would be the development of a stakeholder map. Ms Smith also noted the work taken forward through the review of how the Whistleblowing Standards were implemented with TSH, especially around external links for confidential contacts as well as revised training within the organisation. In the next six months, there would a change in Executive Leadership as well as in the management of cases. She also referenced the work being led by Organisational Development in respect of the "health" of the organisation, and taking forward culture change. She also summarised the work being led around

succession planning, as well as wider the wider assurance framework and collaborative working with regional and national partners.

Ms Fallon commented positively on the work progressed to date, and the helpful focus that stakeholder mapping would bring, and that this should encompass engagement with patients, carers and with staff. Mr Moore commented on the opportunity for TSH to be an influencer with partners in forensic mental health services, as well as Scottish Government, to support progress in key areas. It was noted that a further update on this plan would return to the Board in April 2025.

The Board:

1. Noted the content of reporting.

16 COMMUNICATIONS ANNUAL REPORT

The Board received a paper (Paper No. 24/90) from the Head of Communications, covering performance during 2023/24 in support of the Communications Strategy 2020/25.

Ms McCarron led the Board through the report, which profiled areas of key achievement. This included raising the profile of TSH through good news stories through local and national media, and social media as well as internal communication campaigns. She also highlighted the continuing advances being made in service delivery in terms of modern methods of communications to add variety and to ensure that existing methods did not become dated. Additionally, there would be focus on the use of resources effectively and also on building capacity within the service including succession planning.

Mr Moore commented positively on the range of work and detail contained within the report, saying that the Communications Service was integral to the organisation at every level, and that this report demonstrated the excellent work taken forward over the past year. Ms Fallon agreed with this assessment, and asked about the position on future recruitment into the department and also about the re- branding exercise for TSH. Ms McCarron confirmed that re-branding was on hold, pending the future of a new Forensic Mental Health Board. Recruitment into the newly defined post in the department would be taken forward early in 2025.

Ms Radage asked about whether there was any room to improve the website even further, for example on analytics. Ms McCarron advised that the refreshed site was working well, and there was limited opportunity to do more. There was the ability to provide feedback online. Mr Moore stated that regular social media activity was noticeable. Ms McCaffrey emphasised the positive impact made on recruitment, attracting staff to the benefits of working for TSH.

Mr McConnell also underlined that this had been a positive year, especially the positive media engagement. He asked about the Memo of Understanding with NHS Golden Jubilee. Ms McCarron confirmed that this was an agreement that had been in place for some time, and provided a two-way engagement process through which support could be supplied.

Mr Moore asked if there was a formal mechanism in place through which staff could provide feedback on the content of staff bulletins. Ms McCarron noted there were upticks in staff engagement in campaigns and news promoted through the bulletin. Informal feedback tended to represent a range of views, but there were no formal surveys undertaken. The department were continuing to refresh the approach, and to create new means of communications e.g. digital newsletters. A key project going forward was the development of promotional videos during 2025.

Mr Moore summed up for the Board, noting the positive work being progressed in this area and provided thanks on behalf of the Board.

The Board:

1. Noted the content of reporting.

17 INFORMATION GOVERNANCE ANNUAL REPORT

The Board received a paper (Paper No. 24/91) from the Finance and eHealth Director, to present the Annual Report for Information Governance. Mr Lawton joined the meeting to provide a summary for the Board. He provided an overview of the key pieces of work undertaken during the year regarding information governance standards, as well as a wider focus on compliance, risk assessment and training. He also summarised the activity on Freedom of Information (FOI) requests and the improvements evidenced.

Mr Lawton also noted the key areas of activity within health records which had included involvement in the further development of the electronic patient record system, as well as development of the Records Management Plan in preparation of a voluntary re-submission of this in December 2025. Lastly, he highlighted the continued progress in areas for improvement identified in the Information Commissioner's Office (ICO) which had previously taken place in November 2022.

Ms McCaffrey offered thanks to Mr Lawton and the wider team for reporting, and the good work evidenced in reporting. There was agreement around the table about the helpfulness of reporting and Mr Moore thanked Mr Lawton on behalf of the Board.

The Board:

1. Noted the content of reporting.

18 e HEALTH ANNUAL REPORT

The Board received a paper (Paper No. 24/92) from the Finance and eHealth Director, and it was greed that presentation of this report would be deferred until the next meeting, as noted at the commencement of the meeting.

19 NETWORK AND INFORMATION SYSTEMS (NIS)

The Board received a paper (Paper No. 24/93) from the Finance and eHealth Director, which provided an update on the Compliance Review taking place this year, as part of the three-year programme of audit in this regard.

Ms McCaffrey asked the Board to noted that the paper confirmed the timing of the next stage of in this process, this being an interim review with full audits on a three-year cyclical basis. The updates required from TSH were in the process of being submitted, with a focus particularly on business continuity and disaster recovery (jointly between Risk and eHealth). The timing of the feedback from this interim review would then follow from the Competent Authority.

Mr Moore noted the earlier discussion on cyber security risk, and the need to place NIS auditing within that wider framework.

The Board:

1. Noted the content of reporting.

20 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report from the Acting Director of Security, Resilience and Estates (Paper No. 24/94) to confirm the updated position. Mr Hardy noted the key highlights of the report, focused on the projected completion date.

Ms Fallon noted that the completion date had again been delayed, and also that costs in respect of the

project continued to increase because of this. It was of concern that the timescale for final completion had continued to slip. There was agreement around the table that this was of concern although this was considered in terms of the high level of complexity of the project. Further, that careful consideration should be given to any lessons to be learned for this project, going forward. It was noted that Scottish Government were being kept closely advised in terms of the project timescale and related costs.

Board Members wished to note their awareness of these issues, and the activity underway through the Executive Team to bring the project to conclusion.

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.
2. Acknowledged concern with the continued delay in bringing the project to final completion

21 AUDIT AND RISK COMMITTEE

The Board received the approved minute of the meeting, which had taken place on 20 June 2024; as well as a summary report (Paper No 24/95) of the key areas of reporting and discussion at the meeting, which had taken place on 26 September 2024.

As Chair of the Committee, Mr McConnell highlighted that the focus of the June meeting had been on the annual accounts process, and related governance reporting. In September, the Committee had received reporting from both internal and external auditors, and had had a helpful discussion around the self-assessment exercise undertaken relating to Committee effectiveness. This had focused on various aspects especially the positive interaction with other strands of governance, and had been a positive review overall.

The Board:

1. Noted the content of the approved minutes ARC(M) 24/03.
2. Noted the update from the meeting held on 26 September 2024.

22 ANY OTHER BUSINESS

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

23 DATE AND TIME OF NEXT MEETING

The next meeting held in public would take place at 9.30am on Thursday 19 December 2024.

24 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.

25 CLOSE OF MEETING

The meeting ended at 12.30pm

Approved as an Accurate Record

ADOPTED BY THE BOARD _____

CHAIR _____

DATE _____

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	April 24	A.O.B	Reporting template review around the monitoring report, and how to re-frame report template	M Smith	February 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.
2	June 24	Workforce Plan – Annual Review	Update requested on gender balance workstream	K McCaffrey	December 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. **December Update:** CMT reviewed, and agreed that extant position to remain for 12 months pending review of Risk Assessment Workstream led by the Head of Psychology.
3	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 Close off**

4	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	February 24	**December Update:** CMT requested further work in this respect to consider how best to support travel scheme, and to link this to the Carers' Strategy, to be further developed and return to CMT for consideration.
5	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 – update included as part of reporting on agenda.** **December: CLOSED**
6 (a)	August 24	Quality of Care	- Quality of Care Reviews implementation	K McCaffrey	December 24	**December Update:** Associate Nurse Director progressed through Patient Safety Forum, and first QoC walkround to commence in January 24.
6 (b)	August 24	Quality of Care	- Consider how to progress informal Non-Executive Walkrounds	M Smith	December 24	**October Update - Separate programme for informal walkrounds – corporate services confirming dates for commencement.** **December Update- programme of dates in place – first walkround completed. Feedback to be routed through Staff Governance Committee. CLOSED**
7	August 24	Whistleblowing	Agree new Exec Lead & re- launch Non Exec Champion role	S Wallace	April 25	**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.

8	October 24	Corporate Risk Register	-Consider Risk SD51 in context of project finalisation – and post completion period and how to re-frame risk -Circulate FD96 full risk assessment – cyber security for consideration -Review Workforce Risks and potential to add to CRR – absence/ WTD etc. - Update on progress of improvement work on management of SAERs	A Hardy	February 25	**December Update:** This will be reviewed fully on completion of the project to understand risk the requirements to mitigate system failure. **December Update**: Risk Assessment included with reporting on agenda. **December Update:** This is under review and will return to the Board. **December Update:** Work remains ongoing to improve SAER process. Risk team will complete this work in the fourth quarter, once all outstanding SAER's are complete
9	October 24	Finance	Updates requested on position on additional allocation, and also info re Distinction Awards	R McNaught	December 24	**December Update:** Updates will be provided in reporting as item on agenda
10	October 24	QI and QA	Further info re timing of progress notes compared to incident – as part of clinical audit reporting – Post Physical Intervention Audit	M Merson	December 24	**December Update:** Clinical Quality reviewed position and this was found to be administrative system error. Patient Safety Forum is taking this forward as part of their improvement plan, in liaison with Practice Development. Posters are been circulated to all wards to remind staff of the importance of accurate record keeping.

Last updated 12.12.24 M Smith

Paper No. 24/100

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2024
Agenda Reference:	Item No: 8
Sponsoring Director:	Director of Nursing and Operations
Author(s):	Patients' Advocacy Service Manager
Title of Report:	Patient Advocacy Service 12 Monthly Report – August 2023-July 2024
Purpose of Report:	For Noting

1 SITUATION

This report serves to provide assurance to The State Hospital (TSH) Board the Patients' Advocacy Service (PAS) continues to meet the needs of State Hospital patients, as set out in the Service Level Agreement (SLA).

2 BACKGROUND

We will highlight progress made within the service including improvements, achievements, and future plans. We also set out any challenges faced, and remedial action taken to overcome these. The following report highlights August 2023-July 2024.

3 ASSESSMENT

August 2023 – July 2024

- Achievements against the Key Performance Indicators (KPI) in the Service Level Agreement this year continue to be met to 83% with statistical reporting evidenced in section 4; The deficits relate in part to factors out with our control in relation to visiting patients within the 7-day timescale and the ward drop in. Patient narratives are in section 7 and accounts in section 12.
- Full and effective use is being made of the budget allocated by the Hospital for the service.
- The additional recurring £20,000 funding received from the Scottish Government following the introduction of the Patients' Rights Bill continues to assist PAS to offer extra support required with hard-to-reach patients.
- Robust arrangements are in place for the growth, professional development and support of all Advocates.

- Positive communication between PAS and TSH continues to foster excellent working relationships beneficial to both organisations and patients.
- Continued increase in the number of contacts, issues and actions with patients in comparison to previous years highlighting the positive working relationships advocates have with both patients and TSH colleagues.
- PAS successfully worked through the tendering process achieving admirable scoring securing the SLA for a further minimum 3-year period.
- Boarding Out and Continuity of Independent Advocacy Protocol finalised.
- Participation in both internal and external consultations, short life working groups and events.
- Planning and moving to an independent database and reporting system further advancing our actual and visual independence from TSH enabling more detailed reporting.

Section 9 of the main report identifies both organisational and service developments planned for the next reporting period.

- Continue to recruit Board Members.
- Update our Patient Board Rep recruitment and training package.
- Continue to find ways to highlight our independence.
- Host an away day for the board to identify priorities and organisational change to progress the service.
- Become more aware of positive ways of working including supported decision making and utilising a variety of communication menthods.
- Responding to consultations and attending short life working groups as appropriate, to champion the voice of our patients in their unique position.
- Complete the annual questionnaire and take forward the views of patients on the PAS service.
- Address issues regarding patients in seclusion or in very restricted positions.
- Work towards more easy read and ID friendly documents such as advance statements.
- Work with social work on a patients rights week to highlight the variety of rights patients have whilst in TSH.

4 RECOMMENDATION

The State Hospital's Board for Scotland are asked to **note** this report.

PATIENTS' ADVOCACY SERVICE

12-Monthly Report

1st August 2023 – 31st July 2024

1 Introduction

The Patients' Advocacy Service (PAS) aims to provide an independent, highly skilled, responsible, and professionally run service within The State Hospital (TSH). Whilst observing the safety and security of the Hospital, the service works independently within it to promote patients as individuals, support and enable them to be fully informed and involved in their care and treatment.

> *"Independent advocacy is about speaking up for, and standing alongside individuals and groups, and not being influenced by the views of others. Fundamentally it is about everyone having the right to a voice, addressing barriers and imbalances of power, ensuring that an individual's rights are recognised, respected, and secured.*
>
> *Independent advocacy supports people to navigate systems and acts as a catalyst for change in a situation. Independent advocacy can have a preventative role and stop situations from escalating, and it can help individuals and groups being supported to develop the skills, confidence and understanding to advocate for themselves.*
>
> *Independent advocacy is especially important when individuals or groups are not heard, are vulnerable or are discriminated against. This can happen where support networks are limited or if there are barriers to communication. Independent advocacy also enables people to stay engaged with services that are struggling to meet their needs."*

Scottish Independent Advocacy Alliance, Independent Advocacy, Principles, Standards & Code of Best Practice (2019).

The Mental Health (Care and Treatment)(Scotland) Act 2003 establishes the right to access Independent Advocacy for those experiencing a mental disorder. The purpose of this report is to inform and evidence the key performance indicators stipulated within the Service Level Agreement, by TSH. The report describes how the service provided by PAS has the ability to adapt to the ever-changing needs of the patient population, especially with the ongoing issues surrounding Covid-19 and the staffing crisis.

1.1 Highlights of the Year

This report relates to August 2023 – July 2024, reflecting on another successful, albeit challenging year, during which we continued to provide an Independent Advocacy service to all patients. Work included this year is as follows.

- Recruitment processes to cover maternity leave; recruitment of a co-opted board member and 3 new board members.
- Continued to support patients during a challenging period of accessing wards due in part to daytime confinement.

- Continued to develop the knowledge and skills of the team by supporting them to attend training and webinars.
- Continued to connect with external advocacy providers including those based in other high secure services in the UK, as well as other independent advocacy services across Scotland.
- Continued to champion the patient voice by responding to important consultations and engaging in short life-working groups relevant to the patient population including the daytime confinement short life-working group and daytime confinement workstream, thus demonstrating patient impact.
- Increased actions and contacts with patients to meet demand for the service.
- Completion of a protocol for continuing to offer patients with independent advocacy when boarding out in general hospitals.
- Continuing our work towards actual and visual independence. This year we implemented our own ID badges along with our own database and reporting system.
- Successful tender process completed to secure the SLA for the next 3 years.

In November 2023 PAS held the 14th Annual General Meeting (AGM) where we delivered our Annual Report for 2022-2023. It was well attended by internal and external colleagues and included a presentation from two of our advocates on the breadth and depth of work to support a patient with Mental Health Tribunals.

2 Governance Arrangements

PAS has dual accountability. Firstly, as an independent company, limited by guarantee to PAS Board of Directors and secondly, as a service commissioned by The State Hospital. We report annually, and in doing so, provide assurance the service meets with the Key Performance Indicators highlighted in the service level agreement. The Person-Centred Improvement Steering Group (PCISG) receives quarterly written reports highlighting the progress with the set KPI's. This year our reports were updated to have more of a human rights focus. The service manager meets separately with the Person-Centred Improvement Lead (PCIL) monthly to provide updates and receive support. Finally, this report, along with our annual report, is circulated throughout TSH to various groups and all TSH staff are invited to attend our AGM.

The tender process went live in early 2024 and PAS completed all required information and submitted our application in a timely manner, which was successful. The 3-year contract with a potential 2-year extension means we can continue to provide a consistent and strong independent advocacy service to patients until a minimum of 2027.

2.1 Finance

The annual cost of the service to the Hospital in the financial year April 2023 - March 2024 was £151,292 which includes recurring funding of £20,000 initially received in April 2012

from the Scottish Government following the introduction of The Patients' Rights (Scotland) Act, 2011. The full financial report can be seen on page 33.

2.2 Committee Membership and Role

The Board of Directors comprises:

- Michael Timmons, Chair
- Innis Scott
- Clare Daly
- Ruth Buchanan
- Monica Griesbaum
- Laura Murphy
- Kirsty McVeigh

2.3 Board Meetings

The PAS Board of Directors held 6 Board Meetings during the year and an AGM. The AGM took place in person in Lanark Memorial Hall. We held 4 online board meetings and 2 in person.

PAS remains committed to supporting our patient representative to meaningfully engage in our board meetings; the patients' voice is invaluable to the service, and it is helpful for PAS Board members to hear directly from the patient representative the issues being faced. Our current patient rep has been involved since January 2021 and actively engages in the Board meetings both by videoconferencing and in-person.

2.4 Workforce

To deliver our KPI's we have a small, dedicated and highly skilled staff team. Our knowledge and experience of engaging with a diverse group of patients continues to expand. Our team continued to provide a flexible, person-centred service to each patient, tailored to their needs. Securing and retaining skilled employees is challenging in such a unique environment, however in this period our staffing has remained static.

As of July 2024, the PAS workforce is as follows:

- 1 x Full time manager 35 hours
- 2 x part-time Advocates 28 hours each
- 1 x part-time Advocate 20 hours

During the period, one of our advocates informed us of her pregnancy and so we have begun recruitment of a fixed term contract for 12 months to cover the deficit and ensure continuity of service.

The service faced numerous challenges this period with the increased patient contact and resulting actions. We saw changes to roles within the staff team due to personal cirumstances. This all meant that we did not have the capacity to sufficiently support the re-implementation of our volunteer programme. We have however, taken steps to identify potential volunteers, and resuming our volunteer programme with a staff lead and support in place, is one of our key priorities for the next reporting period.

2.5 Working Relationships

The PAS Manager maintains regular contact with hospital professionals including the PCIL, PCIT, Lead Nurses, Senior Charge Nurses and Complaints Officer. This ensures effective communication, collaboration and joint working whereby issues are dealt with promptly and locally. In addition, the PAS manager attends other relevant meetings throughout the Hospital and attends each PAS Board meeting providing a report highlighting the work completed between meetings.

As per our last report, the bi-monthly link meeting with a PAS board member and director of nursing has continued to share relevant updates and discuss any issues.

2.6 Training

Staff continue to complete and keep up to date with all mandatory training specified by TSH, including LearnPro modules and in person training. PAS welcomes the opportunity to engage in training and development offered by The State Hospital. This enhances the knowledge and skills of our staff group, positively benefiting outcomes for patients. The PAS team engages in external training through the Scottish Independent Advocacy Alliance (SIAA) and other external bodies.
We actively encourage staff and volunteers to undertake training and continued professional development that will build on their personal development and contribute to improving the service we offer to patients. All staff have a learning plan where they are able to highlight training needs. These plans are reviewed and updated annually.

2.7 Policies and Procedures

Policies for PAS remain integral to the service operating effectively for both staff and patients. We adhere to all TSH policies and PAS specific policies continue to be reviewed when necessary, ensuring they are GDPR and data protection compliant. We continue to increase the number of policies, which have been equality impact assessed. Throughout the last year, we have continued to work on our Staffing Handbook with our human resource service to ensure this continues to be in line with legislation. This piece of work is now complete, ensuring we are up to date on all policies.

2.8 Participation / Integration

PAS staff participated in several State Hospital groups to facilitate and support integrated ways of working benefitting patient care including:

- Person Centered Improvement Steering Group
- Patient Partnership Group
- Child & Adult Protection Forum
- Complaints and Feedback
- SLWG: Daytime Confinement (DTC)
- Workstream on Impact of DTC
- Admissions Processes Group

We also attended external events including:

- SIAA Managers Support Sessions
- SIAA Peer Support Sessions
- SIAA AGM
- SIAA: SMHLR Recommendations
- SIAA: Human Rights Roundtable
- SIAA: Prisons and Forensic Mental Health Group
- Advocacy Managers Group
- Mental Health Service Users and Carers Group
- Meeting with Mental Welfare Commission
- SLWG Trans Guidance
- Mental Health Tribunal Service Users and Carers Group

PAS remains involved with the Scottish Independent Advocacy Alliance (SIAA) providing the distinctive perspective of patients within a high secure environment ensuring this is included in any developmental work. The events attended by PAS over the reporting period can be seen above.

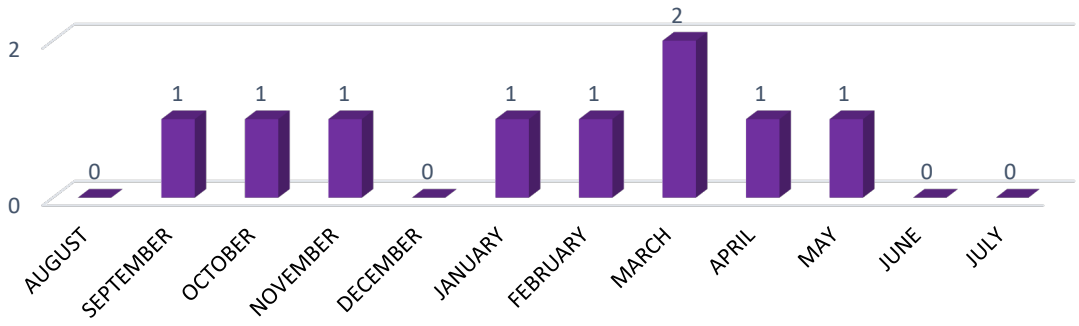
Consultations both internal and external we have responded to over the reporting period include:

- Unescorted Grounds Access
- Human Rights Bill
- National Care Service
- SIAA Outcomes Framework

We are involved in the induction process of new TSH staff, including students from various departments. The graph below shows on a monthly basis the inductions provided to new staff. These include student nurses, student occupational therapists, new social workers and health records staff. This reporting period we also increased our staff inductions to

include new nursing staff and are now on the roster for providing regular inductions to those new to TSH.

Figure 1: Staff Inductions



3 Patient Questionnaire

The patient questionnaire is a requirement of our SLA. The PCIT distributed the easy read questionnaire to all patients and supported some to complete in February 2024. The PCIT collated the questionnaires and provided PAS with a report. 69 of 98 patients responded totaling a 70% response rate which is an increase from the previous questionnaire.

Actions Resulting from the Questionnaire

PAS are extremely grateful to both the patients who took the time to complete the questionnaire, as well as the input from patients and the PCIT in organising the questionnaire, distribution and collation.

The board and staff discussed the results and the key points to focus on are:

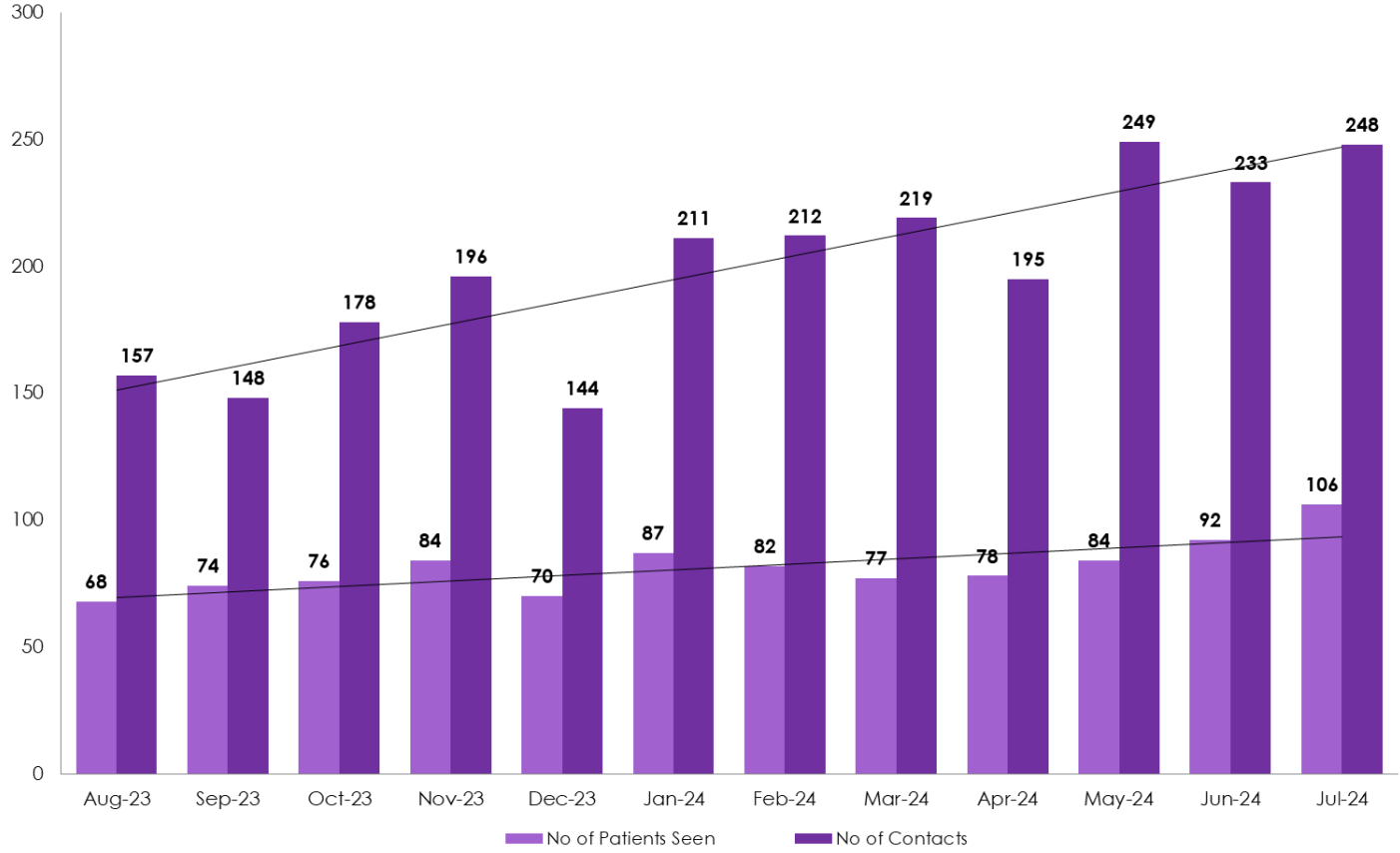
- Increasing Skye Centre availability and resuming the Skye Centre Drop In
- Ensuring to reaffirm our independence regularly to patients

We attended the PPG to inform patients of the report and this was disseminated through the Person Centred Improvement Steering Group.

4 Key Performance Indicators

4.1 Contact

Figure 2: Number of Patients Seen and Contacts

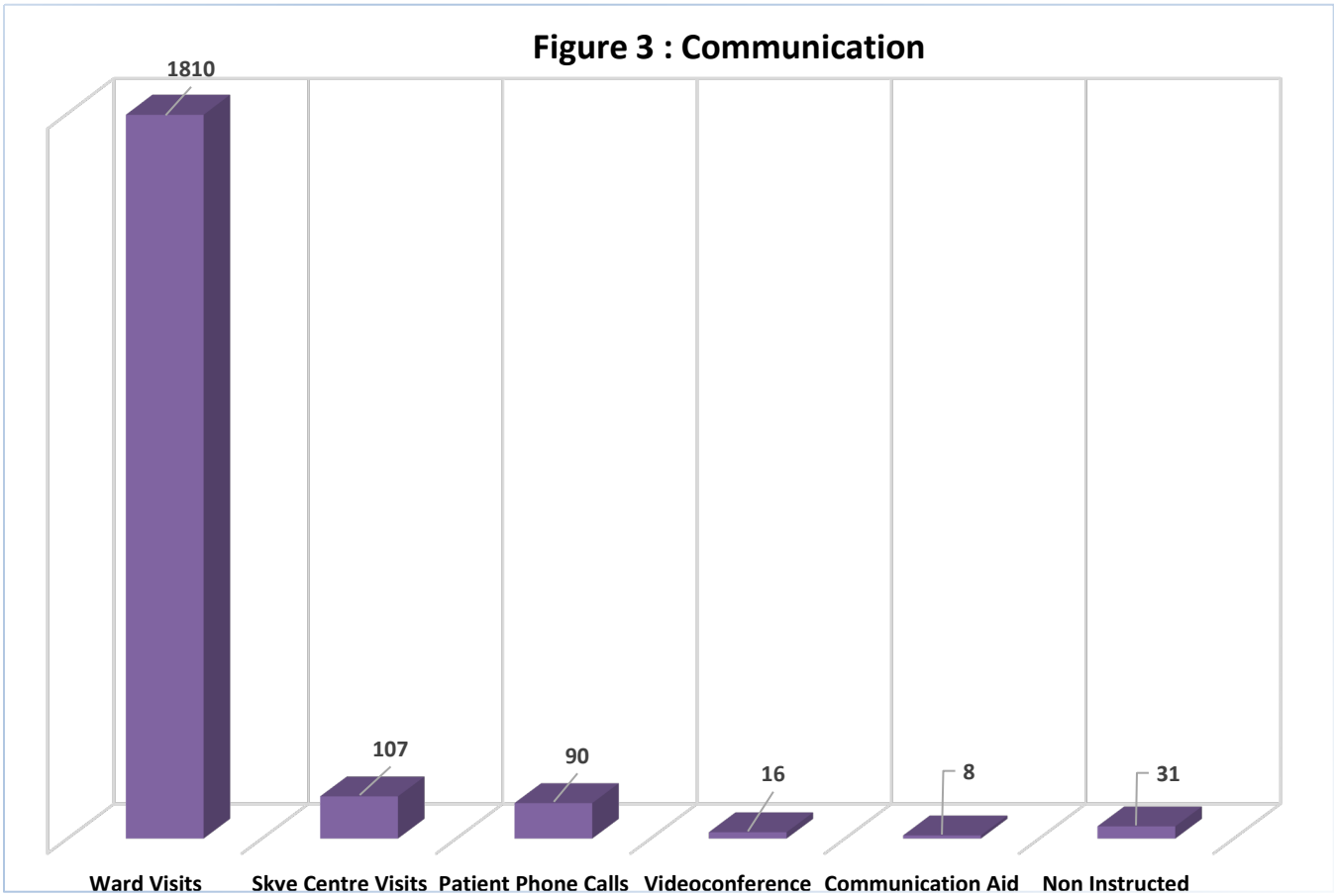


Overall, we made 2390 contacts, an increase of 637 from the previous year equating to a massive 36%, with 133 patients. All patients within TSH are seen by PAS a minimum of twice per year as we ensure each patient is approached prior to their case review, of which they have 2 per year. The average number of contacts per patient throughout the period was 13 highlighting roughly a 4-week discussion with each patient. These figures include 30 patients transferred to medium secure units, returned to prison, discharged to the court. Sadly, there was 1 death throughout this period. There were also 33 admissions.

As can be seen by the trend lines, the number of patients seen remained static across the year but the number of contacts had a sharp increase. PAS has worked hard to ensure an equitable service continues to be provided to all patients offering a range of communication formats. The drops in specific months correlate to holidays where there

are often multiple periods of annual leave correlating with school holidays, although we continue to meet all requests for independent advocacy during these periods.

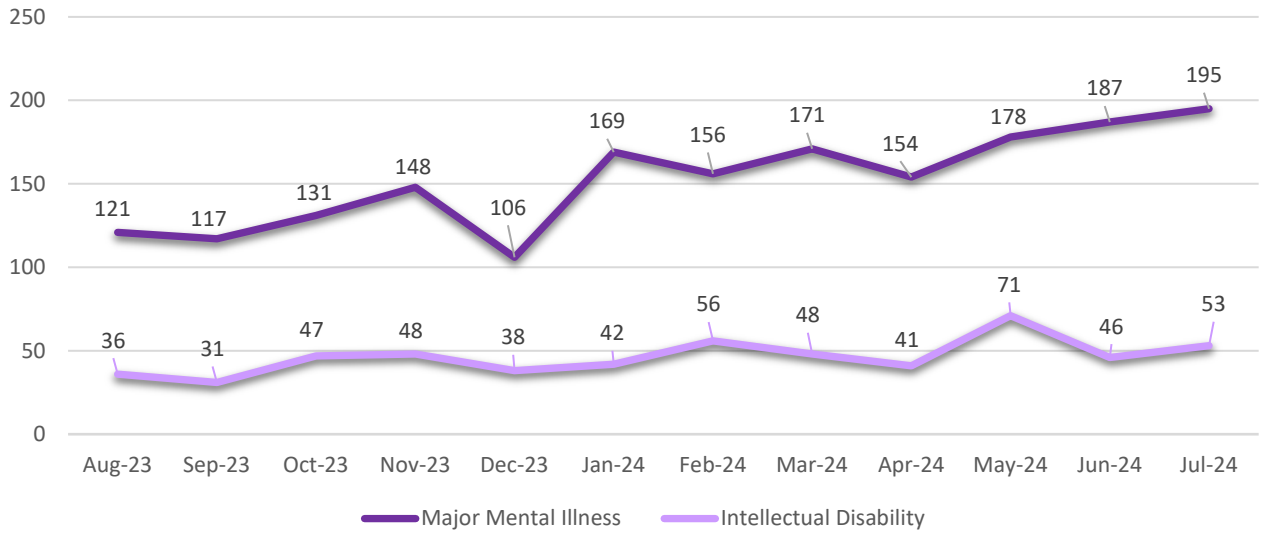
4.2 Communication



The graph above shows how we communicated with patient. This highlights the diverse ways we interact with our patients. As shown, the majority of our contacts are ward based, however patient phone calls have remained consistent this year. Videoconferencing (VC) has continues to decrease. One area to note is the increase in non-instructed advocacy. This is due to increased communication with clinical teams for those patients who lack capacity and the continued involvement of independent advocacy. Another point of note is the increased contacts in the Skye Centre with the resumption of the Tuesday morning Skye Centre drop in offering all patients the option to meet with independent advocacy outside of the ward on a monthly basis when attending personal appointments such as haircuts or visiting the charity shop.

4.3 Major Mental Illness and Intellectual Disability Contacts

Figure 4: Intellectual Disability and Major Mental Illness Contacts Per Month



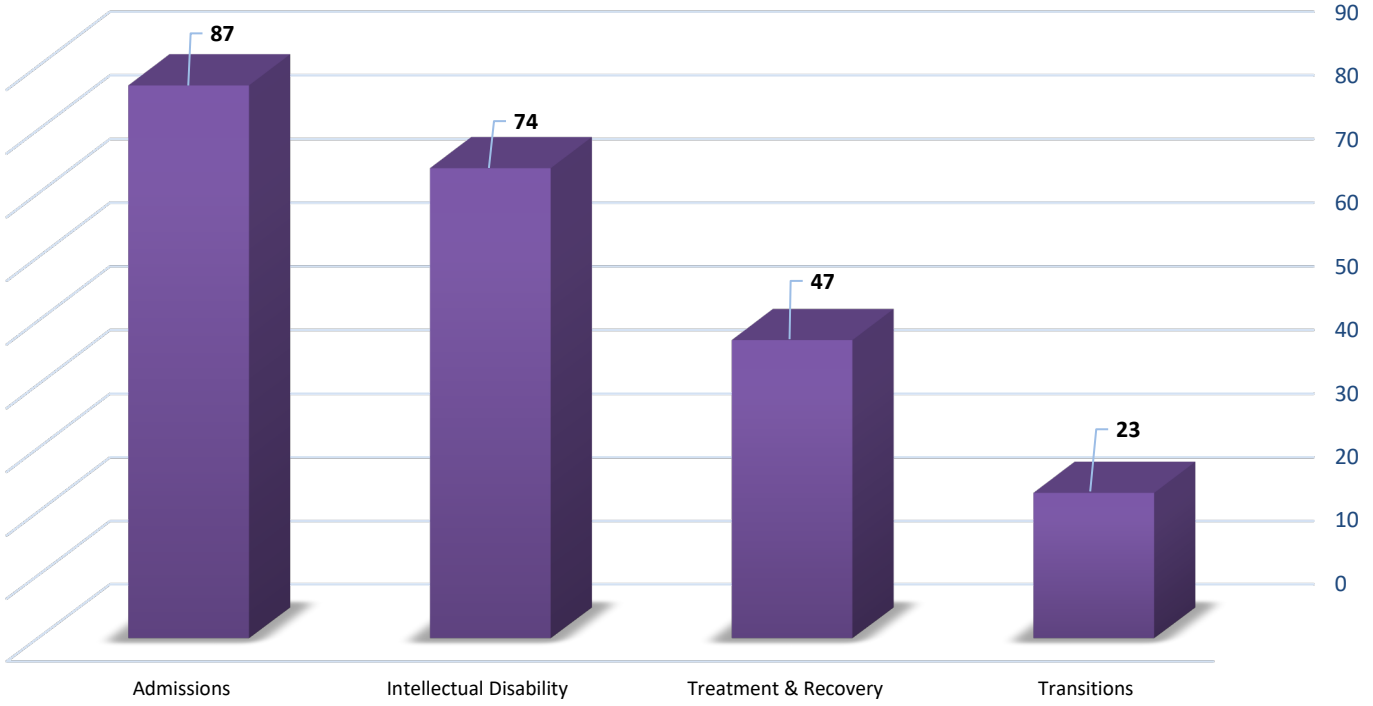
Within the service level agreement, it notes reporting on the number of contacts specifically with patients identified as having an intellectual disability (ID) and the types of intervention provided. Shown in the graph above are the number of contacts per month for those with an intellectual disability and those with major mental illness (MMI).

Throughout the reporting period a variety of issues were discussed with individuals. A lot of the work related to legal work such as supporting a patient to engage the services of a solicitor, facilitating contact with a solicitor or attending solicitor meetings. In addition, there were discussions surrounding CPA's, tribunals and parole boards. Alongside the legal element, there were conversations regarding a patient'streatment, complaints, staff and discussing options.

4.4 Ward Drop In

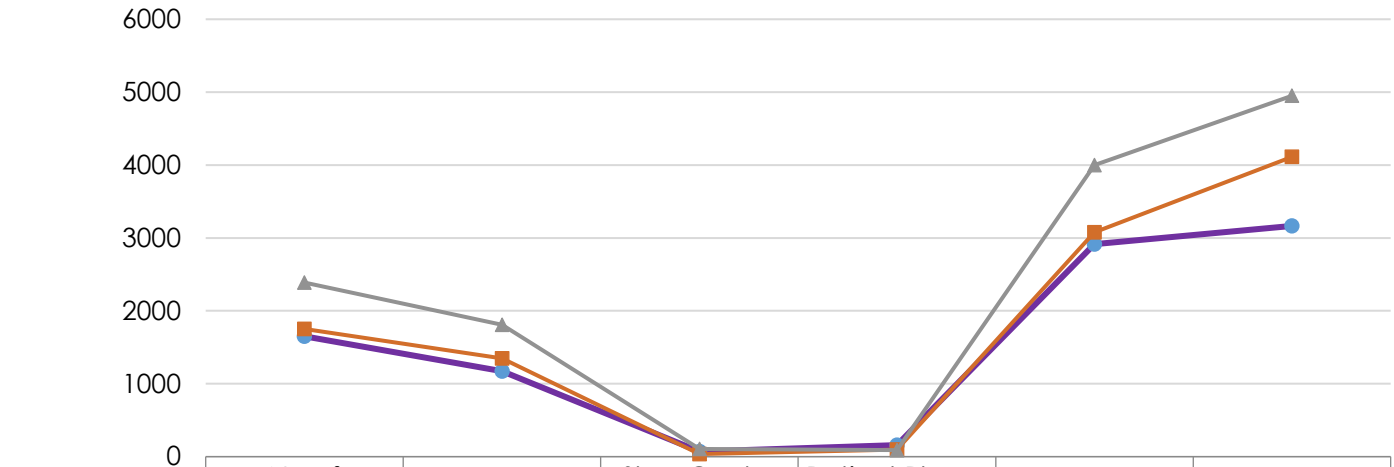
The service level agreement requires PAS to provide a monthly drop-in to each ward. The following graph reflects this target was not fully met during August 2023-July 2024. This is partly due TSH staffing difficulties over the past year where it has been challenging to get on the wards at times due to daytime confinement as well as the increased workload. However, we would note there was only one occasion whereby a transitions ward plus a treatment and recovery ward was not visited as prescribed. Both admissions and intellectual disability wards had a weekly drop in aside from the weeks where the Skye Centre slot was theirs to ensure equitable access for all patients.

Figure 5 : Ward Drop In



4.5 3 Year Comparison (2021-2022, 2022-2023, 2023-2024)

Figure 6: KPI 3-Yearly Comparison

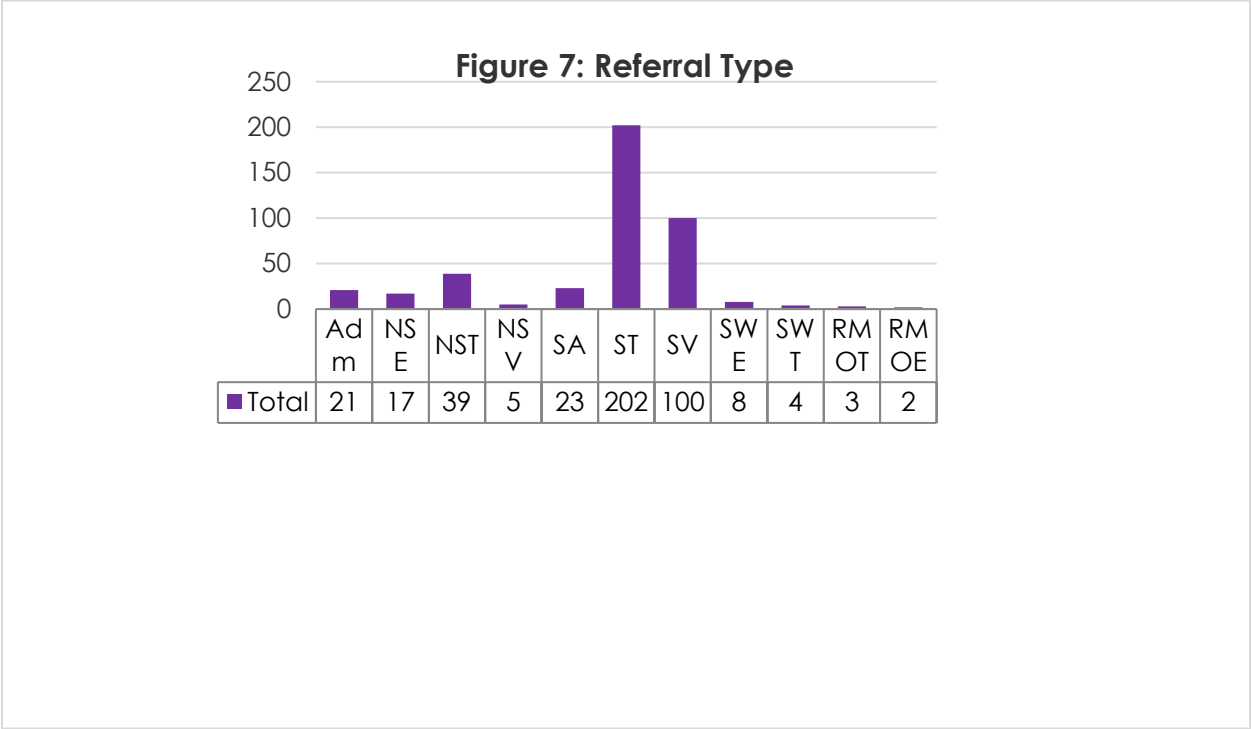


	No of Contacts	Ward Visits	Skye Centre Visits	Patient Phone Calls	Issues	Actions
2021-2022	1652	1174	71	157	2917	3165
2022-2023	1753	1350	36	99	3079	4112
2023-2024	2390	1810	107	90	3998	4950

The figures in the above graph shows an increase over the past 3 reporting periods for the number of contacts which have increased considerably since 2020 as have the number of issues and resulting actions.

We have noted an increase in the amount of CPA's, tribunals and parole boards with which patients request support, with very few declining this service (See figure 13 for more information). One of the other notable increases is the discussion with staff outside of a telephone call or email which offers quick resolve to issues a patient may be facing.

4.6 Formal Referral Routes

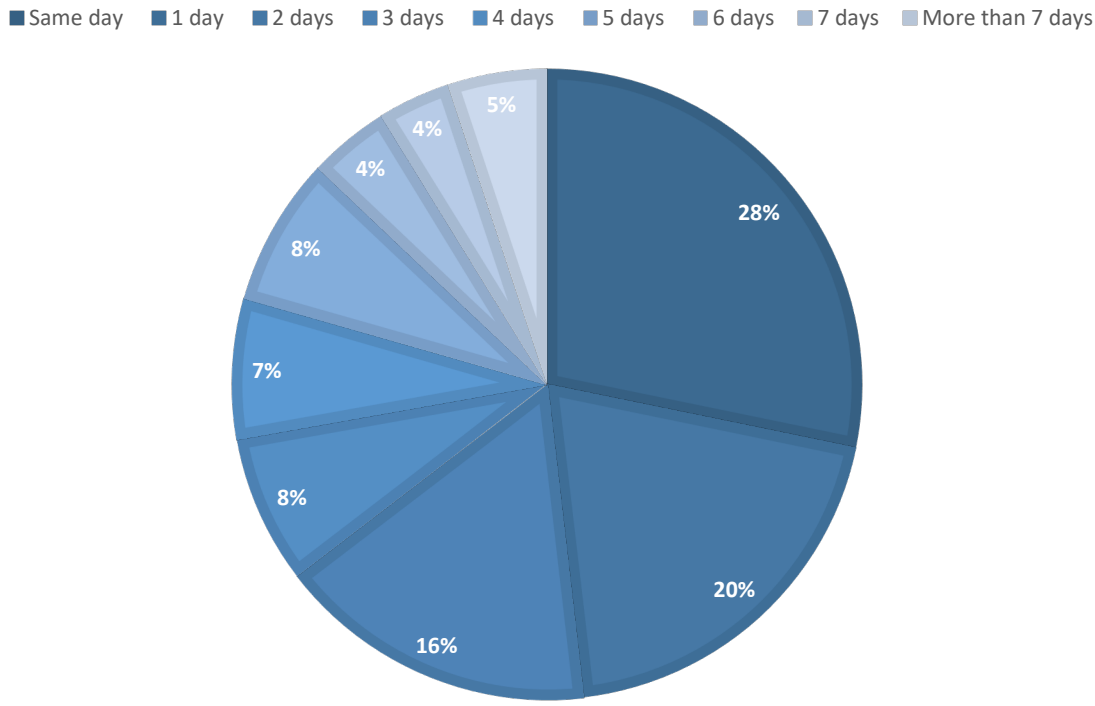


Abbreviations in Appendix 2

The above statistics relate to formal requests to see an Advocate. 77% of referrals came directly from patients, an increase of 4% from the previous report. Hospital staff continue to be vital for us to provide support to patients, with a further 18% of referrals coming from nursing staff, social work and RMO telephone calls and emails, a decrease of 2%. The final 5% relate to new admissions to the hospital.

4.7 Patient Referral Timescales

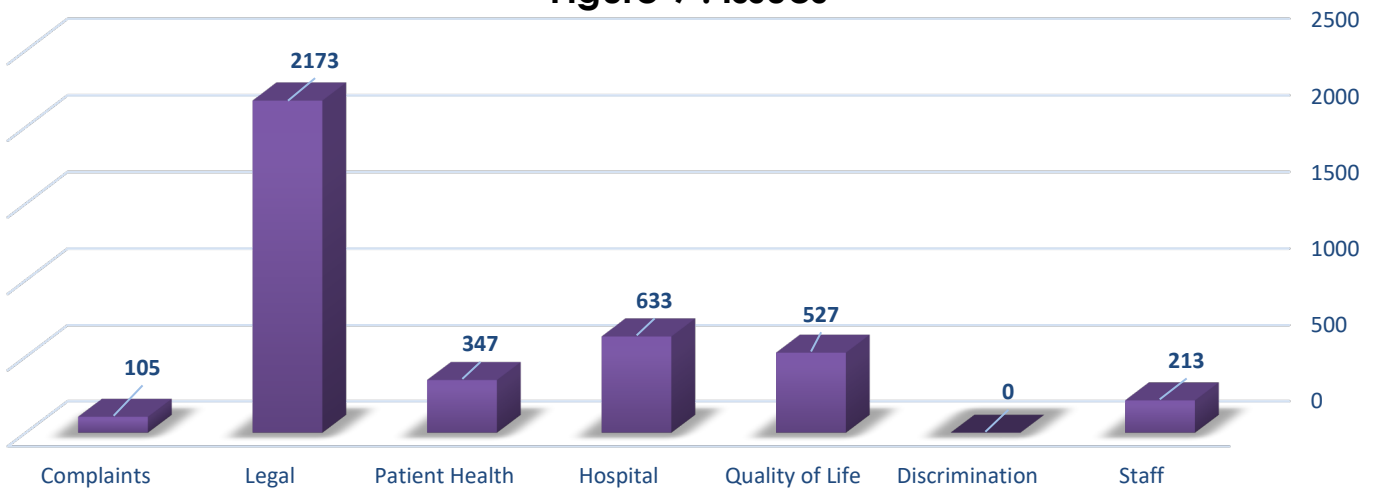
FIGURE 8: ANNUAL REFERRAL TIMESCALE



This graph relates to how quickly PAS responded to requests to see an advocate. As shown, 28% were responded to on the same day with a further 20% seen within 2 days. This highlights 48% of patients were responded to within a 2 working day period. This is an increase from last year's report, which was 37%. 5% of patients were seen out with the 7 day period, which remains the same as previous report. This related to new admissions who nursing staff deemed too risky to visit or patients in isolation who were unable to be seen, therefore out with the control of PAS. We engaged with nursing staff to keep updated of how a patient was and whether they could be visited. It also encompasses those patients who requested advocacy support but wished to wait until their designated advocate was back on site from annual leave or isolation.

4.8 Issues

Figure 9 : Issues



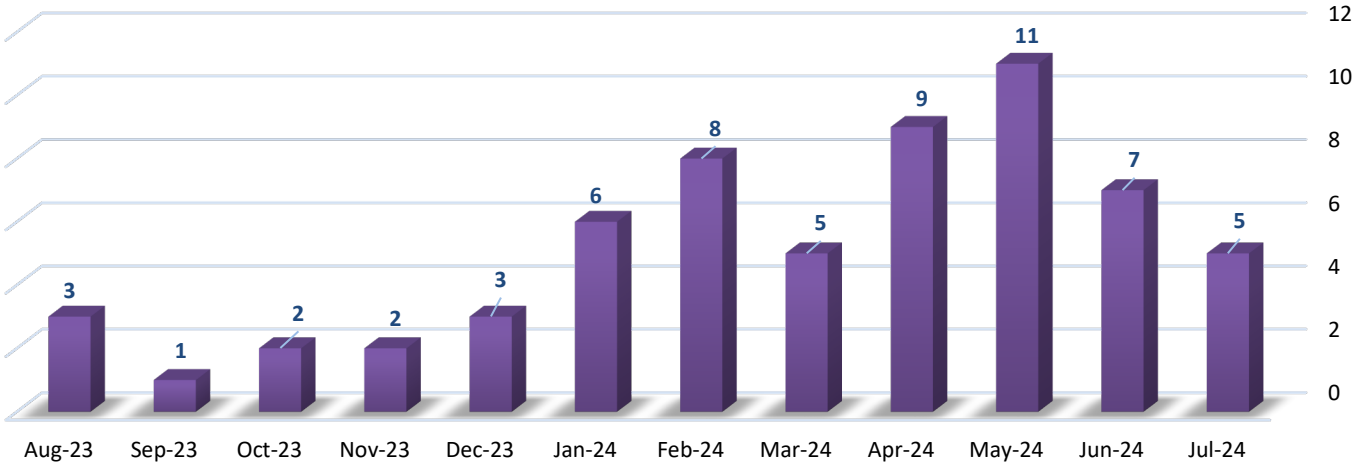
"I just speak to you when I feel like this and you help sort it all."

Patient

The service dealt with 3998 issues, a sharp increase from 3079 in the previous reporting period; of highlight Legal issues remain a majority contributor with 2173 issues (54% of the total, mirroring the previous report). Hospital issues, which cover hospital-based issues including policies and procedures; ward or hub moves and changes to a patient's clinical team account for a further 16%, a 3% increase from the last report. Lastly, quality of life issues relating to food, family, and grounds access etc. account for 13%, an increase of 1% from the last report.

4.9 Complaints and Outcomes

Figure 10 : Number of Complaints Advocacy Assisted With



PAS recorded 62 complaints submitted which is an increase from 49 in the previous reporting period. These complaints related to a variety of factors with no specific patterns in place. Ward closures were also prominent over the period. 3 complaints were retracted by patients wishing to let the issue go. 12 were resolved locally prior to formal complaint and there were 60 discussions of a potential complaint recorded. These discussions encompass informing patients of their right to submit a complaint, discussions about the process but which do not get to the stage of a complaint being submitted.

"The number of complaints upheld is clearly down to the support PAS provides".

Complaints

4.9.1 Complaint Outcomes

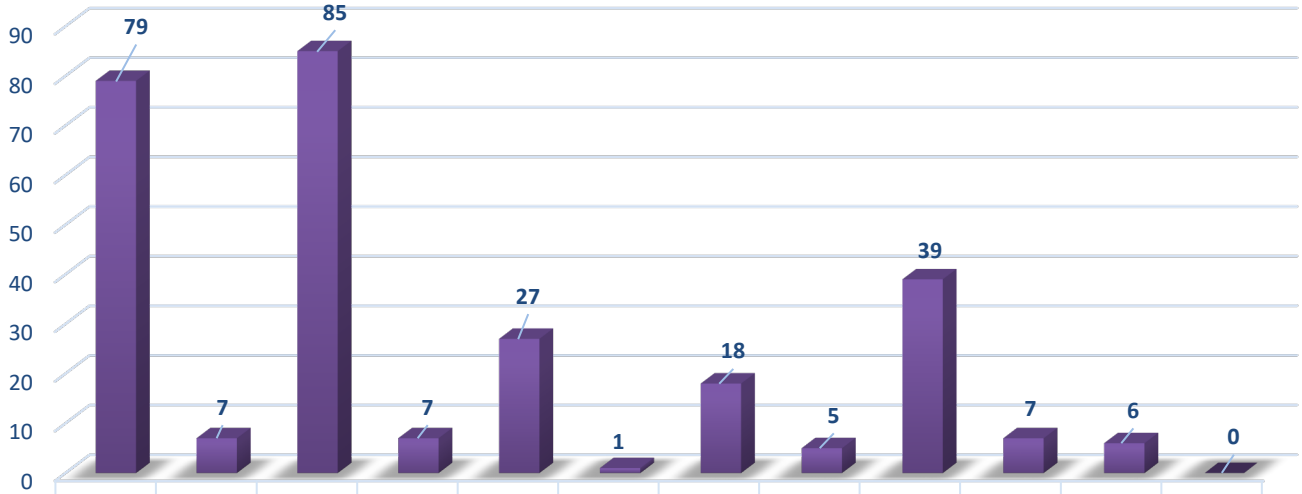
Action	*Patient Outcome*	*Hospital Outcome*	*Total*
Discussion about a complaint	Patient able to express dissatisfaction and discuss their options in line with TSH Policy.	Locally resolved by complaint not being submitted. Patients' rights met.	60
Formal Complaint submitted	Patients' dissatisfaction expressed in line with TSH policy.	Patients' right to make a complaint upheld.	62

4.10 Legal Activity and Outcomes

Activity classified as legal is associated with support and attendance at formal meetings with patients, such as Care Programme Approach meetings (CPA), Adult Support & Protection Investigation (ASPI), Mental Health Tribunals, Parole Boards and Solicitor

meetings with the patient; all of which require to support prior, during and following the meeting.

Figure 11 : Legal Meetings



	Annual CPA's Attended	Annual CPA's Declined	Intermediate CPA's Attended	Intermediate CPA's Declined	Discharge CPA's Attended	Discharge CPA's Declined	Admission CPA's Attended	Admission CPA's Declined	Mental Health Tribunals Attended	Mental Health Tribunals Declined	Parole Boards Attended	Parole Boards Declined
Total	79	7	85	7	27	1	18	5	39	7	6	0

As noted above, we attended the vast majority of legal meetings throughout the reporting period. Of the 281 meetings PAS supported patients' either by attending with them or on their behalf. PAS was present at 90.5% of all meetings, a decrease of 3%. This equates to 100% of meetings patient's requested our attendance at. Those who declined gave reasons such as them not feeling as if there was any need to attend as they knew where they were at in their progress and feeling like they were sufficiently able to advocate for themselves.

4.10.1 Care Programme Approach Outcomes

The following table highlights the patient and hospital outcomes relating to care programme approach (CPA) meetings with further insight into the volume of work-included pre and post CPA.

Action	***Patient Outcome***	***Hospital Outcome***	***Total***
Pre-discussion to Admission CPA	Patient supported to understand the process of a CPA, what is involved, who will attend, support to formulate questions and informed of their options regarding attendance.	Patients' rights to independent support upheld. Patients fully informed of the procedure of a CPA saving staff the time of discussing this information.	23
Attendance at admission CPA	Patients fully aware of what is discussed at the CPA by attending in person or by having advocacy representation on their behalf.	Patient involvement in the CPA process, ensuring patient centred care and accessing their rights to independent support in line with the Mental Health Act.	18
Reflective Discussion separate to admission CPA	Supported to fully understand contents of the CPA, the actions to be taken and plans for the next 6 months.	Ensuring patient understanding of the CPA, reaffirming of actions to be taken saving staff time disseminating this information.	12
Declined advocacy support at admission CPA	Having the choice to decline advocacy support following discussion of the admission CPA.	Patients right to independent support upheld and autonomy in decision-making.	5
Discussion prior to Annual or Intermediate CPA	Patient supported to prepare for a CPA by discussing the format, formulating questions, writing a statement and deciding on their attendance.	Patient centred care ensuring patient involvement in CPA process.	218
Attendance at Annual or Intermediate CPA	Patient and/or advocacy attendance at the CPA. Ensuring the patient voice is heard and questions answered.	Patient involvement in the CPA process ensuring patient centred care and accessing their rights to independent support in line with the Mental Health Act.	79 Annual 85 Intermediate
Reflective Discussion separate to the Annual or Intermediate CPA	Supported to fully understand the content of the CPA. If not in attendance, ensuring they are aware of discussions and actions to be taken.	Ensuring patient understanding of the CPA, reaffirming of actions to be taken saving staff time disseminating this information.	93
Declined advocacy support at Annual or Intermediate CPA	Patient approached and discussed the CPA process ensuring their right to independent support. Making the choice to decline advocacy support at the meeting.	Patient rights to independent support upheld and autonomy in decision making.	7 Annual 7 Intermediate

Pre-Discussion to Transfer/Discharge CPA	Patient supported to prepare for a CPA by discussing the format, formulating questions, writing a statement and deciding on their attendance.	Patient centred care ensuring patient involvement in CPA process.	23
Attendance at Transfer/Discharge CPA	Patient and/or advocacy attendance at the CPA. Ensuring the patient voice is heard and questions answered.	Patient involvement in the CPA process ensuring patient centred care and accessing their rights to independent support in line with the Mental Health Act.	27
Reflective Discussion separate to Transfer/Discharge CPA	Understanding the content of the CPA and plans for their transfer.	Ensuring patient understanding of the CPA, reaffirming of actions to be taken saving staff time of disseminating this information.	12
Declined Advocacy Attendance at Transfer/Discharge CPA	Patient able to self-advocate and make an autonomous choice to decline support.	Patients right to independent support upheld and autonomy in decision making.	1

4.10.2 Mental Health Tribunal Outcomes

The following table shows the outcomes relating to Mental Health Tribunals alongside the pre and post discussions which take place to ensure the patient understands their rights and potential outcomes.

Action	*Patient Outcome*	*Hospital Outcome*	*Total*
Pre-discussion to Mental Health Tribunal	Patients provided with verbal and written information ensuring they understand their legal rights and the process of the Mental Health Tribunal. Supported to actively write a statement if they wish.	Patients informed and supported with their legal rights i.e., their right to a solicitor and support from Advocacy in line with the Mental Health Act.	152
Attendance at Mental Health Tribunal	Patients supported to attend the mental health tribunal or have their voice heard through advocacy attendance in their absence.	Patients' legal rights to independent support met. Patient involvement in their care.	39
Reflective discussion after the Mental Health Tribunal	Patients supported to understand the outcomes of a tribunal and their legal rights following.	Patient supported to understand their rights and the outcomes saving staff time sharing this information.	23
Declined advocacy support at a Mental Health Tribunal	Able to make an autonomous decision and attend with their solicitor or had no challenges and declined all attendance.	Patient supported to understand their rights and make a choice.	7

4.10.3 Other Legal Outcomes

This final table highlights the outcomes relating to other legal matter such as Adult Support and Protection (ASP), Parole Boards and attending meetings with solicitors.

Action	Patient Outcome	Hospital Outcome	Total
New Admissions	Patient is informed of the role of Advocacy, their legal rights and how we can support them through their care and treatment.	Legal obligation to provide Advocacy is met as per the Mental Health Act.	29
Supported during a meeting	Patient supported by Advocacy to attend meeting and express their views.	Patients supported as per their right to have Advocacy support as per the Mental Health Act.	74 – Staff, Independent Dr's, MHO's etc. 53 - Solicitors
Parole Board	Patients provided information regarding their legal rights and the process of the Parole Board Hearing. Ongoing discussion with patients to ascertain levels of understanding and support accordingly. Statement written and submitted in advance if desired.	Patients informed and supported with their legal rights i.e., their right to a solicitor and support from Advocacy.	51 Pre-Discussions 4 Reflective Discussions 6 Attended 0 Declined
Adult Support and Protection	ASP referral made when patient feels or is deemed at risk. Advocacy support to attend the meeting.	Hospital fulfilling legal obligation to support patients through ASP process.	39 Discussions 20 Attended 0 Declined

4.11 Advance Statement Outcomes

The table below shows the outcomes for both the patient and hospital of this input from PAS.

Action	Patient Outcome	Hospital Outcome	Total
Advance Statement Completed	Patient's wishes expressed regarding future care and treatment giving a guarantee the clinical team will take these into account.	Fulfilling legal obligation, providing knowledge of Advance Statements and support to complete these. Advance Statements are person centred, considering patient's wishes.	17 Completed Advance Statements

		Accurately recording and storing Advance Statements with medical records.	9 Updated Advance Statement 241 Discussions

5 Progress to Actions of the Last Report

Action	Outcome
Organisational:	
Continue to recruit Board Members.	Ongoing. The advert remains live on Volunteer Scotland where we respond to requests. 3 new board members recruited with a variety of expertise.
Updating patient rep recruitment and training materials.	Not achieved due to organizational pressures.
Update our staff handbook to be current with legislative changes.	This has been completed and is now fully updated.
Further expand our knowledge by maintaining current training and continuing to attend relevant courses and webinars.	Achieved, all staff completed human rights training.
Continue to find ways to highlight our independence.	Achieved, we have successfully moved to our independent database system.
Prepare for the upcoming tender process.	Achieved, we ensured training was in place for the service manager and regular communication was had with the Nursing director to ensure a quick and easy process when the tender was released.

Service:	
Become more aware of positive ways of working such as with supported decision making.	Achieved, a variety of communication methods are in place to support patients to share their views.
Remain committed to responding to consultations as appropriate, to champion the voice of our patients in their unique position.	Achieved.
Complete the annual questionnaire and take forward the views of patients on the PAS service.	Achieved, the patient questionnaire was completed.
Further enhance our ward drop in service and how this can better support our patients.	Achieved, we have implemented a weekly drop in for the admissions service to best support them during the first 12 weeks of their time in TSH.
Address issues regarding patients in seclusion or in very restricted positions.	Partially achieved, we have approval from PCIG to progress and have started working on the protocol.
Construct an admission booklet for new admissions to TSH detailing the role of advocacy and the support we can provide.	Not achieved as TSH are working on the admission documentation patients are provided to ensure this is not overwhelming. Explored whether this is something which could be digitalized and available when digital inclusion resumes.
Explore the options for having our own independent database.	Completed, we moved to our own independent database along with our own reporting service ensuring we are further independent from TSH.
Continue to work towards independent email addresses.	This has been partially achieved with amendments made however, we are exploring whether this is currently achieved in other secure services which provide independent advocacy.

Finalise a protocol on Patients Boarding Out.	Finalised and approved by TSH. Any use will be included in future reports.

6 Areas of Good Practice

We continue to maintain good practice and meet requirements of the Service Level Agreement by:

- Review of Policies and Procedures
- Monthly support sessions with all staff
- Ongoing staff growth, professional development and training
- Approachable, unbiased, and visible service
- Positive and professional relationships with stakeholders and other professionals relevant to patients and independent advocacy
- A variety of expertise within PAS team providing knowledge and experience in a unique setting
- Flexibility to adapt and meet the needs of TSH and patient group as required
- Annual feedback on the service from patients with patient involvement on the development of the Patient Questionnaire such as the Skye Centre Drop In
- Development of projects which benefit the patient group positively, for example Boarding Out Protocol and patients in restricted positions.
- Concerns raised on behalf of patients to ensure policy and practice is followed.

"Think it is really important the advocacy is independent. PAS staff always treat patients with respect and trust. Patients are able to open up about care and treatment due to trust. I feel PAS should be involved in more things for patients like court cases, CTMs as they have an unbiased approach. I would like PAS to be available in the Skye Centre drop-in."

Patient

7 Patient Stories

7.1 Missing Property

Patients who come to The State Hospital tend to require more support than those in other services; this is often due to their current mental health. We noticed an increase in the number of newly admitted patients with missing property on arrival. This can be frustrating for patients as they are limited in what they can do to resolve the issue. PAS identified ways to support patients with this issue to reduce this added stress.

PAS can support patients get a copy of their property list in TSH, sometimes property can be stored in various areas due to restrictions. However, for those that have property that is not within the hospital, PAS can support patients by contacting the relevant service they were admitted from to discover what property is missing. At this stage, if the property is located in the prior service we liaise with social work colleagues to ensure this can be returned. In the case where property is lost, we can support the patient through the claims process for the relevant service. This ensures patients understand the rights they have in relation to their property, they feel heard and listened to throughout the process and we can keep them updated on the progress. With the influx of patients in quarter 3, this was something patients raised with us regularly and we were able to ensure their property was located and rightly returned to them. In addition, this builds trust in ensuring that we as independent advocates are detailing the process, following through and feeding back to patients, which encourages them to approach us with other issues they may face.

Missing property can also occur at other stages of a patient's journey. Again in quarter 3 we had a few patients from the T&R service approach us regarding property they were unable to locate, in these circumstances we can support a patient to complete the claim form, or alternatively in cases where the claim form is unauthorised, go through the complaints process. At each stage we ensure patients are aware of all rights they have in relation to missing property to establish a positive outcome.

7.2 Subject Access Requests to Court

With much of the information and relevant forms being online patients are unable to access these Within TSH. Further to this, patients often do not have access to any forms of Identification, which may be requested to prove identity when accessing information, further affecting their ability to exercise their rights. In this quarter, PAS noticed an increase in patients seeking support to access their personal information held by the courts.

Two patients wanted to access court transcripts from previous hearings. An information search by PAS revealed this could be done by completing a Subject Access Request, which can be downloaded from the Court website and two forms of ID would be

required. The patient wanted to go through this process but did not know how to provide the required identification. PAS initially sought advice from security managers regarding how this could be facilitated. The information received was that although the hospital would be unable to provide proof of identity for the patient, a letter could be requested from RMO confirming identity. PAS then had subsequent discussions with the Data Protection Officer, who advised providing photo identification is not a legal requirement and if a suitable alternative is provided, i.e. a letter from the RMO, this should be acceptable. Therefore, it would be a breach of patient's right to access his personal information if this were to be rejected, as he is unable to provide this due to current circumstances, out with his control.

Once all information was obtained this was discussed with the patient, who was happy to request a letter from the RMO to complete the required forms. PAS facilitated this by printing out the form and relevant information for the patient, as well as requesting the letter confirming the patient's identity from the RMO. The patient then filled out the forms with support from independent advocacy, who then sent these in the post on his behalf. When this was not returned within the stated timescale of 4 weeks, PAS contacted the Court to request an update and ask when this would be sent to the patient. Following this, the documents were sent directly to the patient. The patient did not wish to discuss the contents of the documents with the independent advocate and there was no further input. However, if the patient requested, independent advocacy would have gone through the documents with them to ensure they understood the contents and carried out any further work as required.

Support from independent advocacy in finding alternative solutions ensured the patient was able to access their own personal information, as is their right, and not be disadvantaged due to the restrictions imposed on them within The State Hospital. Furthermore, now this procedure has been identified it will be implemented for patients in the future where identification is requested.

"I am comfortable talking to you, I can be myself when I speak to you and not worry that everything is going to be reported to everyone. You are a really good listener."

Patient

7.3 Legal Documents

PAS have a wealth of knowledge, relating to the law and legal issues relevant to patients within TSH. This includes supporting patients with wills, funeral plans, ASP referrals, name changes, access to records, access to birth certificates or ID documents and completion of advance statements.

PAS liaises with relevant teams, organisations and professional's internal and external to TSH to ensure the patient has all the information they require to make an informed choice about any given matter. PAS supports many patients to complete documents on their behalf, or to liaise with the service necessary to gain the outcome they are looking for.

By having a consistent team with a positive working relationship, we are able to discover the processes and relay these to patients allowing them to take action in their own lives with the appropriate support required.

Many of the legal issues mentioned above can involve lots of work, relationship building and multiple conversations with patients to ensure they have all the information and have had the time to consider all of their options. For instance, when discussing completion of a will or a funeral plan, PAS needs to be sensitive and understand this can be a difficult process for many.. At all times we ensure to check in on how the patient is feeling and if there is any need to refer the matter to another team such as nursing or psychology for additional support. It is important to PAS to ensure all patients understand their rights in relation to legal matters and have the option of support to act on these rights.

"Really pleased you won the tender, a lot of us were anxious about losing you. The relationships you have with patients are really good and that means a lot to us. I have been the recipient of great support from Advocacy."

Patient

8 Future Areas of Work and Service Development

8.1 Organisational

PAS remains committed to providing the highest quality independent advocacy service to TSH patients. We continue to develop the service to meet the needs of the changeable patient group and the changing environment we work in. As an organisation we aim to develop in the following areas:

- Continue to recruit Board Members.
- Update our Patient Board Rep recruitment and training package.
- Continue to find ways to highlight our independence.
- Host an away day for the board to identify priorities and organisational change to progress the service

8.2 Service

As a service, we continue to look at ways to improve in the following areas:

- Become more aware of positive ways of working such as with supported decision making and utilising a variety of communication methods.
- Responding to consultations and attend short life working groups as appropriate, to champion the voice of our patients in their unique position.
- Complete the annual questionnaire and take forward the views of patients on the PAS service.
- Address issues regarding patients in seclusion or in very restricted positions.
- Work towards more easy read and ID friendly documents such as advance statements.
- Work with social work on a patients rights week to highlight the variety of rights patients have whilst in TSH.

"I use Advocacy regularly, I think I speak for majority of patients when I say we would be lost without Advocacy."

Patient

9 Financial Report

Income and Expenditure Report

For the period from 1 April 2023 to 31 March 2024

	£
Gross Income	151,440
Gross Expenditure	138,196
Incoming Resources	
Government Funding	151,292
Bank Interest	148
	151,440
Cost of Charitable Activities	
Employment Costs	115,909
Establishment Costs	1,798
Social Security	5,359
Print, Post, Stationery	135
Subscriptions and donations	429
Training	175
Computer Costs	8,586
Trustees/Meeting Expenses	416
Sundries	847
Advertising	243
	133,897
Governance Costs	
Accountancy Fees	2,824
Professional Fees	1,475
	4,299
Total Resources Expended as per Account	**138,196**
Cash & Bank Accounts	**64,430**
Liabilities payable in one Year	4,209
Net Current Assets	**60,221**

10 Next Review Date

The Patients' Advocacy Service Annual Report will be available to The State Hospital Board from August 2025.

11 Reference List

Equalities Act (2010), [Online], Available at https://www.legislation.gov.uk/ukpga/2010/15/contents

Scottish Independent Advocacy Alliance (2019), Independent Advocacy, Principles, Standards & Code of Best Practice. [Online], Available at https://www.siaa.org.uk/wp-content/uploads/2019/10/SIAA_Principles_Standards_Best_Practice_report_2019.pdf

The Patients Rights (Scotland) Act (2011), [Online], Available at https://www2.gov.scot/Topics/Health/Policy/Patients-Rights

The Mental Health (Care and Treatment)(Scotland) Act (2003), [Online], Available at http://www.legislation.gov.uk/asp/2003/13/contents

12 Appendix 1

Abbreviation	Full Name
Adm	Admission
MHOT	Mental Health Officer Telephone
NSE	Nursing Staff Email
NST	Nursing Staff Telephone
NSV	Nursing Staff Verbal
SA	Self-Answer machine
ST	Self-Telephone
SV	Self-Verbal
SWE	Social Work Email
SWT	Social Work Telephone
RMOT	Registered Medical Officer Telephone
RMOE	Registered Medical Officer Email

Paper No. 24/101

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2024
Agenda Reference:	Item No: 9a
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 (CRR)

N/A

3.4 Corporate Risk Register Updates

HR

HRD112- Failure to Comply with Level 2 Refresher Training – A reduction in PMVA Lv2 refresher training compliance was highlighted to OMT in October 2024, and the risk rating on the corporate risk register was subsequently increased from low to medium. Risk has been increased to Medium following a reduction in the level of compliance from 95.3% in March 24 to 78.4% a reduction of 16.9%. Acceptable minimum compliance is 80% Training sessions have been scheduled to improve figures and situation is being monitored.

Medical

MD30 Failure to Prevent or Mitigate Obesity – This risk is under review following the relaunch of "Moving towards a Healthier State Hospital: A whole system approach" Agreement for risk to be reviewed with the Supporting Healthy Choices Group. An update will be available to the board in March on progress.

MD32 Absconsion of Patients – Risk to be combined with SD50 Serious Security Incident. SD50 contains reference to the risk of absconsion and fits under the criteria of serious security incident. Control Measures specific to the risk will be noted in SD50 including the Clinical Teams Role in the process. Noted that the number of incidents is 0 in recent years.

MD33 No Doctor On Site Out of Hours between 5pm & 6pm – Risk to be moved to Local Risk Register. No incidents recorded that cause concern relating to the issue and other control measures are in place to reduce the risk.

MD34 Out of Hours Medical Cover – Risk assessment to be updated with up to date information.

Corporate

CE10 Breakdown in Corporate Governance and CE13 Inadequate Compliance with CELs and other Statutory Requirements are to be combined following a review. It was noted there were similarities in the hazards and control measures and by combining will allow a more streamlined approach to managing the risk.

CE15 Impact of Covid Statutory Inquiry – Risk is to be reduced to low following a review of the impact the inquiry has had so far. The Corporate Team has successfully managed the impact of the enquiry alongside other work pressures, the team has also recruited vacant posts which builds further resilience on any future impact. Awaiting final appointment before reduction takes place. Risk will be monitored should the impact of enquiry increase pressures on the service.

Due to other work pressures, the meeting to review the Corporate risks managed by the Chief Executive was postponed. The meeting is currently being rescheduled for late December/January to review risks and discuss additions to the overall risk register.

3.5 High and Very High Risk – Monthly Update

The State Hospital currently has 4 'High' graded risks:

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

Monthly Update:

Obesity/overweight figures for Nov are as follows; 86.1% with 4% refusals/data missing.

- There is a positive shift being seen in the numbers overweight with a reduction observed in obese category 1 (positive downward shift).
- SHC actions; Case study exploratory work to look at new admission patients are being integrated into admissions SLT work stream to support the mitigation of weight gain following admission.
- A SLWG is looking at the shop environment.
- The project group are supporting options for increasing physical activity.
- Health psychology training to support staff knowledge around behaviour change has been delivered.
- Average physical activity targets have seen that seasonal decline along with security measures, showing a drop from a median average of 68% to 55%.
- Use of GLP -1 agonists continues with consideration to wider remit of use given the new Scottish Government Consensus Statement issued.

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. This risk will be updated to “Failure to Meet Agreed Patient Care Standards due to Staff Resourcing”

The board are receiving a paper, as part of todays meeting, in regard to nursing resource to support this risk

Monthly Update:

Risk Management Team Leader has met with Head of Clinical Quality and Business Support Manager to review the current data and establish a baseline level of risk. The data to support the risk is available and a baseline is being developed to work alongside the TSH Risk Matrix. Once complete the data will inform the level of 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. A further review of this risk will take place following the outlined Scottish Budget.

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

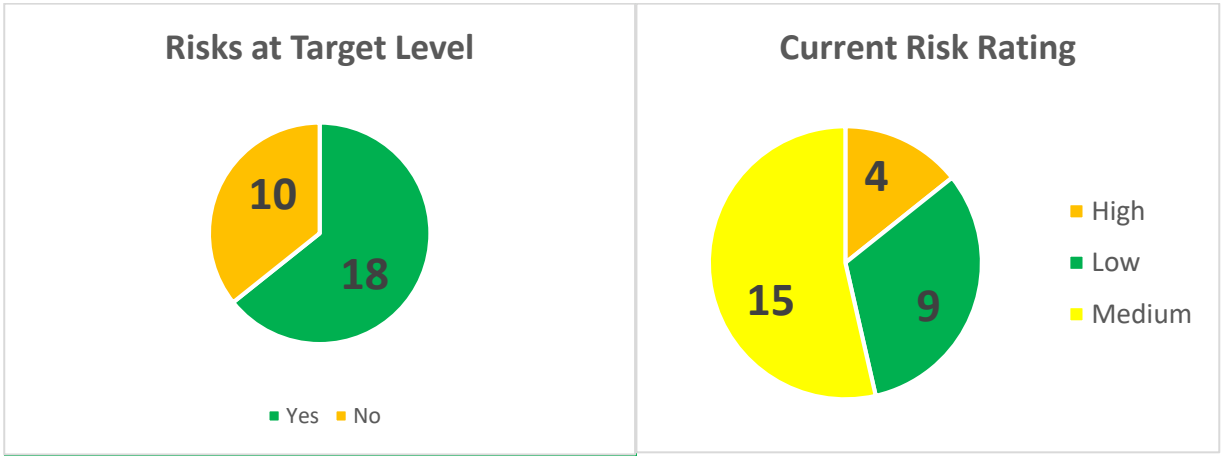
- SD57 Increased to 'High' following a review in October 2024. The Risk and Resilience Team have identified the risk of adverse event reviews and resultant actions not being completed on time has increased following recent pressures within the team. The team will continue to review the risk and share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

Monthly Update:

An improvement plan is being developed that has a more robust governance overview on timescales and actions. This will be developed and implemented once complete.

The Risk & Resilience Team are currently experiencing pressures related to absence which in turn is impacting on completion and return in a timeous manner. The team however continue to ensure reviews are completed in a timely manner and actions are driven forward.

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. The Corporate Risk Register continues to be reviewed and updated working closely with directors across the services.

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.
- 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. This will be confirmed at meeting with Chief Executive when it is re-scheduled .
- Medical Directorate Review completed, actions to be taken forward as noted above.
- Chief Executive CRR Review was postponed to late December/January.
- 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 Committee
Risk Assessment (Outline any significant risks and associated mitigation)	There are no significant risks related to the publication of the report.
Assessment of Impact on Stakeholder Experience	There is no impact on stakeholder experience with the publication of this report.
Equality Impact Assessment	The EQIA is not applicable to the publication of this report.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	The Fair Scotland Duty is not applicable to the publication of this report.
Data Protection Impact Assessment (DPIA) See IG 16	Tick One ✓ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

Paper No. 24/101

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	Jan 25	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	Jan 25	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	Jan 25	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	Jan 25	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	Feb 25	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	Feb 25	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	Feb 25	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	Feb 25	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 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Possible	Moderate x Possible	Moderate x Rare	HR Director	Training & Professional Development Manager	Dec-24	Clinical Governance Group	6 Monthly	↑
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	-

Cyber Security Ref: FD96

Corporate Objective	Better Workforce	Risk Owner	Director of Finance & eHealth	Action Officer	Head of eHealth

Risk	Complete the relevant details of the operation/ activity giving risk to the risk
Cyber attack on TSH digital infrastructure	

Category		Tick the box to indicate the type of risk Descriptions of categories and level of impact are available in TSH Risk Matrix
Patient Experience	☐	
Objectives/ Project	☐	
Injury (physical or psychological)	☐	
Complaints/ Claims	☐	
Service/ Business Interruption	☒	
Staffing and Competence	☐	
Financial (inc damage, loss or fraud)	☒	
Inspection/ Audit	☐	
Adverse Publicity/ Reputation	☒	
Physical Security	☐	
Other (Specify)		

Hazards		Details the hazards associated with this risk, i.e. the effect. Impact of this risk if realised
• Cyber attack on TSH digital infrastructure ie. ransomware or wiper attack that prevents access to systems, compromises data or prevents access to systems. • Financial implications to resolve issue with potential to pay fines. • Reputational damage		
Individuals or group exposed	Staff, Patients, Carers and Volunteers	Highlight those who would be affected by risk

Benefits	Detail any benefits associated with this risk being mitigated. (e.g. cost savings)
Managing this risk ensures TSH has a safe and secure digital infrastructure and provides assurance to stakeholders that any potential threats can be managed.	

Existing Control Measures	List any existing measures in place to mitigate this risk.
• Maintain computer patching	

• Reduced end user rights and restrictions on staff/patient user accounts • Sophos Anti-Virus with Intercept X (that detects multiple encryption attempts), anti malware and ransomware protection. • Windows 10 devices Advanced Threat Protection (ATP) which is monitored nationally. • End user awareness of malicious emails, regular communications and Data Protection training given to all staff. • Any documentation meets standard of ISO27001:2013 • All desktop and laptop computers support Windows 10 and all corporate systems are updated to the latest patch level available. • Support from the National CSOC (email scanning and detection, SWAN monitoring and updating). • Solutions are in place to segregate our storage and backup solutions ensuring any malicious actors would be unable to compromise them easily. • We run regular backups of all our systems with data backups on physical storage (live and immutable) which are also copied to tapes and located in a fireproof safe in a different building. • Our Internet access is restricted to the Scottish Wide Area Network (SWAN). This is monitored 24/7 and is protected by two firewalls. SWAN also has protected DNS capability to protect against a denial of service. We also have two additional firewalls on site. The multiple networks within the hospital are segregated with encryption in places to reduce the vectors malicious actors could utilise. • We also have 802.1X authentication network access control system in place to prevent the connection of non-approved devices connecting to our network. • User accounts are disabled on notification from HR and Security reception when users leave. • External access is limited to the least number of connections possible with time restrictions and segregated machines for support contractors.	

Likelihood	Impact/Consequence				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Risk Rating Refer to the QIS Matrix and descriptors (appendix 1) to assess the likelihood of the risk occurring and the impact it would have and determine the overall level of the risk.	**Impact/Consequence** (use descriptor relevant to proposal and select level of impact)	**Likelihood** (use descriptor relevant to proposal and select level of impact)	**Rating** R=I/C x L
Initial Risk Rating Risk grading without controls	Major	Likely	High
Target Movement Movement since last review	-	-	-
Target Risk Rating	Moderate	Rare	Low
Current Risk Rating	Moderate	Unlikely	Medium

Further Control Measures Required	Include any additional controls identified to eliminate or reduce the risk further.
• Initiate regular backup testing. • Cyber desktop response exercises (exercise in a box). • Staff training modules to be updated. • Cyber security training (Executive level). • Cyber security training (eHealth IT Infrastructure staff). • Finalise Level 1 plan and begin regular business continuity plan testing. • Increased monitoring of cyber security threats. • Regular penetration testing (Digital and physical) • Improved incident response awareness and monitoring. • Improved project management to include information security.	

Assurances and KPIs	What assurances are there that current controls are effective? (Internal and external) Detail any existing KPIs that would link to risk and show performance against risk
• Datix used to monitor incidents, staff encouraged to report any attempts and phishing, malicious emails etc • Regular scans and updates of digital infrastructure • Support from nationally supported system (SWAN)	

Date Added	January 2019
Completed by	Thomas Best, Head of eHealth
Date Reviewed	01/11/2024
Reviewed by	Robin McNaught, Finance & eHealth Director
Next Review	01/02/2025

Risk Register	Corporate Risk Register
Directorate	Finance and eHealth
Group/Committee Monitoring Risk	Finance and Performance Group

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2024
Agenda Reference:	Item No: 10
Sponsoring Director:	Director of Nursing and Operations
Author(s):	Associate Director of Nursing/Senior Management Accountant
Title of Report:	Clinical Model - Resourcing
Purpose of Report:	For Decision

1. SITUATION

This paper outlines a proposal to recruit an additional ten WTE Band 3 Healthcare Support Workers on fixed term contracts (until March 2026) following a detailed review of the current funded establishment and minimum staffing requirements to support safe daily operations across each of the wards.

2. BACKGROUND

The nursing department is currently over-budget for the 2024-2025 financial year with overtime costs identified as a primary contributing factor. The average monthly overtime spend for 2024-2025 is estimated at £177K. This is approximately £37K more per month than last year and an increase of almost £74K per month since 2020.

In keeping with other Boards, The State Hospital is required to look at overtime and supplementary staffing (agency) spend. To better understand the contributing factors to these escalating costs a deep dive of the nursing resource was undertaken. This work involved:

- A review of clinical activity across the site
- A review of the Nursing Predicted Absence Allowance (PAA)
- A review of resourcing requirements to safely deliver against the clinical model
- A review of requirements needed to reduce reliance on overtime
- A review of the resource requirement to eradicate daytime confinement

Data included in the review covered the period April 2023 – October 2024 (inclusive).

3. ASSESSMENT

Findings from the review highlighted that the nursing operating model (i.e. the number of nursing staff required to provide safe daily care) has consistently run above the agreed funded establishment of 56/56/26 since April 2023. To deliver optimum care with no impact on the patient day (i.e. periods of restrictions and/or daytime confinement) then an average of seven staff per day have been required. This has resulted in a real-time daily operating model of 60/58/27.

A review of the data indicated that clinical acuity and boarding out pressures were the main contributors to increased staffing requirements. Whilst it is not possible to predict fluctuations in clinical acuity it has been possible to identify some patterns in clinical outing requirements. As a consequence, a separate piece of work to undertake a Test of Change project around dedicated staff to support outings was approved by CMT in April 2024. Whilst it is recognised that clinical acuity and boarding out are areas out with Nursing Directorate control the review did note areas where improvements can be made. These include better rostering practices, better management of training allocation, improved absence monitoring and management processes and improved monitoring of all “other” leave (e.g. union duties, special leave). There is also an opportunity to review the funded establishment requirements across the clinical service areas.

In order to reduce organisational reliance on such high levels of overtime to mitigate against significant shift deficits it is proposed that the Nursing Directorate recruit an additional 10WTE Healthcare Support Workers, surplus to the current funded establishment. These posts should initially be offered on fixed-term contracts until the end of March 2026. This will allow for ongoing monitoring of effectiveness and a further detailed evaluation of impact to be undertaken. It will also allow opportunity for the underlying principles of the new clinical model to be fully embedded into practice. Towards the end of the trial period opportunities to recruit staff into permanent positions through vacancies created by retirals, reduced hours and graduation of staff into Registered positions following completion of Open University programme will all be undertaken in line with Once for Scotland policies and processes.

Costings

A detailed financial analysis has been undertaken to inform costings for the proposed new posts along with the identification of anticipated cost pressures and savings within the Nursing Directorate for the remainder of this financial year in addition to the 2025/2026 period. Whilst the Directorate can afford to cover the recruitment costs for the ten additional staff for the proposed fixed-term period the funding for this has largely been through vacancies held within the Directorate budget. Given that the Directorate have used vacancy management as a method of achieving year-on-year savings targets this proposal compromises our ability to do that for the year 2025/2026.

Table 1 and 2 (below) outline cost pressures and anticipated savings for 2024/2025 and 2025/2026:

Table 1: Anticipated Pressures versus Savings 2024/2025 period

December 2024 – March 2025			
Anticipated Pressure	**Cost (£)**	**Anticipated Savings**	**Cost (£)**
Ongoing funding for Employee Director role	£39,378	Nursing Directorate Vacancies (AHP, Admin, Infection Control, Person Centred improvement, Nursing Practice Development, Skye Centre)	£246,718

Gap in funding for night duty Senior Clinical Cover	£11,878	Superannuation Savings	£426,128
Proposed HCSW (Band 3) recruitment *	£89,761		
Remainder of 3% savings to be achieved	£358,000		
Remaining pressures for Dec '24 - March '25	£499,017	Total anticipated savings for 2024/2025	£672,846
Overachieved Savings: £173,828			

*Assumption made for recruitment is 5WTE in January increasing to 8WTE in February and reaching 10WTE in March 2025.

Based on the noted over-achievement of savings recruitment could be supported for the remainder of the 2024/2025 financial year.

Table 2: Anticipated Pressures versus Savings 2025/2026 period

Financial Year 2025/2026			
Anticipated Pressure	**Cost (£)**	**Anticipated Savings**	**Cost**
Ongoing funding for Employee Director role	£94,507	Nursing Directorate Vacancies (AHP, Admin, Infection Control, Person Centred improvement, Nursing Practice Development, Skye Centre)	£411,545
Gap in funding for night duty Senior Clinical Cover**	£28,508	Psychology Link/Liaison Nurse Savings	£43,446
Clinical Service Manager posts (uplift) *	£29,604	Superannuation Savings	£193,695
Lead Nurse Workforce Planning*	£52,843	Overtime Reduction	£392,124
Proposed HCSW (Band 3) Recruitment	£468,320		
Required Savings	£828,000		
Total	£1,501,692	Total	£1,040,810
Remaining savings to be identified: £460,882			

*** These posts have been recorded as cost pressures for 2025/2026 however funding has already been identified as part of the Nursing Directorate restructuring process.**

****Considering different model for overnight Senior Clinical Cover to address identified funding gap.**

As noted at the bottom of Table 2 a remaining shortfall of £460,882K has been predicted for 2025/2026. It should be noted that this figure does **not** include the WTE loss that will be incurred as the result of moves towards implementing the reduced working week (estimated to be at 4/5WTE per 30min reduction). Nor does it include ongoing pressures from the temporary opening of an additional ward (Iona 1).

Consideration of Risks and Issues: Status Quo versus Recruitment of Additional Staff

If we do nothing, the annual financial pressure created by overtime hours within ward nursing for 2025/2026 is estimated to further increase again to £857,461 with weekly shift deficits continuing to range from 155-265, dependent on clinical acuity. With relatively small numbers of Supplementary Staff available these

shifts will continue to be filled by overtime from the current workforce. It is worth noting that early reviews of data indicate this overtime tends to be covered by a relatively small proportion of the staffing group. Therefore, in addition to the financial pressures expected from overtime shifts it is prudent to consider the wellbeing and safety impact of staff working excessive hours on a routine basis by continuing with the status quo. Without the introduction of additional staff these financial and workforce pressures will remain ongoing, or potentially worsen.

Benefits of Proposal:

Savings from the anticipated reduction in overtime with the introduction of ten additional Healthcare Support Workers is currently estimated at £392,124 This is a prudent figure based on an 80% (8wte) of Band 3 overtime hours. Should 100% (10wte) reduction be achieved with an even split of Band 3 and Band 5 the savings would increase to circa. £580,979. The introduction of additional staff would support an ease in the pressures experienced across ward-based nursing, releasing time for the Senior Nursing staff to focus on driving forward improvements in areas such as better rostering, improved attendance management and training allocation. An easing in staffing pressures will also allow greater focus on fully embedding the principles new clinical model into practice, strengthening decision making processes based on evidence and sound risk management. With the over-recruitment of Band 3 staff, we would reduce the over-reliance on overtime and the only time we should need to use overtime is if we are requiring the shifts are experiencing a deficit in registrants.

Despite the forecasted reduction in overtime, it should be noted that there will remain an outstanding pressure of £460,882 within the Nursing Directorate at the end of the 2026 financial period therefore further mitigations measures will need to be identified.

4. RECOMMENDATIONS

- Members of the Board are asked to consider the above proposal to recruit an additional ten Healthcare Support Workers on fixed-term contracts until March 2026 and support the Nursing Directorate to continue to reduce the level of overtime spend and maximise the efficient use of nursing resource.

- The Board are also asked to note the impact on achieving savings plan for 2025/2026.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	This proposal supports the organisation to comply with the Health & care Staffing (Scotland) Act as well as delivering our financial and workforce plans.
Workforce Implications	Over recruitment will provide the necessary stability to address workforce challenges and practices. Key posts will be deferred to fund this work.
Financial Implications	Impact on using vacancies to meet savings target for 2025/26 but will have a positive impact on the overall OT spend.
Route to SG/Board/CMT/Partnership Forum Which groups were involved in contributing to the paper and recommendations.	• CMT • Partnership Forum • Clinical Leads • Workforce Governance • Staff Governance • Clinical Governance
Risk Assessment (Outline any significant risks and associated mitigation)	Risk identified and noted on TSH register ND 70
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

BOARD

Date of Report:	4 December 2024
Agenda Reference:	Item No: 11
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 31 October 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 a projected breakeven forecast, regular meetings between TSH and SG monitor progress against targets.

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

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £48.712m 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 addition, there is a further anticipated allocation not yet input to budgets as awaiting confirmations, as follows –

- OU Students Backfill, phase 2 £50k

The Central Funding for Distinction Awards (£36k) which was noted as awaited in earlier Board reports was confirmed through the Scottish Advisory Committee in early December. The Committee also noted that the 2025/26 awards are expected to remain at the same level.

The October accounts show an over spend to date of £0.157m, which is mainly in connection with Ward Nursing pressures, partly offset by a number of staffing vacancies. Capital Charges backdated adjustment for depreciation of buildings has also caused a pressure in October.

3.2 2024/25 Budget

The 2024/25 budget template required by SG includes 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 for the start of the year, achieved savings will be reported monthly.

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.

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

Directorates / functions	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (bud - act) for period 7	Budget WTE	Actual WTE	Comments on variance
Cap Charges	3,112	1,815	1,868	(53)	0.00		RRL has been anticipated for phase 1 increase in asset values (capital charges) from perimeter project capitalisation. A further element (phase two Perimeter £445k) will hit later in the year so while not yet reflected in the budget but has been notified to, and confirmed by SG.
Central Reserves	808	0	43	(43)	0.00	0.00	Phased to period 12 and released as required, includes Apprenticeship Levy (year end charge from balance sheet), PAIAW, On-call, SLAs, Utilities, and consultants' discretionary points, new RRL.
Chief Exec	2,416	1,397	1,408	(11)	26.17	23.82	A small variance is noted arising from savings below trajectory to date.
Finance	3,305	1,912	1,903	9	29.18	31.92	eHealth strategic allocation has now been released in order to support the funding of four posts on a permanent basis instead of fixed term.
Human Resources Directorate	1,158	657	633	24	16.30	15.36	The underspend is arising from non-pay variances, particularly in training.
Medical	3,433	2,042	2,014	28	23.95	19.68	A small variance in non-pay costs to date is noted.
Misc Income	(100)	(58)	(22)	(36)	0.00		The timing of income (mainly VAT, CNORIS) is slightly at variance from budget phasing
Nursing And Ahp's	26,517	14,963	15,195	(232)	406.67	426.68	See below for detailed narrative from Nursing Directorate.
Security And Facilities	8,064	4,612	4,456	157	123.63	115.65	Accruals B/F are helping to support electricity and biomass pressures, a central reserve was also created (although this may be light). Vacancies are contributng to underspend.
	48,712	**27,340**	**27,497**	**(157)**	**625.90**	**633.11**	

The expected costs for AFC 5.5% pay award was received in October, and has been released in month, and phased for remaining months.

Nursing & AHPs (as provided from Nursing Directorate Oct '24)

In keeping with previous months, it is noted that the main contributors to nursing overtime costs are a combination of clinical acuity, out boarding, Band 5 nursing vacancies and sickness absence.

The Directorate continue to actively recruit to all nursing vacancies in an attempt to mitigate against overtime spend in addition to robust attendance management processes and regular reviews of employee relation cases.

As noted above, primary nursing vacancies sit within Band 5 positions. There are currently 2.2.WTE vacancies noted however this is forecast to increase slightly following a combination of leavers and requests for reductions to hours (estimated to increase to 5.8WTE vacancies). Pro-active recruitment is already underway with interviews scheduled for 18th November 2024.

Clinical acuity continues to fluctuate regularly which impacts on the nursing 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 out boarding however there remains a number of external outings (e.g. court and transfers) that have required to take place.

As noted in previous reports, an additional ward was opened 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 on daily operations. 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 out boarding team which consists of one registered and unregistered nurse. This trial has proven successful and work is underway to develop a business case for making the additional unregistered post permanent.

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. Across the Nursing Directorate all Heads of Service continue to meet the savings targets set.

3.4 Financial pressures / potential benefits.

The above position includes certain specifis pressures which have arisen in 2024/25 – with ward nursing items as follows having been raised with SG for ongoing consideration –

- Boarding out costs to date – £483k
- High risk enhanced care requirements – minimum 4 staff am, 4 staff pm and 2 staff night duty (since 6th July) – £509k
- Escorted transfers – £1.7k

Other pressures / benefits include :-

eRostering Project
The project itself will incur costs but at a significantly lower level than the previous year's set up costs, the charge via Payments on Behalf (POB) of £11k has now been received for 24/25.
M365
Quarter 1 and 2 are now charged via POB 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.
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 (now funded).
• AFC pay uplift in year (now funded).
• Adjustment of a number of posts – yet to be determined – from B5 to B6 (funding awaited).
•Training – protection.
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.
Benefits:-
Travel & Training
Less spend following Covid, meetings and some training now on line.

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 - Oct 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)	570	(258)
Security And Facilities	(233)	80	(153)
Total	(1,335)	**745**	(590)
Underachieved to date (1/12ths)	(778)	**745**	(34)

It should be noted that of the Hospital's budget only 14% of costs are non-pay related, certain boards also treat vacancy savings, as recurring savings, we class ours as non-recurring.

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.

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 December, with retention spend due.

SG return Oct 24 Capital CRL 2024/2025	Annual Plan £'k	YTD Spend £'k
Perimeter Security		
Stanley Security Solutions LTD		7
Thomson Gray LTD		127
TSH Staffing		99
Income re Covid recharges, sale of radios etc.		-63
Perimeter Security Total	**521**	**170**
Capital		
IM&T		52
Other		49
Capital	**269**	**102**
Total CRL	**790**	**272**

6 RECOMMENDATION

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

Revenue
The year to date position is an over spend of £0.157m, 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:	19 December 2024
Agenda Reference:	Item No: 12
Sponsoring Director:	Medical Director
Author(s):	PA to Medical Director
Title of Report:	Bed Capacity within The State Hospital and Forensic Network
Purpose of Report	For Noting

1 SITUATION

Capacity within the State Hospital (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 October 2024 until 30 November 2024.

Table 1

	Admissions & Acute	**Treatment & Recovery**	**Transitions**	**ID**	**Total**
Bed complement	24	48	24	12 ID beds (and 12 contingency beds) Total 24	120 (+ 20 additional unstaffed beds)
Beds in use	20	48	21	12 + 3 ID surge	104
Admissions	6 (external) 0 (internal)	0 (external) 1 (internal)	0 (external) 1 (internal)	0 (external) 0 (internal)	6 (external) 2 (internal)
Discharges/Transfers	1 (external) 1 (internal)	0 (external) 1 (internal)	1 (external) 0 (internal)	0 (external) 0 (internal)	2 (external) 2 (internal)
Bed occupancy as at 30/11/2024	83.3%	100%	87.5%	125% (ID beds) 62.5% (all beds)	86.7% (available beds) 74.3% (all beds)

Please note that in total there were 104 patients as of 30 November 2024. Within this number 15 patients are under the care of the Intellectual Disability Service (the service is currently 3 patients in excess of their 12 patient allocation).

Table 2 – Time between admission and referral

Date	6 weeks or less	More than 6 weeks	Total Number
30/11/2024	6	0	**6**

All six patients were admitted within 6 weeks of referral.

There are 10 patients identified for transfer (9 MMI and 1 ID), 5 of whom have been fully accepted. No patients have been waiting longer than 12 months. There have been 0 excess appeals won. Full details are available but not included for reasons of patient confidentiality.

There are two patients currently in TSH under the Exceptional Circumstances clause; the first was admitted on 26/07/24 and the second on 23/11/24.

b) Bed Occupancy since start of new Clinical Model

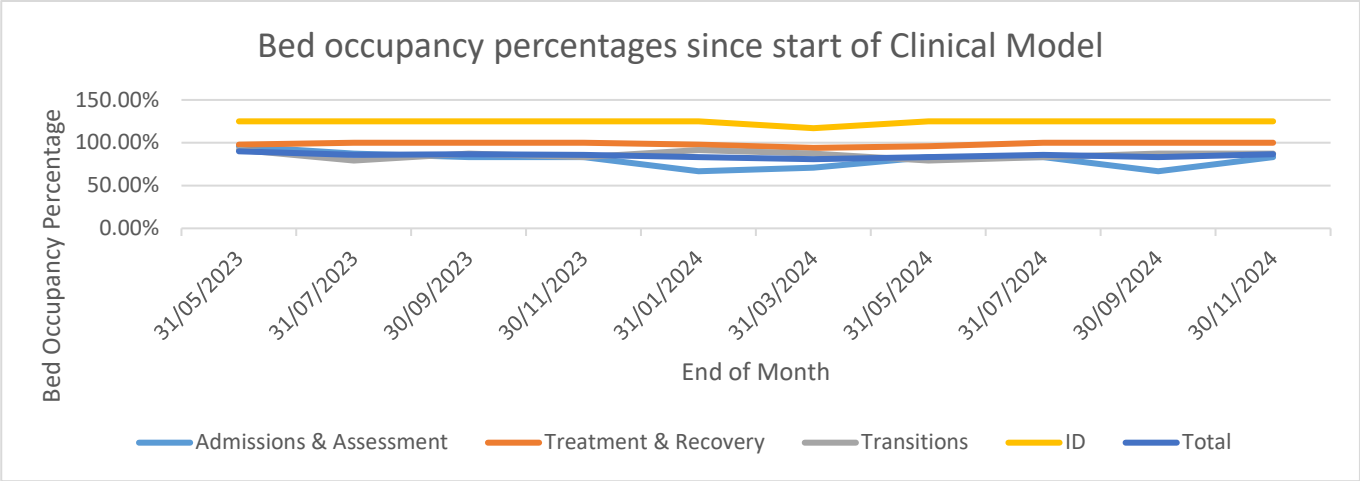


Table 2 Bed Occupancy by Service and in Total

Service	31/05/23	31/07/23	30/09/23	30/11/23	31/01/24	31/03/24	31/05/24	31/07/24	30/09/24	30/11/24
Admissions & Assessment	95.80%	87.50%	83.30%	83.30%	66.70%	71%	83.30%	83.30%	66.7%	83.3%
Treatment & Recovery	97.90%	100%	100%	100%	97.90%	94%	95.80%	100%	100%	100%
Transitions	91.70%	79.20%	87.50%	83.30%	91.60%	87.50%	79.20%	83.30%	87.5%	87.5%
ID	125%	125%	125%	125%	125%	117%	125%	125%	125%	125%
Total	**90%**	**85.8%**	**86.7%**	**85.8%**	**83.3%**	**80.8%**	**83.30%**	**85.8%**	**83.3%**	**86.7%**

Table 2 shows more patients in the admissions service, which reflects the greater number of admissions 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

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

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.

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 2 December 2024	High Secure		Medium Secure							Low Secure																Private Sector			
	TSH Male MI	TSH Male LD	Orchard Clinic Male	Orchard Clinic Female	Rohallion Male	Rowanbank Male	Rowanbank Female	National LD Male	National LD Female	Beckford Lodge Male	Beckford Lodge Mixed Forensic Rehab	Bellsdyke Male	Bellsdyke Female	Leverndale Male	Leverndale Female	Leverndale Male LD	Rohallion Male	Blair Unit Male (as at w/c 25.11.24)	Blair Unit Female (as at w/c 25.11.24)	Stratheden Male (as at w/c 02.09.24)	Woodland View Male	Kirklands Hospital Mixed ID	Lynebank Male ID	Strathmartine Male ID	Ayr Clinic Male	Ayr Clinic Female	Surehaven Male	Surehaven Female
Bed capacity	108	12	30	2	31	56	6	8	4	15	12	12	6	38	5	10	24	32	2	12 (2 beds in lodge)	8	2	10	8	34	22	15	6
No. of beds in use	89	15	30	2	27	49	4	7	1	15	11	9	4	37	4	9	20	33	2	10	6	1	9	8	34	22	14	6
No. empty beds	6	-3	0	1	4	7	2	1	3	0	1	3	2	1	1	1	4*	0	0	2 in lodge (not external admitting beds)	0	1	1	0	0	0	1	0
No. available beds	6	0	0	1	2 rehab	2 rehab + 2 acute	2	0	3	0	1	2	1 * 1 bed on hold until mid Dec	0	1	0	3*	2	0	0	0	0	1 regional	0	0	0	1	0
No. on waiting list for access to service	0	0	4	0	3	1	0	1	0	1	0	1	0	24	0	1	0	3	1	1	2	2	0	0	3	4	1	0
No. on waiting list currently placed out of area	0	0	0	0	0	1	0	0	0	0	0	0	0	18	0	1	0	3	1	1	0	2	0	0	0	2	0	0
No. of patients on transfer list for lower security settings	8	1	3	1	3	11	0	1	0	1	0	1	0	0	0	0	0	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	0	0	0	0	0
No. of patients on transfer list for community or other services	0	0	4	0	1	4	0	0	0	0	0	3	0	11	2	2	9	5	0	0	1	0	5	0	2	3	3	0
No. of delayed discharges	0	0	4	0	0	1	0	0	0	1	1	1	0	2	1	2	5	5	0	0	1	0	3	0	0	0	0	0
No. of patients on transfer list fully accepted for transfer	4	1	0	0	4	6	0	1	0	0	0	0	0	9	0	0	0	3	0	0	0	0	0	0	3	4	0	0
No. of admissions in the last week	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
No. of those admissions that were an emergency	1	0	0	1	0	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 discharges in the last week	0	0	0	0	2	1	0	1	0	0	0	0	1	0	0	0	0	2	0	0	0	0	0	0	0	0	1	0
Any foreseen potential issues this week in terms of capacity						x1 acute bedroom out of comission awaiting repairs; high levels of obs and acuity		ID pt in Elm acute adm ward; x1 bedroom out of commission requires major repairs				2 patient living in trial flat full-time, 1 patient living in trial living flat part time	1 patient living in trial living flat full-time				* 1 bed unavailable due to outstanding repair work	These numbers include IPCU bed usage. In addition to the above we have 1 patient in adult wards	One further patient is decanted out of the ward for operational reasons			Review of beds being undertaken by the service					
Total Bed Availability Across Forensic Estate	30																											

Monitoring of Prison Transfers

No. of patients awaiting assessment/transfer from prison	1	1x referral to Orchard Clinic
No. of cases on Problematic Case Register	0	

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

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2024
Agenda Reference:	Item No: 13
Sponsoring Director:	Director of Nursing & Operations
Author(s):	Carers Strategy SLWG
Title of Report:	Carers Strategy 2025-2028
Purpose of Report:	For Decision

1. SITUATION

The Carers (Scotland) Act 2016 (the Act) came into effect 1 April 2018 and intends to ensure that all carers are better supported to ensure that they can continue to provide care, if they choose, in good health and wellbeing, and allow them to have a life beyond caring. The Act gives carers rights to a new adult carer support plan or young carer statement without first requiring them to be providing care on a substantial and regular basis. This reflects a preventative approach to identify each carer's personal outcomes and needs for support through meaningful conversations with individual carers. This preventative approach is also reflected in the requirement to provide information and advice services to carers.

Carer involvement is a key principle of the Act. It is intended to empower carers with more useful information about the support that may be available to them and to ensure that they can share their caring experiences and knowledge with those responsible for providing support or services. Carers and carer representatives must be involved in the preparation of local carer strategies and planning of carer services. Carers must also be involved in hospital discharge processes.

2. BACKGROUND

In Scotland there are approximately 800,000 carers including 45,000 young carers. Within The State Hospital many of our patients will have carers who support them throughout their recovery. There are 344 individuals identified as carers, from two key groups: Approved Visitors and Key Carers. Approved Visitors are able to visit in-person, while Key Carers, though not approved for visits, have a significant role to play in patient care. Our carers' insights are invaluable for developing effective carer support strategies at The State Hospital

Section 31 of the Carers (Scotland) Act 2016 requires each local authority and health board to prepare a local Carer Strategy which deals specifically with the exercise of all functions relating to carers. A local Carer Strategy must include the following:

- Plans for identifying carers and information about the care they provide.
- An assessment of the demand for support to relevant carers

- Support available to relevant carers
- Any gaps in meeting the demand for support
- Plans for supporting carers
- Plans for helping carers arrange for the provision of care in emergencies
- An assessment of how plans for supporting carers will reduce any impact of caring on their health and well-being
- Information relating to the particular needs and circumstances of young carers.
- How we engage with External stakeholders to support carers
- How we engage with Local Authorities, strengthening links that will support statutory roles.

In addition to developing our strategy we will also consider the carer pathway through the Forensic estate along with how we engage with Local Authorities to ensure that we are addressing our statutory responsibilities a defined in the Act.

As a specialist board, some of the functions listed do not apply in the same way they would in a territorial board and may require some adaptation to meet the specific needs of carers involved in this High Secure Forensic setting.

3. ASSESSMENT

A short life working group was commissioned by the Person Centred Improvement Group to develop a local Carer Strategy, taking into consideration the Carers (Scotland) Act 2016 statutory guidance issued by the Scottish Government in July 2021.

The group has developed an initial draft strategy which is presented to the group, Appendix 1, for discussion and feedback, regarding the content and identified key priorities.

Following the Visitor Experience audit and subsequent engagement with carers, we have identified the following priority areas for development:

- Priority 1 - The Triangle of Care self-assessment tool will enable us to identify ways that we can support our carers to navigate and understand what the standard of care is beyond ‘the gate’ to enable them to better understand our policies and procedures. Due to the high secure nature of our environment they are unable to walk in and look for themselves.
- Priority 2 - Carer Communication & Sharing of Information. Providing good quality, appropriate, and timely information and advice to carers has dual benefits of improving the health and wellbeing of carers, and the cared-for person, reducing the potential need for, and costs of, crisis management.
- Priority 3 – Improve the Carers visiting experience – Continue to work with patients and carers to continue to improve the visiting experience. Offer visitors a check-in following visits.
- Priority 4 - Carer Pathway – it is an important aspect of our patients’ journey through the hospital to ensure our carers are linked with the wider Forensic Network. Establishing and maintaining good partnerships with third sector organisations will also play an important part in ‘delivering effective local personalised support to carers, which meets their personal outcomes and helps them continue in their caring role’.

The Person Centre Improvement Group will devise a detailed delivery plan with at least three improvement activities under each of our priority areas, and assurances that what our carers told us they wanted to improve will be included in these actions.

4. RECOMMENDATION

The Board are invited to discuss and approve the Carer Strategy 2025-28.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supports the compliance with Legislation, Equality Agenda and ongoing work related to the Person Centred Improvement Group
Workforce Implications	Awareness Training and development of staff in the area of the priorities set within the Strategy and outcomes of the Triangle of Care self-assessment
Financial Implications	N/A
Route to Committee Which groups were involved in contributing to the paper and recommendations.	Person Centre Improvement group – reporting via the Clinical Governance Group
Risk Assessment (Outline any significant risks and associated mitigation)	
Assessment of Impact on Stakeholder Experience	
Equality Impact Assessment	To be completed.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	
Data Protection Impact Assessment (DPIA) See IG 16.	Tick (✓) One; ☐ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

The State Hospitals Board For Scotland

Carers Strategy 2025-28

Sponsoring Director - Karen McCaffrey,
Director of Nursing and Operations
October 2024

Foreword

We are delighted to present the State Hospitals Board for Scotland's Carers Strategy 2025 - 2028, which has been developed in recognition of the role and contribution carers make, to the lives of our patients. Whilst recognising the unique role of this high secure mental health hospital, the strategy enables us as an organisation to consider how we can we meet the requirements of the Carers (Scotland) Act 2016.

Whilst not providing hands on care it is still an important element of the care provision, for our carers to be actively involved in our patients care. We recognise how important it is for our patients to maintain those vital connections with loved ones. We also recognise the need for our carers to have the same level of involvement and opportunities to see for themselves the quality of the care and treatment provided. This in the context of a secure environment where access is not as readily available as it would be in mainstream care.

Therefore, the aim is to support our carers to continue to have an active role in the care of our patients, to support further meaningful engagement with our carers and together think creatively to overcome any barriers to provide assurance regarding the care provided here and encourage further development partnership working with our carers and clinical teams.

This strategy also recognises the difficulties our carers have faced prior to being involved with the State Hospital, including the impact of stigma and trauma. The wellbeing of our carers is a key priority and it recognises that there are very few supports available that will meet the bespoke needs of our carers.

This strategy also seeks to identify the needs and supports required for carers in the wider forensic care settings, by supporting the carers as their loved ones transition through the various levels of forensic care, by working in partnership with the Forensic network.

This strategy includes an action plan (pages 13-16) which identifies specific actions required to address the key priorities set out in this document, progress will be reported on an annual basis.

We look forward to continuing to work with our carers and partner agencies, to not only continue to improve and develop services but also to ensure their own needs are also met.

Karen McCaffrey

Director of Nursing and Operations

and Deputy Chief Executive.

Contents

Section 1: Why do we need a strategy?

Carers (Scotland) Act 2016

The Carers (Scotland) Act 2016 (the Act) came into effect 1 April 2018 with the intention to ensure that all carers are better supported to ensure that they can continue to provide care, if they choose, in good health and wellbeing, and allow them to have a life beyond caring.

Carer involvement is a key principle of the Act. It is intended to empower carers with more useful information about the support that may be available to them and to ensure that they can share their caring experiences and knowledge with those responsible for providing support or services. Carers and carer representatives must be involved in the preparation of local carer strategies and planning of carer services. Carers must also be involved in hospital discharge processes.

Section 31 of the Carers (Scotland) Act 2016 requires each local authority and health board to prepare a local Carer Strategy which deals specifically with the exercise of all functions relating to carers. A local Carer Strategy must include the following:

- Plans for identifying carers and information about the care they provide.
- An assessment of the demand for support to relevant carers
- Support available to relevant carers
- Any gaps in meeting the demand for support
- Plans for supporting carers
- Plans for helping carers arrange for the provision of care in emergencies
- An assessment of how plans for supporting carers will reduce any impact of caring on their health and well-being
- Information relating to the particular needs and circumstances of young carers.
- How we engage with External stakeholders to support carers
- How we engage with Local Authorities, strengthening links that will support statutory roles.

As a specialist board, some of the functions listed do not apply in the same way they would in a territorial board and may require some adaptation to meet the specific needs of carers involved in this High Secure Forensic setting.

In addition we will also consider the carer pathway through the Forensic estate along with how we engage with Local Authorities to ensure that we are addressing our statutory responsibilities a defined in the Act.

Care in Secure Settings

The State Hospital is one of four high secure hospitals in the UK. Located in South Lanarkshire in Central Scotland, it is a national service for Scotland and Northern Ireland and one part of the pathway of care that should be available for those with secure care needs. The principal aim is to rehabilitate patients, ensuring safe transfer to appropriate lower levels of security.

There are 120 high-secure beds (plus four beds for emergency use) for male patients requiring maximum secure care. A range of therapeutic, educational, diversional and recreational services including a Health Centre is provided. This clinical model is described on page 9.

Patients are admitted to the Hospital under The Mental Health (Care and Treatment) (Scotland) Act 2003 / 2015 and other related legislation because of their dangerous, violent or criminal propensities. Patients without convictions will have displayed seriously aggressive behaviours, usually including violence.

When devising this strategy we considered a number of key policy and legislative drivers, a breakdown of which is noted in section 6.

Every year there are approximately 20-35 patient admissions and discharges. Patients are admitted for a minimum of four to eight weeks for assessment. Thereafter, length of stay depends on the individual patient's care and treatment and detention order.

A patient would be considered for transfer to lower security once their mental health had improved, their risk factors significantly mitigated, and their behaviour was settled for a prolonged period. Transfers involve a series of visits to the receiving service.

Around 70% of patients are 'restricted' patients within the jurisdiction of Scottish Ministers. That is a patient who because of the nature of his offence and antecedents, and the risk that as a result of his mental disorder he would commit an offence if set at large, is made subject to special restrictions without limit of time in order to protect the public from serious harm. This number also includes patients undergoing criminal court proceedings who are also subject to the supervision of the Scottish Ministers.

All patients are male, the average age is 40 years old (currently a range of 21 to 80). The most common primary diagnosis is schizophrenia. The average length of stay is just over five years, with individual lengths of stay ranging from less than one month to over 36 years.

Who are our carers?

Carers or forensic carers are terms used to describe relatives and friends who play a role in the care of the patients within the State Hospital. Refocussing the Care Programme Approach (Department of Health, 2008) suggests that a carer is 'an individual who provides or intends to provide practical and emotional support to someone with a mental health problem. They may or may not live with the person cared for'. This idea aligns with the experience of carers in relation to the State Hospital patients who provide care at a distance.

Within the State Hospital many of our patients have carers who support them throughout their recovery. There are approximately 344 individuals currently identified as carers, from two key groups: Approved Visitors and Key Carers. Approved Visitors are able to visit in-person, while Key Carers, though not approved for visits, have a significant role to play in patient care. Our carers insights are invaluable for developing effective carer support strategies at the State Hospital.

Section 2 - Where are we now?

Impact of Covid 19

During the pandemic it was necessary to place restrictions on face to face contact and ~~had to~~ stop events that ran at key points throughout the year. However, once the restrictions were lifted we have been working hard to encourage visitors to return with good effect.
Whilst restrictions where necessary we were able to introduce video visiting and this has been retained as a valuable means of supplementing face to face contact and keeping our patients connected to their loved ones, some of whom live some distance away.

Carer Engagement

Carers were invited to participate the annual Carer Experience questionnaire, which guaranteed anonymity to protect their privacy. The objectives of the annual questionnaire are to:

- *Assess Carer Needs:* Understand the diverse emotional, informational, and practical needs of carers associated with patients at the State Hospital.
- *Evaluate Existing Support:* Assess the effectiveness of current support services for carers, identifying areas for improvement.
- *Inform Strategy Development:* Gather data to inform the development of the State Hospital's Carers Strategy, ensuring it meets carers' needs and legislative requirements.
- *Enhance Communication:* Evaluate communication channels between the State Hospital and carers, seeking opportunities for improved collaboration.
- *Monitor Satisfaction Levels:* Measure carers' satisfaction with State Hospital services, providing a foundation for future improvements.
- *Promote Inclusivity:* Ensure all carers, including those facing engagement barriers, contribute to the feedback process.
- *Track Progress:* Establish benchmarks for monitoring the impact of carer-related initiatives and ensuring ongoing enhancement.
- *Identify Training Needs:* Highlight areas where additional resources or training could better support staff and carers alike.

The State Hospital Carer Experience Questionnaire 2024 was developed by building on the foundation of the previous 2017 questionnaire, adapting it to reflect recent changes and challenges, especially those arising from the COVID-19 pandemic. This approach ensured continuity while addressing new issues relevant to carers.

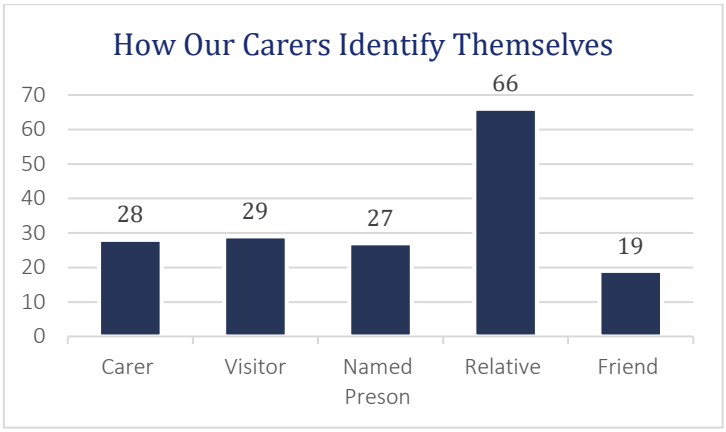
The Carer Questionnaire 2024 was distributed using tailored methods to maximise participation and response rates i.e. email distribution, SMS distribution and postal distribution. The overall response rate was 91 out of 344 (26.5%).

The themes identified throughout our engagement with carers enable the identification of our strategic priorities for the next three years.
The themes were the need to:

- Enhance the visitor experience, providing more flexible visiting times and safely supporting the use of the Family Centre environment i.e. outdoor spaces
- Recognise and support carers
- Keep carers connected
- Provide better access to information related to care and treatment and progress throughout the hospital.

Interestingly, when carers were asked how they would describe themselves, only 28 of the respondents identify themselves as carers.

Figure1



It is essential that our service understands the needs of our carers and responds appropriately. Carers should be treated with respect and in culturally appropriate ways, taking account of needs associated with culture, language and faith. The support and involvement of carers should also take account of other relevant protected characteristics.

We recognise that carers for our patient group may have experienced trauma and distress and may experience stigma as a consequence of their loved ones association with the State Hospital. We aim to ensure that the carers we work with are recognised, feel valued and included.

Person Centred Improvement

Stakeholder involvement and engagement, equality and diversity, spiritual and pastoral care and volunteering work streams have been aligned to the Person-centred Health Care aspect of the NHS Quality Strategy, in recognition of the contribution these elements make within the delivery of this aspect of the national strategy.

The Person Centred Improvement Group (PCIG) monitors, on behalf of the State Hospital Board, the mainstreaming of processes supporting delivery of the above remit. This group ensures the organisation is compliant with legislative requirements and responds appropriately to national drivers relating to the above portfolio. The group agrees an annual work plan to support the delivery of the above objectives.

A number of national drivers including the Person Centred 'What Matters to You?' initiative, 'Realistic Medicine' and 'Excellence in Care' programmes call for NHS Boards to have robust systems in place, through which they can demonstrate that patients are enabled and supported, where necessary, to share their feedback as partners in the care journey.

The Patient Partnership Group (PPG) provides a forum for patients to share feedback which helps to identify trends and themes emerging from wider sources. The co-produced format empowers the patient group to adopt a solution focussed approach and contributes to informing ongoing service development.

The group, chaired by a patient, elected by his peers, meet weekly, supported by members of staff from the Person Centred Improvement Team. All wards are represented and members are tasked with cascading information to peers as well as eliciting feedback and supporting a Hospital wide approach to ensuring the views of as many patients as possible are heard. In addition to the more formal nature of this group, members welcome the opportunity to form friendships with peers, bonding together as a result of a common interest in influencing change.

In addition weekly patient ward meetings have been introduced also supporting delivery of the above remit and enabling the organisation to respond appropriately to stakeholder feedback and national drivers. The feedback from these meetings contributes to improvements to service delivery, contributes to the annual NHS Complaints and Feedback Report and Learning from Feedback Report, and supports the planning and development of ward based activity.

Carer Story (August 2024)

A story was shared with the Board by the grandmother of a patient, reflecting on her grandson's journey from custody to recovery. Over a decade ago, her grandson was sent to prison, where she found him in a deeply distressing state—painfully thin, withdrawn, and experiencing frightening hallucinations. Fearing for his life, she was deeply concerned that without proper care, he would not survive prison. As his mental health worsened, he was admitted to the State Hospital for treatment. Initially, she was terrified by the belief that once admitted, patients never left the Hospital, and she struggled with the pain of seeing him enter high secure care.

However, over time, both she and her grandson grew to trust the Hospital, its staff, and the community of carers. She was overjoyed to see him gradually recover and return to his true self. Now, her grandson is thriving, preparing to transition to medium secure care, and looking forward to the future. She described the Hospital as a "lifesaver" for her grandson, praising the exceptional care provided to both patients and their families.

Triangle of Care

The Triangle of Care is a therapeutic alliance between carers, service users and health professionals. It aims to promote safety and recovery and to sustain mental wellbeing by including and supporting carers. The Triangle of Care is based on six principles which health and care providers can use to include and support carers, staff and those in receipt of care. The six key standards are:

- Carers and the essential role they play are identified at first contact, or as soon as possible thereafter.

- Staff are 'carer aware' and trained in carer engagement strategies.
- Policy and practice protocols in relation to confidentiality and sharing information are in place.
- Defined post(s) with a responsibility for carers are in place.
- A carer introduction to the service is available with a relevant range of information across the care pathway.
- A range of carer support services is available.

During the Covid Pandemic a dedicated visiting area was established, enabling the interpretation of the national guidance and a person-centred approach to be adopted to visiting. The nature of our high secure setting required a compassionate approach to be taken, tailored to individual need, where it was safe and clinically appropriate to offer a visit. The visiting model has evolved with visits primarily taking place in our dedicated visit area (Family Centre). The Triangle of Care self-assessment tool was paused but work has recommenced in order to further enhance the experience for our carers.

Clinical model

The State Hospital Clinical Model was implemented in May, 2023. It provides the basis upon which clinical teams plan and deliver patient care.

The Clinical Model encompasses four clinical service areas:

- Admission and Assessment Service (Arran 1 and Lewis 1)
- Treatment and Recovery Service (Arran 2 and 3 and Lewis 2 and 3)
- Transitions Service (Mull 2 and 3)
- Intellectual Disability Service (Iona 2 and 3).

These services will work collaboratively with the Skye Centre, which is the therapies and activities centre of The State Hospital.

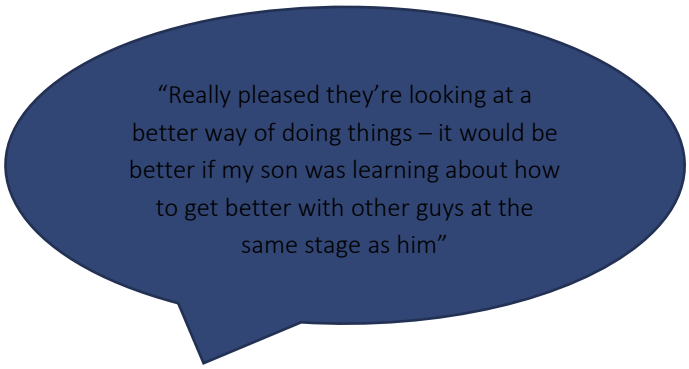
This is a recent example of proactive engagement with key stakeholders when developing and implementing the clinical model. There has been consistent approval and support of the proposed model changes from engagement with staff, patients and carers.

The introduction of the clinical model also adds additional transitional points for not only our patients but also their carers and therefore we need to consider what information and support carers will require to navigate these.

Carer quotes: Clinical Model Stakeholder Session

"We're looking forward to seeing what's better for us as carers when the wards have patients at the same stage in them – because that means that probably carers will be at the same stage of their journey and we might get to know folk we want to speak to"

"We don't like visiting in the ward my son is in, some of the other patients aren't well at all and it feels like we're intruding on their privacy"



The Forensic Estate

The Director of Nursing and Operations has taken over as chair of the Forensic Network's, Improving Carer's Experience. The renewed focus of this group will be to support the carer coordinators in all forensic settings including private sector providers, with a focus on supporting at key transitional points. Explore ways to improve engagement with carers across all levels of forensic care and ensure the carer's voice is heard. Scope out the support services available to our carers across Scotland. The forum will also develop a National Forensic Services Carers Toolkit to support carers to navigate these healthcare settings and provide vital information and signpost to relevant supports services.

Section 3 – Where do we want to be?

Our Commitment

We will engage effectively with our carers as equal partners empowering them with more useful information about the support that may be available to them.

We will involve them in every aspect of the patient's journey, in particular involving our carers in hospital discharge processes.

By ensuring more personalised and effective delivery of support to carers, the Act seeks to address the issues that may reduce or impede the wellbeing and positive outcomes for Scotland's carers. We are committed to supporting our carers to recognise the importance of improving their own physical and emotional wellbeing of our carers, which in turn also benefits their loved ones and friends that are being cared for by us, which can help to sustain good caring relationships. This will be delivered through the provision of information, check-ins following visiting and signposting to relevant supports within their community.

A cornerstone of the Act is the provision of information and advice services to carers, which must be accessible and proportionate to the needs of carers who use these services. The third sector is well placed in helping to deliver information and advice services to carers and we will strengthen our links with Local Authorities and across the Forensic Network to ensure that our carers are supported during the patients stay and at the point of transfer.

Identified Priorities

Following the Visitor Experience audit and subsequent engagement with carers, we have identified the following areas for development:

- **Priority 1 – Review the Triangle of Care (ToC) Standards**. The ToC self-assessment tool will enable us to assess how well we continue to comply with the standards and identify areas requiring improvement. The ways that we can support our carers to navigate and understand what the standard of care is beyond 'the gate' to enable them to better understand our policies and procedures. Due to the high secure nature of our environment they are unable to walk in and look for themselves.
- **Priority 2 - Carer Communication & Sharing of Information.** Providing good quality, appropriate, and timely information and advice to carers has dual benefits of improving the health and wellbeing of carers, and the cared-for person, reducing the potential need for, and costs of, crisis management.
- **Priority 3 – Improve the Carer's visiting experience –** Continue to work with patients and carers to continue to improve the visiting experience. Offer visitors a check-in following visits.
- **Priority 4 - Development of a Carer Pathway** – Whilst we focus on the patient's care journey we must acknowledge the carers go through their own carer's journey and require the same level of consideration and support. We recognise that with the introduction of the Clinical model we have introduced transitional points within our care environment which we need to provide support for both patients and carers to navigate. It is also important prepare our carer's for their loved ones discharge and through established links with the wider Forensic Network support the carer to engage with their loved ones new care team. Establishing and maintaining good partnerships with third sector organisations will also play an important part in 'delivering effective local personalised support to carers, which meets their personal outcomes and helps them continue in their caring role'.

Section 4 - How do we get there?

- Review carer information packs and Carer page on website
- Carer and Workforce Training and Development
- Carer's support group
- Developing relationships with Partner Agencies
- Supporting transition within TSH
- Preparation for discharge

The Person Centre Improvement Group will devise a detailed delivery plan with at least three improvement activities under each of our priority areas, and assurances that what our carers told us they wanted to improve will be included in these actions.

The State Hospital Board for Scotland Carer Strategy Action Plan 2024 – 2027

Priority		Action	Responsibility	Timescale
1. Review the Triangle of Care (ToC) Standards				
To assess how well we continue to comply with the standards and identify areas requiring improvement.	1.b	Implement a review cycle to ensure that the required criteria remains relevant and updated	Skye Centre Manager	
2. Carer Communication & Sharing of Information				
To provide good quality, appropriate, and timely information and advice to carers. This has dual benefits of improving the health and wellbeing of carers, and the cared-for person, reducing the potential need for, and costs of, crisis management.	2.a	Review carer information packs and Carer page on TSH website	Person Centred Improvement Advisor (PICA)	
	2.b	Explore how we re-establish a Carers support forum, working with the Forensic Network currently to consider if a national approach would be more appropriate and sustainable.	Skye Centre Manager/PICA	
	2.c	To work in collaboration with our Forensic Network partners, Carers Trust (Scotland) and carers in order to tailor national training modules to the needs of the carer	Person Centred Improvement Advisor	

3. Improve the Carer Visiting Experience				
To provide a comprehensive introduction to the Hospital, offering a range of carer support mechanisms to further enhance the visiting experience.	3.a	To provide details of the support available, identify any specific support needs and seek consent for information relating to practical matters (e.g. transport, travel expense claims, social events) to be sent.	Person Centred Improvement Advisor/Social Work	
	3.b	On arriving for the initial visit, the Person Centred Improvement Advisor / a member of the Clinical Team meets the carer in Reception and escorts them to the ward/Family Centre to provide one to one support to reduce potential distress and address any concerns.	Person Centred Improvement Advisor/Clinical Team.	
	3.c	To further develop the feedback mechanisms we have in place to enable us to act on carer feedback and demonstrate improvement to service delivery, directly attributable to this feedback.	Skye Centre Manager/PCIA	
4. Development of a Carer Pathway				
To provide support for both patients and carers to navigate the transitional points within our care environment, and prepare our carers for their loved ones discharge through	4.a	The Act seeks to address the issues that may reduce or impede the wellbeing and positive outcomes for Scotland's carers. We are committed to supporting our carers to recognise the importance of improving their own physical and emotional wellbeing of our carers. This will be delivered through the provision of wellbeing information, check-ins following	Director of Nursing/Skye Centre Manager	

established links with the wider Forensic Network.		visiting and signposting to relevant supports within their community.		
	4.b	Carers will be supported to seek support and offer feedback throughout the care pathway through regular contact with the Clinical Team / Person Centred Improvement Advisor.	Clinical Teams / PCIA	
	4.c	Information relating to the receiving service is provided to carer, prior to patient's discharge/transfer.	Clinical Teams / PCIA	

Section 5 – How do we know we're getting it right?

Monitoring and Review

The delivery Plan accompanying this Carers strategy will be overseen by the Person Centre Improvement Group. This will collate the evidence of the progress made, including the cycle of auditing in relation to the Triangle of care standards and reported quarterly to the through our Clinical Governance Group, and annually to the Board.

Continued carer engagement - *You said, We did*

Carer involvement is a key principle of the Act. It is intended to empower carers with more useful information about the support that may be available to them and to ensure that they can share their caring experiences and knowledge with those responsible for providing support or services. We will involve our carers and carer representatives in the preparation and monitoring of our local carer strategy delivery plan, and planning of carer services.

We will achieve this through the development of our **Carer Support Group** and the contribution of our Carers' feedback through the Person Centred Improvement Group.

Section 6 - Legislation & Policy Drivers

Carer (Scotland) Act 2016	Outlines the rights of carers and the duties of local councils to make provisions for Carers including identification of carers needs through Adult Carer Support plans and Young Carers Statements for carers under 18 years old.
NHS Quality Strategy 2010	To deliver the highest quality healthcare services to people in Scotland. The strategy is built on the following priorities: * Caring and compassionate staff and services * Clear communication and explanation about conditions and treatment * Effective collaboration between clinicians, patients and others. * A clean and safe care environment * Continuity of care * Clinical excellence
Equality Act 2010	The Equality Act legally protects people from discrimination in the workplace and in wider society. It replaced previous anti-discrimination laws with a single Act, making the law easier to understand and strengthening protection in some situations.
Carer (Equal Opportunities) Act 2004	Aims to help carers achieve fair access to training, work and leisure opportunities. The Act: * Places a duty on local authorities to inform carers of their rights.

	* Places a duty on local authorities, when completing a carer's assessment, to consider whether the person works, wishes to look for work, wishes to study or have some leisure activities. * Gives local authorities strong power to enlist the aid of health, housing and education authorities in providing support for carers.
Refocussing the Care Programme Approach (Department of Health, 2008)	The Care Programme Approach (CPA) has been instrumental in embedding principles of holistic collaborative assessment and management into mental health care. Initially, its implementation was assisted by targeting those at greatest need. CPA principles are now applied to all patients in mental health services and practice needs to move to individualised care, focusing on meeting quality standards and achieving positive outcomes.
The Mental Health (Care and Treatment) (Scotland) Act 2003 / 2015	In March 2003 the Scottish Parliament passed the Mental Health (Care and Treatment) (Scotland) Act. The major civil provisions of this new mental health legislation commenced in October 2005 The Act sets out a number of principles that must be considered by any person utilising the provisions of the Act or, indeed, deciding to take no action under the Act. These principles include: 1. • participation of the patient in the process; 2. • respect for carers, including consideration of their views and needs; 3. • the use of informal care wherever possible; 4. • the use of the least restrictive alternative; 5. • the need to provide the maximum benefit to the patient; 6. • non-discrimination against a person with mental disorder; 7. • respect for diversity, regardless of a patient's abilities, background and characteristics; 8. • reciprocity in terms of service provision for those subject to the Act; 9. • the welfare of any child with a mental disorder being considered paramount; 10. • equality.

Carers, Consent and Confidentiality – Mental Welfare Commission Scotland.	This practice guide issued by the Mental Welfare Commission for Scotland, 'the expert knowledge family members have about the person they care for is important for staff to be aware of, even where staff do not have consent to share a person's information. It is vital that families have a means to discuss their concerns and share them with the professionals looking after their relatives.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2024
Agenda Reference:	Item No: 14
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. The report highlights activities in relation to Quality Assurance (QA) and Quality Improvement (QI) outlining 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.

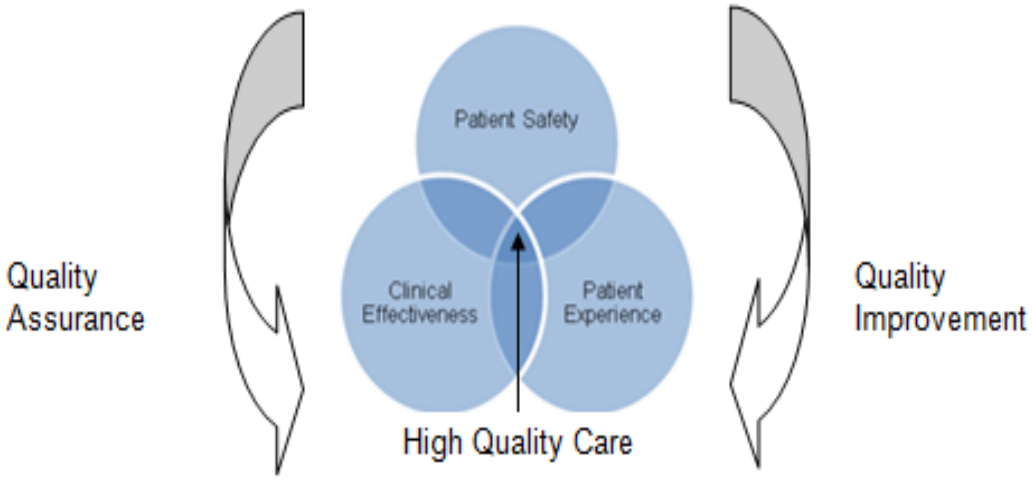
2. BACKGROUND

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:
  - Medication Trolley Audit.
  - Medicine Fridge Audit.
  - HEPMA Audit. (first cycle)
  - POMH Rapid Tranquilisation Audit.
- 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 support 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 four audits completed and actioned during this reporting period.

- Medication Trolley Audit.
- Medicine Fridge Audit.
- HEPMA Audit. (first cycle)
- POMH Rapid Tranquilisation Audit.

The Board asked Clinical Quality for a visual for all future audits. We have started to prepare a master audit sheet that contains all the local audits that have taken place and colour coded the compliance for each ward. Green shows that improvement areas are very minimal (and they should celebrate their excellent adherence), amber shows that the ward has been given some improvements that require to be actioned and red means we have concerns that there is a system/process failure within the ward for that audit.

	Arran 1	**Lewis 1**	**Arran 2**	**Arran 3**	**Lewis 2**	**Lewis 3**	**Mull 1**	**Mull 2**	**Iona 1**	**Iona 2**	**Iona 3**
Medication Trolley Audit											
Medicine Fridge Audit											
HEPMA Audit											
PMVA Post Physical audit							n/a	n/a	n/a		
Unvalidated progress notes											
Nurse progress note on each shift											

Medication Trolley Audit
This audit was completed in August 2024, with the report being submitted to the November meeting of the Medicines Committee. The recommendations agreed at the Committee included:

- The correct version of the medicine trolley check form should be used consistently with obsolete versions deleted from local drives.
- The medicine trolley check form should be completed after each medicine round to confirm the trolley has been checked and meets the standards.
- The HEPMA checklist should be completed after each medicine round to confirm all patients have been closed off for the current medicine round to enable the next medicine round to be opened without any issues.

Actions were agreed and will be progressed through the Medicines Committee.

Medicine Fridge Audit
There was excellent adherence with this audit with only a minor improvement area around ensuring the log is completed every day to show that the temperature has been checked.

HEPMA Audit
This is the first time this audit has been completed. There were nine aims looked at:

1. Ascertain the number of patients that had been given a psychotropic PRN within the last two weeks and if these had been noted onto RiO. (the hospital's main patient administration system)
2. Ensure all patients on clozapine had their clozapine withheld on the day they were due to have bloods taken.
3. Ascertain the reasons for non-administration of medicines.
4. Ensure all medications had been verified by a pharmacist.
5. Ensure all medications marked as 'other' are not already on the HEPMA system as a named medication.
6. Ensure all existing notes are still relevant.
7. Ascertain the time taken for medication rounds. (over three separate days)
8. Ascertain if there are any staff that have inactive HEPMA accounts.
9. Ascertain HEPMA downtime and whether the contingency had been triggered successfully.

Areas of Good Practice

- All patients had their clozapine withheld on the day they were due to get their clozapine bloods.
- HEPMA and RiO corresponded 100% of the time with regards to the medication given and route
- Only 1.3% of medications had not been verified by a pharmacist and some of these had only been prescribed within the last 2 days.
- Except for 1 medication, all medication marked as 'Other Drug' within HEPMA were categorised correctly as the medicines are not on the list.

Areas for Improvement

- There were 12 out of 76 (16%) PRN forms missing from RiO. This means we will be under-reporting the number of PRNs given when we report into the Service Leadership Teams and Clinical Governance.
- Care should be taken when choosing the reason for medication not being administered as errors were found during the audit.
- All registered nursing staff should ensure their HEPMA account remains active to comply with their NMC code as we found 3 members of staff had allowed their account to become inactive, with 2 working shifts whilst their account was inactive.
- The procedure for administering medications is not being followed in some wards as the full medicine round is not long enough for the amount of patients and the number of medications being administered.

Actions were agreed at the Medicines Committee with these being tracked through the Committee. Some actions have already started with members of the Medicines Committee visiting wards to support staff with their understanding of the policy.

Prescribing Observatory for Mental Health (POMH): Rapid Tranquillisation in the Context of the pharmacological management of acutely disturbed behaviour

The standards being looked at within this national audit were:

Following an episode of rapid tranquillisation:

1a There should be a prompt debrief, involving, as a minimum, a nurse and a doctor, to identify and address physical harm to patients or staff, ongoing risks and the emotional impact on patients and staff, including witnesses.

1b Within a week, the patient's written care plan should address the management of episodes of disturbed behaviour.

1c Within a week, the patient's written care plan should acknowledge his/her preferences and wishes should they become behaviourally disturbed again.

2 Intramuscular haloperidol should not be used as part of rapid tranquillisation in the absence of a recent ECG.

Monitoring after rapid tranquillisation:

3a Following rapid tranquillisation, the patient should be monitored at least every hour on the following measures, until there are no further concerns:
- Mental and behavioural state (behaviourally disturbed/agitated, asleep or awake, impairment of consciousness).
- Physical observations (pulse, blood pressure, respiratory rate, temperature.

3b Such monitoring should occur every 15 minutes if any of the following apply:
- The BNF maximum dose has been exceeded.
- The patient appears to be asleep or sedated, has taken illicit drugs or alcohol, has a pre-existing physical health problem and/or has experienced any harm as a result of any restrictive intervention.

Areas of good practice for The State Hospital included:

- All 15 episodes had evidence of the patient's written care plan being updated to reflect the management of any future episodes of disturbed behaviour.

Areas for improvement for the State Hospital included:

- There was no evidence found for four out of 15 episodes that a debrief had taken place.
- Seven out of 15 episodes had no evidence of the patient's preferences should they become behaviorally disturbed.
- Seven out of 15 episodes had no evidence of physical health monitoring of pulse rate, blood pressure, respiratory rate or temperature in the hour following IM being given.

Variance Analysis Tool (VAT) – Flash Reports

The most recent flash report was circulated in November 2024 and covers the month of October 2024

HOSPITAL WIDE VARIANCE ANALYSIS FLASH REPORT

Date: October 2024

Overview and areas of good practice

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

The monthly VAT report is split as follows:

October 24	Annual	Intermediate	Total	VAT completion	MDT attendance
Admission	0	1	1	98%	86% - increased from 79% in Aug 24 (no reviews in Sept)
Arran T & R	1	1	2	100%	75% - increased from 65% in Sept 24
Lewis T & R	2	0	2	100%	69% - increased from 66% in Sept 24
ID	1	1	2	100%	75% - increased from 71% in Sept 24
Transition	1	1	2	100%	50% - decreased from 55% in Sept 24

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

VAT form completion was excellent at 99.9% and all interventions continued to show random variation.

Points to note are:

- Medical completion increased from 87% to 100% in October 24. Provision of reports and Consultant attendance were 100%.
- All nursing assessments and reports were provided and patient attendance increased from 63% to 78% in October 24.
- There was improvement in all Occupational Therapy interventions, this was due to an improvement in staffing levels.
- All Skye Activity Centre reports were provided.
- All Psychology reports were provided and Clinical Psychologist attendance was 100%.
- Social Work attendance was 100%.
- All Pharmay reports provided.

Areas of concern
• Key Worker attendance decreased from 63% in September to 56% in October 24. • Pharmacy attendance decreased from 44% in Sept to 33% in October 24. • Security attendance decreased from 56% to 33% in October 24.
Any challenges with the systems that are being addressed
None at present.

QUALITY IMPROVEMENT

QI Forum

Since the last Board meeting, the QI Forum has undertaken a review through the development and design of a driver diagram to remain focused on its objective and purpose to champion, support and lead quality improvement initiatives across the hospital and raise awareness and understanding of QI approaches.

QI Capacity Building

QI Essential Training cohort three commenced training on 28th of August 2024 and is running over four half days into November 2024. The last segment of the training took place on the 28th of November 2024. Six members of staff completed the full course and will continue on the QI Journey by completed a Qi Project using the tools and learning that they have gained. A feedback session is being arranged for March 2025 where the cohort will return to present on their experience and learning using QI methods and approaches, including their QI projects. QI Essentials cohort four is currently being considered for early 2025 with the format of the course being reviewed to allow for a more varied cohort of students.

Scottish Improvement Leaders (ScIL) training is ongoing with two members of TSH staff currently undertaking this programme as part of cohort 46/47. ScIL cohort 50 commenced in November 2024 with three staff members successfully offered a place.

Realistic Medicine
Scottish Government Update - Six-month update on the 2024/25 Realistic Medicines action plan was submitted to the Scottish Government on the 18th of October 2024. The Realistic Medicine Lead and Programme Manager met with the Scottish Government on the 15th of November 2024 to discuss the report. The Scottish Government were positive in the work that has been undertaken at the State Hospital and were impressed with how we are embedding realistic medicine into everyday practice at the State Hospital due to its unique environment. Although there is a national area for improvement in relation to the completion rate of the Shared Decision-Making module, they are keen for us to continue to promote the advantages of completing and increase the completion rate on this module.

Team Based Quality Reviews (TBQR) - As part of Learning into Practice aims, TBQRs are continuing to be established throughout the site. TBQR's are service based panels responsible for selecting the material to be discussed at a monthly TBQR. The task of the panel is to identify the material with the most potential for learning and improvement. This will not necessarily be the most serious or, on the face of it, significant incidents. The panel will consider a range of sources to identify material for example, day-to-day work (we often overlook the value in sharing things we think are routine), other notable events or incidents (anything unusual – good or bad), things that went well, or things that didn't go so well, complaints or other forms of feedback and regular data reporting.

As part of establishment of these reviews, panel members have been identified through the four Service Leadership Teams and Human Factors training arranged for panel members on the 11th and 19th December 2024 which will be facilitated by a Senior Lecturer in Human Factors for Dundee University. The training

will provide panel members with the necessary tools to support Team Based Quality Reviews. It is hoped that following this training TBQR's will be embed into the Service Leadership Teams early 2025.

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 1st to 31st of October 2024, nine guidance documents have been reviewed. There were four documents which were considered to be either not relevant to TSH or were overridden by Scottish guidance and four documents which were circulated for information and awareness. The one remaining NICE guideline in relation to acute kidney injury will be reviewed by the Physical Health Steering Group regarding relevancy.

Table 2: Evidence of Reviews

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

There are currently three additional evaluation matrix, which have 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	Mental Health Practice Steering Group	Review group met twice with draft gap analysis currently out for review. Awaiting staff return from annual leave to progress outstanding sections	April 2024	December 2024
Scottish Government	Quality prescribing for antidepressants – A guide for improvement 2024-2027	Medicines Committee	Gap analysis produced and review group membership currently being agreed with a meeting date to be arranged thereafter	August 2024	January 2025
Scottish Government	Quality prescribing for Benzodiazepines and z-drugs – A guide for improvement 2024-2027	Medicines Committee	Gap analysis produced and review group membership currently being agreed with a meeting date to be arranged thereafter	August 2024	January 2025

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE **CGC(M) 24/03**

Minutes of the meeting of the Clinical Governance Committee held on Thursday 8 August 2024.

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

Chair:	
Non-Executive Director	Cathy Fallon
Present:	
Non-Executive Director	Stuart Currie
Vice Board Chair	David McConnell
In attendance:	
Health Psychologist	Alison Eadie [Item 4]
Skye Centre Manager	Jacqueline Garrity [Items 9 & 18]
Acting Director of Estates and Resilience	Allan Hardy
Chief Executive	Gary Jenkins
Head of Corporate Planning, Performance & Quality	Monica Merson
Board Chair	Brian Moore
Director of Nursing and Operations	Karen McCaffrey
Director of Finance and eHealth	Robin McNaught
Consultant Clinical Psychologist	Dr Claire Neil [Item 11]
Head of Corporate Governance	Margaret Smith
Head of Clinical Quality	Sheila Smith
Medical Director	Professor Lindsay Thomson

1 APOLOGIES AND INTRODUCTORY REMARKS

Ms Fallon welcomed everyone to the meeting and noted apologies from Ms Shalinay Raghavan, Non-Executive Director. It was also noted that the following could not be in attendance at the meeting: Dr Elizabeth Flynn, Head of Psychology, Dr Gordon Skilling, Consultant Psychiatrist, Lindsay MacGregor, Lead Allied Health Professional and Dr Khuram Khan, Consultant Psychiatrist.

2 CONFLICTS OF INTEREST

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

3 TO APPROVE THE MINUTES OF PREVIOUS MEETING

The Committee approved the minute of the previous meeting held on 23 May 2024.

The Committee:

1. Approved the minute of the meeting held on 23 May 2024.

4 MATTERS ARISING

The Chair noted the emailed updates received since the date of the last meeting, which had been very helpful.

- **Supporting Healthy Choices Update**

The Committee received a paper in respect of the Supporting Healthy Choices workstream, to provide a summary of the work being progressed especially in relation to the Admissions Service. Ms Edie joined the meeting at this point, and introduced herself to the Committee, providing some background to her work as a Heath Psychologist. She led the Committee through the key points, highlighting the finalisation of practice guidance specific to high secure settings, and the resultant action plan.

Ms Eadie outlined the key aims in the short and longer term of this. In respect of the Admissions Service, she noted that this is a point of key vulnerability to rapid weight gain, and that a multidisciplinary approach was being taken to improve this picture through test of change. Further, the group was progressing a scoping exercise which could be focused on individual case studies.

Both Ms Fallon and Mr McConnell commended the report and the work undertaken in a challenging area. Mr McConnell asked what the key areas for development were; and what was different from previous approaches. Ms Eadie referred to the evidence led approach linking this to behavioural science, within the unique environment of the State Hospital (TSH). She provided assurance that the SHC Group fully appreciated the potential to make a real difference to the physical health of patients within TSH, and their quality of life moving forward. There was also a focus on embedding good physical health opportunities in the day-to-day environment and culture in the hospital.

Professor Thomson underlined the importance of this evidence led approach, and the focus on the Admissions Service – in terms of whether it was possible to prevent the weight gain in the first place. This would also help to inform the approach for all patients within TSH.

Mr Currie agreed that the report helped the Committee to focus on the key areas, and asked for future reporting to include a mapping exercise to help to demonstrate which of the points of the action plan, were found to be most effective in impact. He noted the danger of not prioritising the key actions with the potential result that these may be the ones that were not progressed successfully, albeit that a range of other actions may have been. He noted the consequences of unhealthy choices from a clinical perspective and the impact for individual patients; but also for the hospital in terms of resource allocation, to ensure value for money in this area. In this respect, should there be improvement going forward, there may also be a potential in terms of financial savings.

Mr Jenkins referred to the Corporate Risk Register and the risk MD30 relating to patient obesity which was first defined in 2015. He noted the need to consider re-framing this in light of the work being progressed, and with a different breakdown of the opportunities and benefits in a realistic way especially in relation to smaller cohorts of patients. Ms Eadie noted the position in terms of population health more generally, and the risk of setting unrealistic goals for the population.

In respect of the action plan, Professor Thomson added assurance that these had been determined by the guidance and were evidence based. These have been reduced to 28 points that were matched into short, medium or longer term.

Ms Fallon summed up for the Committee in terms of the importance of this work, and the helpfulness of the update provided.

<u>The Committee:</u>

1. Noted the Supporting Healthy Choices Update.

5 PROGRESS ON ROLLING ACTIONS LIST

The Committee received the Rolling Actions List, and Ms Fallon queried why there was not yet a definitive start date for water damage and leaks to the Skye Centre and Islay building, referencing the fact that this has been an outstanding for some time. Mr Hardy provided assurance that the works had been scheduled to begin in mid-August. He noted that this would be a protracted piece of work that would affect grounds access for patients, which had to be carefully coordinated with the contractors.

The Committee was content to note the remaining updates as detailed in the Rolling Action List.

The Committee:

1. Noted the updates from the Rolling Actions List.

6 DUTY OF CANDOUR ANNUAL REPORT 2023/24

Members received the Duty of Candour (DoC) Annual Report, and Dr Alcock joined the meeting to provide a summary of the content. This included an outline of the process followed by the group, and noted that outcomes were reviewed in each case to ensure that these were bring actioned appropriately within TSH. He also advised the Committee that staff training compliance in this area remained high.

Mr McConnell noted that the number of potential incidents had halved, but that the number then confirmed as being DoC had gone up, and asked if this was random variation or if there was any discernible theme. Dr Alcock thought that this could be multi-factorial referencing increased confidence in staff in identifying DoC incidents in particular. At the same time he noted that it was possible that there was random variation at play. He advised he would review this with the risk department and provide a further update.

Action – D Alcock

Mr Moore asked if there was any learning from a national perspective in terms of ongoing implementation of what was fairly recent legislation in this area, and if so, how this would be relevant to TSH especially in terms of emerging patterns. Dr Alcock agreed it would be helpful to take learning from other Boards, and advised that he would do so and provide an update in future reporting.

Action – D Alcock

He also advised that the process within TSH had been refreshed to give the DOC Group greater independence in terms of the consideration of whether an incident was DOC, and that this aligned more solely with the intention of the legislation. This was working well, with more confidence within the team. On this point, Professor Thomson noted the necessity to make a decision on whether an incident was DoC within a short time frame, based on the information to hand at the time. Therefore, the group have been asked by the Corporate Management Team (CMT) to also provide the rationale for the decision at the time it was made, which could be helpful should there be an area of doubt at the time.

Ms Fallon welcomed this change in process, and the Committee was content to note reporting.

The Committee:

1. Noted the Duty of Candour Annual Report 2023/2024.
2. Requested further updates in relation to the change in the number of incidents, and benchmarking to other Boards.

7 RESEARCH COMMITTEE ANNUAL REPORT 2023/24

Members received the Research Committee Annual Report 2023/24, which was presented by Professor Thomson. She outlined the importance of this area for TSH in having a very active research programme. There was a high level of commitment to research and the report provided the Committee with an overview of the key aspects. She also drew attention to the key performance indicators, indicating that the activity demonstrated therein was very positive for a hospital of the size of TSH. She confirmed that this workstream was taken forward in close collaboration with quality assurance colleagues, and all evaluations were reviewed by the Research Committee to ensure that they were each of the right methodological standard. She advised that the Research Assistant role was being embedded within the budget, and this would have a particular relevance in relation to the update on the meeting agenda on the clinical model.

Professor Thomson recognised the need to reflect on the experiences of those with lived experience of forensic settings, and that this was an area in which progress should be made, and that this was important in a wider context than research. She advised that the R&D Strategy remained outstanding, but that this would be taken forward imminently.

Mr McConnell asked about the financial context in terms of allocation of funding to projects, and Mr McNaught confirmed that confirmation in this respect had just been received, so this could be progressed toward resolution. He advised that this had been an administrative issue only, and had not hindered workstreams. Ms Fallon asked for an update at the next meeting.

Action – R McNaught

Ms McCaffrey commented on the number of nursing colleagues involved in research, which was very encouraging. She would link in with them, from the perspective of encouraging other nursing colleagues to get involved. Ms Fallon commented in particular on the importance of the work in relation to lived experience, and thanked Professor Thomson for reporting.

The Committee:

1. Noted the Research Committee Annual Report 2023/24.
2. Asked for an update on fund allocation.

8 MENTAL HEALTH PRACTICE STEERING GROUP 12M REPORT

Members received the Mental Health Practice Steering Group 12M Report, and Ms S Smith advised that she would provide the Committee with an overview of the content of the report. In doing so, she highlighted in particular the focus on the CPA processes, and a link to RiO (electronic patient records system). She also noted the work in relation to trauma informed care, as well as the intended future focus on structured clinical care and family interventions. She also noted the change being made in practice relating to clinical Risk Assessments, so that data would be reviewed on a quarterly basis rather than every six months to help support improvement in that area.

Mr McConnell asked about pre-admission assessment forms, and the variance in performance in this respect. Ms S Smith advised that these were completed to get a better understanding of patients' day to day needs e.g. religious requirements or walking aids so that preparation could be made in advance. Professor Thomson advised that this could be monitored through the weekly Patient Pathway Meeting, as this considered referrals for admission.

Mr Moore asked for more clarity about the section on clinical outcomes pilot report, and a reference to seeking an alternative to the existing tool used. He asked how assurance could be provided in terms of having a tool that was fit for purpose. Professor Thomson advised that this was an ongoing piece of work to seek out the best way forward. This will be through a series of workshops with relevant staff, and would be evidence based looking at outcome progress

measures. This approach should place the hospital in a much stronger position in this regard.

The Committee:

1. Noted the Mental Health Practice Steering Group 12/M Report.

9 REHABILITATION THERAPIES SERVICE 12M REPORT

Members received the Rehabilitation Therapies Service 12M Report, which was presented by Ms Garrity. She provided a summary of the key points as detailed in the report, including focusing on the data presented, and the relevant assessment tools used. The report also detailed the work of the different disciplines in the team and the range of workstreams, as well as providing data on the number of individual and group contacts with patients. There would be further focus on how to build on activity rates, and what had been put in place in conjunction with the Skye Centre to lessen impact on patients through cancelled sessions. This was an area of importance and was monitored through the Activity Oversight Group.

Mr Moore commented that this was a particularly helpful report, and provided a reminder on the different specialisms and activities taking place, and the multidisciplinary approach. It was positive to see more activity in hubs, and for different professional groups working together and considering new ways of working. Ms Fallon echoed these comments especially around multidisciplinary working. She also passed the Committee's congratulations to the patients who completed their SVQ courses; and noted the Activity Boxes in wards as being a good initiative.

The Committee:

1. Noted the Rehabilitation Therapies Service 12/M Report.
2. Passed on their congratulations to the patients who had completed SVQ courses.

10 SCOTTISH PATIENT SAFETY PROGRAMME 12M REPORT

Members received the Scottish Patient Safety Programme (SPSP) 12M Report presented by Ms McCaffrey. She outlined the main aspects of the report, highlighting the introduction of the new clinical care policy, and the substantial amount of work involved, and the way in which this would place the hospital in a good position going forward. She also noted the impacts of daytime confinement, and the way in which the SPSP provided support in the approach taken. Further she underlined the importance of keeping in contact with partners, especially the Mental Welfare Commission (MWC) ensuring openness and transparency in relation to the processes put in place. She also referred to the planned approach to the coming year in terms of quality assurance and improvement.

Mr Moore asked about quality and safety walkrounds, and thought that it was important to progress this area, even whilst awaiting national guidance. He recognised that the Board requirements may differ from the quality and safety elements of this. Ms McCaffrey agreed noting the pilots being trialled at other NHS Boards, but it would be important to see what could be commenced. Mr McConnell noted that it was helpful for Non-Execs to do walkrounds as an additional insight into the organisation. Mr Jenkins agreed that this should be taken forward, and it was noted that there would be a paper brought to the Board later in the month.

Ms Fallon noted the comprehensive nature of the report, and the helpfulness of the content.

The Committee:

1. Noted the Scottish Patient Safety Programme 12M Report.

11 PSYCHOLOGICAL THERAPIES 6M REPORT

Members received the Psychological Therapies 6M Report, from the Head of Psychology and Dr Neil joined the meeting to present the paper. She highlighted the increase in clinical activity and in the delivery of therapeutic sessions. She also referred to the National Specification for the Delivery of Psychological Services, and the intention to establish a psychology governance group within TSH in this respect. Professor Thomson advised that the Clinical Governance Group had reviewed this paper, and were in support of the new governance group.

Mr Moore asked about data sharing arrangements, and how this worked with partners such as the police, and the impact should the relevant information not be available for a patient risk assessment. Mr Jenkins advised that an exercise had been undertaken with police as well as the prison service in terms of data sharing, and Mr Hardy would be able to link this across to ensure that work was not being taken forward in parallel.

The Committee:

1. Noted the Psychological Therapies 6M Report.

12 INFECTION CONTROL QUARTERLY REPORT

Members received a verbal update on Infection Control from Ms McCaffrey, who noted that the hospital had just recruited successfully to the senior nurse post, who would take up post on 19 August 2024. She provided assurance that the Infection Control Committee continued to meet quarterly, and the related groups continued to be active in taking forward monitoring actions. There were no specific areas of concerns to be escalated to the Committee for this meeting, and a full report would be presented at the next meeting.

The Committee:

1. Noted the Infection Control Quarterly Update.

13 NURSE RESOURCE QUARTERLY REPORT

Members received and noted the Nurse Resource Quarterly Report present by Ms McCaffrey.

Firstly, she highlighted that *ND70 - Failure to utilise our staffing resources to optimise excellent patient care and experience* remained a high risk, which continued to be monitored. She noted the continued use of the Supplementary Staff Register (SSR) and the need to monitor overtime. She also noted the increased pressure on staff due to clinical acuity and patient out boarding for acute care, and related episodes of daytime confinement. There was stringent oversight of this to ensure it was for the shortest duration possible. There continued to be a proactive approach to recruitment, and the recent open day held within TSH had been very successful.

Mr Currie commented on the success of the open day, and on the possibility that TSH could offer an interesting and stable environment through which nurses could progress their skills and experience in their careers. It would be good to see this type of approach being embedded within TSH. Ms McCaffrey agreed with this, and that it was a great opportunity to emphasise the unique selling points of TSH. It had been a very encouraging start.

Mr McConnell asked about the number of staffing resource incidents within the reporting period, and Ms McCaffrey outlined the unusual circumstances that had occurred within the quarter in terms of patients who required emergency outings. Mr Jenkins referred to work undertaken through Clinical Quality which showed the running trends should there be challenges in relation to clinical activity that's over and above the baseline expected. This would be referred to later in the agenda, under reporting on incidents.

The Committee:

1. Noted the Nurse Resource Quarterly Report.

14 BED CAPACITY REPORT

Members received the Bed Capacity Report presented by Professor Thomson. She noted that the report format had been reviewed to align it with reporting to the Board. She summarised the data within the report for the Committee, including patient movement across services with TSH. She also noted the position across the forensic estate, and that there did continue to be capacity issues. There had been improvement in the west, but the Orchard Clinic remained an area of pressure. There had been a case across forensics which required conflict resolution, which had been resolved through use of an exceptional circumstances admission to TSH although this route is not formally open. Beds were available in medium secure units. This issue has been discussed at the Network's Inter-regional Group and is being taken forward by Scottish Government via a meeting of medical directors.

Mr Jenkins also asked the Committee to note that the hospital was currently operating on 11 open wards, due to clinical need. Mr Currie noted the occupancy rates, and asked about how this was assessed from a clinical point of view, and what was considered comfortable and would give a degree of flexibility. He referred to the opening of a ward around clinical need as a good example of flexibility in the delivery of services. He offered the view that the existence of such capacity within TSH should not necessarily be seen as requiring to be used unless it was clinically assessed as appropriate to do so.

Professor Thomson agreed with this, and noted that ideally capacity in forensic mental health settings should be around 80%. She thought that TSH was managing capacity well but this was always pressured. This was subject to close oversight by the Patient Pathway Meeting on a weekly basis; and exceptional circumstances should not be used routinely as these were patients who should be placed in a medium secure setting. Such cases were also automatically reported to the MWC.

Mr Jenkins also commented on the need for a contingency ward within TSH, given the unique nature of the service.

The Committee:

1. Noted the Bed Capacity Report.

15 QUALITY STRATEGY

Members received the Quality Strategy presented by Ms S Smith. She provided the Committee with an update on the development of the strategy, which had previously been discussed at a Board Development Session as well as by the CMT. The strategy adopted NHSScotland core values, and described the quality vision and aims of the hospital, including the quality management system, assurance and improvement. Some of the key aspects related to Excellence in Care as well as Realistic Medicine. The focus was on looking at the five priority areas, and how success would be measured. The next step was a delivery action plan, tailored to the resources available within TSH.

Mr Moore welcomed the strategy, and the content of it, particularly the King's Fund guiding principles as well as Realistic Medicine. He asked about whether the references to the data could be more pronounced within the guiding principles, and how it is collected and used within TSH. He also referred to the person centred section, and whether this could be more clearly linked to the practices within complaints and feedback, reporting on each of which was also received by this Committee. Lastly, whether this could be used more proactively to engage staff, to build

ownership and appreciation of this approach across the organisation. Mr Jenkins concurred with this in terms of how to do this, especially with front line staff, perhaps through induction. This may help understanding as to how TSH sees the strategy and how it spans the whole organisation.

Actions(s): M Merson / S Smith

Ms Fallon agreed with this approach, commenting that this may help to bring the strategy alive for staff groups. She noted the Committee's agreement that monitoring of the strategy could be through the Clinical Governance Group.

The Committee:

1. Endorsed the Quality Strategy update.
2. Endorsed the reporting and monitoring arrangements for the strategy as outlined.
3. Asked for consideration of how to embed this approach across staff groups

16 CORPORATE RISK REGISTER - CLINICAL RISKS

Members received the Corporate Risk Register - Clinical Risks presented by Mr Hardy. He summarised the content of reporting, and the 11 risks aligned to this Committee. He noted that the two risks rated as high had already been discussed at this meeting, and reflected that the risk assessments for each reflected the work being progressed in each area. He also provided an update from the Risk Department, both in terms of the focus on refreshing risk registers, as well as supporting Significant Adverse Event Reviews.

Ms Fallon thanked Mr Hardy for the update, and the helpful connections made to previous papers received at the meeting today.

The Committee:

1. Endorsed the Corporate Risk Register - Clinical Risks.

17 INCIDENTS AND PATIENT RESTRICTIONS REPORT Q1

Members received Incidents and Patient Restrictions Report Q1, presented by Mr Hardy. He highlighted the key points, including the background to personal attack alarm activations and the use of Soft Restraint Kits (SRKs). In terms of incidents, he described the range of areas this covered and the way the data was collected, and also that Service Leadership Teams would be provided with data for their own areas. He also noted to the Committee that the way in which staff resource incidents were reported would be reviewed and refined to ensure that the data reported on was meaningful and accurate. Mr Jenkins picked up this point, and added that the inclusion of staff resourcing incidents had been an adjustment made some time ago, but in practical terms it was not the most useful way to record and report day to day operational issues. Therefore, work was being progressed to see how this the system could be improved.

Mr Moore referred to incident reporting within the Intellectual Disability (ID) Service, and if this was something that should be considered by the Board further in terms of the resourcing and financial impacts, and this should be kept in mind as a matter that may require further discussion. Professor Thomson noted that a Reflective Review which related to the ID service was near completion, and would inform any future discussions. She also noted that the episodes of physical restraints had increased overall, and the number of patients involved was 21 which is a fifth of the total patient population. The Clinical Governance Group would look at this in more detail in terms of the circumstances and clinical background. Mr Currie agreed that getting the context and background on this would be very helpful to understand the impacts on patients and on staff, and in terms of assurance and decision-making. Mr Jenkins added agreement to this linking in the additional complaints and feedback received through the Patients' Advocacy Service. Professor Thomson

provided additional context in relation to the safety survey carried out previously and the move to a two ward model within the ID service as part of the clinical model, as well as reflecting on the very skilled workforce within TSH in this area.

Ms Fallon thanked Mr Hardy for detailed reporting, noting that there would be areas of further discussion here that would come back to the Committee through reporting.

The Committee:

1. Noted the Incidents and Patient Restrictions Report.

18 LEARNING FROM FEEDBACK REPORT

Members received the Learning from Feedback Report, and Ms Garrity re-joined the meeting to present the report. She noted that the amount of feedback received had decreased during this quarter, with a downward trend overall. She also highlighted a compliment relating to attendance at a CPA and visit from a carer. She also noted feedback related ongoing work on volunteers and their induction into TSH. There had been further feedback in relation to the arrangements for visiting, including some confusion around food items being brought into the hospital, which had been resolved.

Ms Garrity provided assurance about strength of functioning in the Patient Partnership Group (PPG) with regular attendance from Non-Executive Directors, as well as a range of other stakeholders.

She acknowledged that there had been some variance in the regularity of ward community meetings and this had been picked up with senior nursing staff with the aim of achieving more consistency across the hospital, as this was an important means of engaging with patients. Lastly, she noted that the report sought agreement from the Committee that in the future this quarterly report could be collated and incorporated into a singular report covering both complaints and feedback. This would allow the PCIT to report on patient engagement work, and this would be reported as part through the Patient Centred Improvement Group. There was agreement around the table to this proposal.

Mr Moore asked about one piece of feedback from a volunteer, which referred to religious information; and Ms Garrity provided assurance that this would have been an individual view provided within the staff group rather than directly to patients, who were supported to engage with the religion of their choice. Mr McConnell asked if the drop in feedback could be due to the change in the way feedback from the PPG was recorded, and Ms Garrity agreed that this could be the case. She provided more background about how points of discussion at PPG would be routed actively through the community meetings and then back to PPG – so that this would be a more iterative process. This should bring more clarity and purpose to the way in which patient views were acted upon across the hospital.

The Committee:

1. Noted the Learning from Feedback Report.
2. Agreed to singular complaints and feedback reporting going forward.

19 COMPLAINTS

Members received the Learning from Complaints Report which was presented by Ms M Smith. Ms Smith noted the key highlights from the report, which included the numbers of complaints received and the issue these raised; as well the complaints finalised within the quarter which had demonstrated learning for the organisation. She noted that the majority of complaints continued to be resolved at an early stage, which was positive.

She noted a general concern that had been highlighted by the Patients' Advocacy Service about the arrangements for patient mealtimes because there had been some instances of this impacting patient contacts/meeting with PAS and/or their legal representatives. This had been a logistical issue, and had been resolved quickly with the help of Lead Nurses and the Catering Department. Ms Smith also reflected on some of the learning from closed complaints, particularly around communication between departments across the hospital, as well as administrative issues around approval of telephone contacts; and the management of patient property.

Lastly, Ms Smith noted that there had been an internal audit of complaints management during this quarter, particularly on the recent changes made within the service. This had resulted in a rating of substantial assurance for the organisation, with a small number of management actions which were being progressed. She noted that the Complaints Officer was moving on to further education, following her secondment in the department, and thanked her for her contribution especially in contact with patients. On this point, she also assured the Committee that a re-structure of her department had been agreed by the CMT, and that this was being taken forward to ensure that complaint handling remained a high priority.

Ms Fallon thanked Ms Smith for providing this additional background, and Mr Currie noted that it was a positive report and that it was good to see the continuing efforts to review how this service was delivered, and trying to improve on the basis of feedback especially from patients. He added that it may be helpful to take a pause during the year to consider any changes made, and how each change did make an improvement from the starting point. It may also be that some changes may have been tried which had been found not to be entirely successful, and this should be considered as well. Ms Smith agreed that this was a helpful suggestion and could be built into reporting going forward.

Action – M Smith

Mr McConnell referred to the internal audit report, which had referred to how this Committee took oversight in this area, noting possible lack of evidence of sufficient challenge within the minutes recorded. He noted that this may be a minuting issue, and also queried as to whether the Committee would interrogate individual complaints. He commended the complaints service for the very positive outcome of the audit. Ms Smith noted that it may be difficult for the Committee to discuss complaints in more detail given issues of confidentiality.

Ms Fallon congratulated Ms Smith on the result of the audit, and offered the view that this was a regular report to the Committee which generated discussion, and that the Committee took oversight in this way.

<u>The Committee:</u>

1. Noted the Learning from Complaints Report.
2. Noted the Internal Audit Report and commended the Complaints Service.

20 DISCUSSION ITEM

- **Clinical Model Evaluation**
- **Clinical Model Internal Audit Report**

Professor Thomson noted that she would share a series of slides with the Committee, but first noted the internal audit report included on the agenda. This had been on the implementation of the Clinical Model, as well as progress made since formal handover from the project implementation team in July 2023. She noted that the audit provided reasonable assurance to the organisation.

Professor Thomson provided a reminder on the history of the development around a new clinical model. She also referred to the interim update provided to the Board at its development session which took place in April 2024. Professor Thomson led the Committee through the detail of a

series of slides which covered the new clinical model aims of tailored security based on risk and clinical presentation, and a sense of progression for patients through supporting physical health, therapeutic activities and treatment goals. She described the way in which the model was implemented, and the careful management of this.

Professor Thomson then provided a summary of the development of the Service Leadership teams, and gave assurance that they were each engaged with Organisational Development. Further, that the Clinical Model Oversight Group was well established, and was developing a reporting and monitoring schedule. She emphasised the importance of continuing to focus on the key factors such as patient progression and flow, which were functioning well in the new model. Further, that the Activity Oversight Group was established and taking oversight in respect of patient activity. Overall, reporting mechanisms were embedded and working well.

Professor Thomson gave the view that services had made good progress, and had in embraced the new clinical model elements and were generally functioning well. Some new patient focussed aspects had been initiated and would require time to grow and develop.

Professor Thomson also provided background detail on the research planned within the hospital, including a follow up staff survey. She concluded by offering assurance that the model was delivering on the key aspects that it had set out to so.

Ms Fallon thanked Professor Thomson for the presentation, and it was agreed that the slides would be circulated to the Committee.

Action – Secretariat

Mr Moore noted that the presentation contained a lot of information. He asked about how the services were adjusting, in terms of their interventions and approach to working with different specialties. For example, he noted the low level of incidents within Transitions, and what that may mean in terms of the interventions made by the multidisciplinary team as well as the staffing levels within that area. It was worth considering how existing staff resources were being utilised to support and maximise benefits to patients. Professor Thomson concurred with this in respect of the opportunities for change and development that could arise.

Ms Fallon said that it would be helpful to see more detail on patient flow, particularly patients who may not have a singular pathway towards Transitions and moving on from TSH. It would be interesting to see how patients felt should they move back to Treatment and Recovery. Professor Thomson noted that there had been two cases of this type, and noted work being progressed through the PPG to capture patients' views.

Mr Jenkins advised the Committee that with reference staff feedback, there was a cohesive programme being led through Organisational Development presently. It was important to ensure that the different elements of staff feedback were linked together in the context of trying to get a central position about how we develop the workforce overall.

Ms Fallon noted that once members had the opportunity to review the slides, there may be further questions and opportunities for discussion, and that this may come back to the next meeting.

<u>The Committee:</u>

1. Noted the content of the presentation, and that the slides would be circulated.

21 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

The Committee noted the following areas as demonstrating good practice: Activity Boxes within ward areas, as well as the hard to reach cafes, which were excellent initiatives.

22 COMMITTEE WORKPLAN 2024/25

The Committee noted that the Carers' Strategy would be deferred and brought to the Board Development Session in October. Some further minor amendments were also noted to refresh the terminology, and to include the Corporate Parenting Plan specifically as part of Child and Adult Protection reporting.

23 ANY ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTEES

The Committee noted that the reporting from internal audit, as well as staffing matters to be shared with the Chair of the Staff Governance Committee e.g. cohesion in staff survey, the SSR, and active recruitment within nursing, as well as the background around the discussion on patient incidents.

24 AGREEMENT OF ITEM FOR DISCUSSION AT NEXT MEETING

The Committee noted some possible topics, including dementia care and trauma informed care.

25 ANY OTHER BUSINESS

There was no other business raised at the meeting.

26 DATE OF NEXT MEETING

The next meeting would be held on **Thursday 14 November 2024** at 09:30 hours via Microsoft Teams.

The meeting concluded at 1300 hours

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2024
Agenda Reference:	Item No: 15
Report Author:	Head of Corporate Governance
Title of Report:	Clinical Governance Committee – Summary Report
Purpose of Report:	For Noting

This report provides the Board with an update on the key points arising from the Clinical Governance Committee meeting that took place on 14 November 2024.

1	Corporate Risk Register / Risk Reporting	The Committee reviewed the clinical risks within the Corporate Risk Register, and agreed that reporting represented an accurate statement of risk.
2	Carer Strategy	The Committee received the draft Carer Strategy which had been developed through the Person Centred Improvement Group, as well as feedback from the Visitors Experience Audit. This is a local strategy aimed tailored to the needs of carers, as well as fulfilling the statutory guidance in this respect. The Committee reviewed the strategy in detail, and recommended that the strategy should go to the Board for final approval.
3	Annual Reports: -CPA/MAPPA -Child and Adult Protection -Physical Health Steering Group -Supporting Healthy Choices -Person Centred Improvement Service	The Committee received assurance reporting in the form of 12 month or annual reporting across a range of areas as indicated. Of particular note as good practice was the 100% completion rate for CPA for patient transfer from the State Hospital (TSH). The Committee was also noted the improvement in the number of child visits that had been accommodated during the year. The Committee took assurance on the high quality nature of the care received by patients in relation to their wider physical care needs, and the progress of the work in regard to the action plan underpinning the Supporting Healthy Choices workstream. Lastly, the Committee noted and discussed the wide range of activity noted within the Person Centred Improvement Service Report including food/fluid/nutrition, health psychology, occupational therapy, quality improvement and assurance activities.

4	Infection Prevention and Control (IPC) Quarter 2 Report	The Committee received reporting to present IPC activity under the headings outlined in the HIS Infection Prevention and Control Standards (2022). The Committee welcomed the refreshed approach to reporting, in this regard.
5	Bed Capacity Report	The Committee received a report to provide data across patient admissions and transfers. This report also provided background on patient movement through services within TSH, as well as the position on bed capacity across the wider forensic estate.
6	Incident Reporting and Patient restrictions	Reporting provided the Committee with the Quarter 2 position on the types and numbers of incidents, including RIDDOR reporting and serious adverse events (SAERs) and patient restrictions during this period. The increased activity on SAERs was noted in terms of management of reviews and resultant actions, and that reporting on the learning from these reviews would be reported to the Committee.
7	Learning from Complaints & Feedback	The Committee received Quarter 2 reporting in relation to complaints and feedback, aligning these areas and streamlining reporting. The report focused on performance in relation to the relevant Key Performance Indicators for complaints handling, and the key areas of learning and improvements made in this quarter. Reporting also included a range of informal feedback from patients and from carers, and the responses made.
13	Trauma Informed Care	The Head of Psychology led the Committee through a detailed presentation, leading a discussion around the different aspects of trauma informed care, and how this was being progressed. There was wide ranging discussion including how the organisation considers what trauma is, and how to take learning forward as part of care delivery. Further, how this is taken forward with staff and the delivery of training. The Committee noted that this is a workstream that continues to progress and is a highly complex area. There would be further consideration on how to define trauma informed care, and to embed this within policy and practice locally, whilst having awareness of the national focus in this regard. It was agreed that this would return to a Board Development Session in 2025.
14	Areas of good practice/concerns	The Committee noted good practice in the development of the Carer Strategy, as well as the 100% completion rate in CPAs prior to patient transfer. Further the increase shown in child contact, as well as the health provision from the health centre for patient physical health needs.

RECOMMENDATION

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

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2024
Agenda Reference:	Item No: 16
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 November 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.

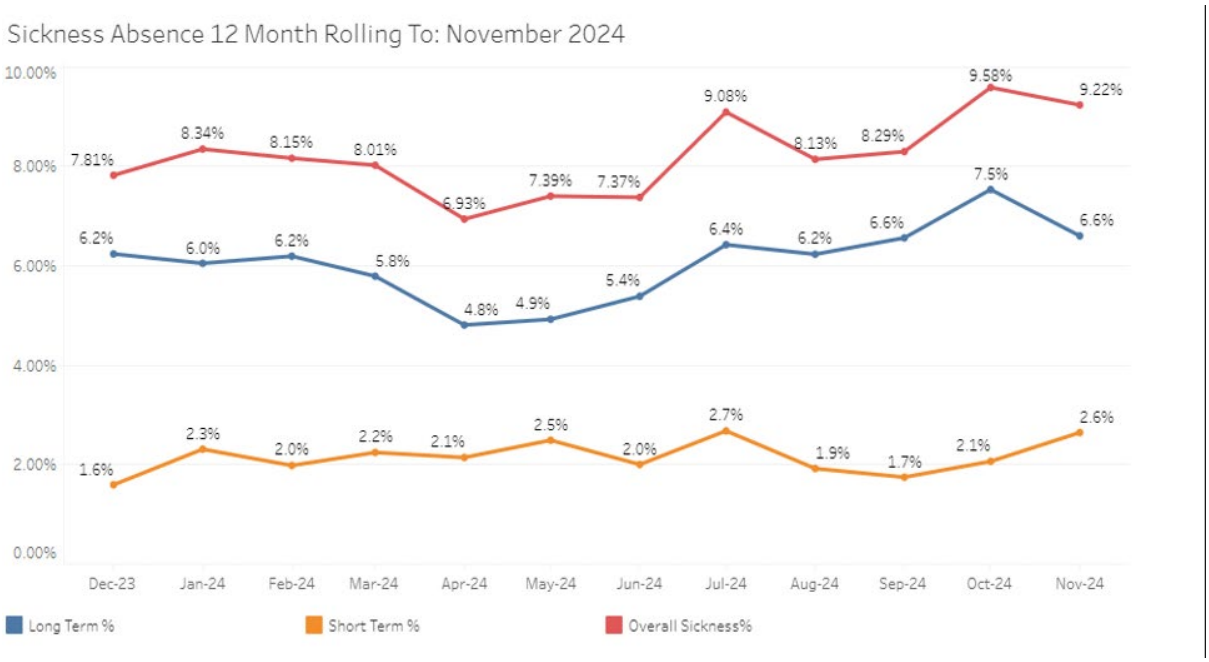
The Tableau dashboards are updated on a daily basis with attendance information using information from the SSTS system, meaning that the information available is live and as accurate and up to date as the information input by managers.

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

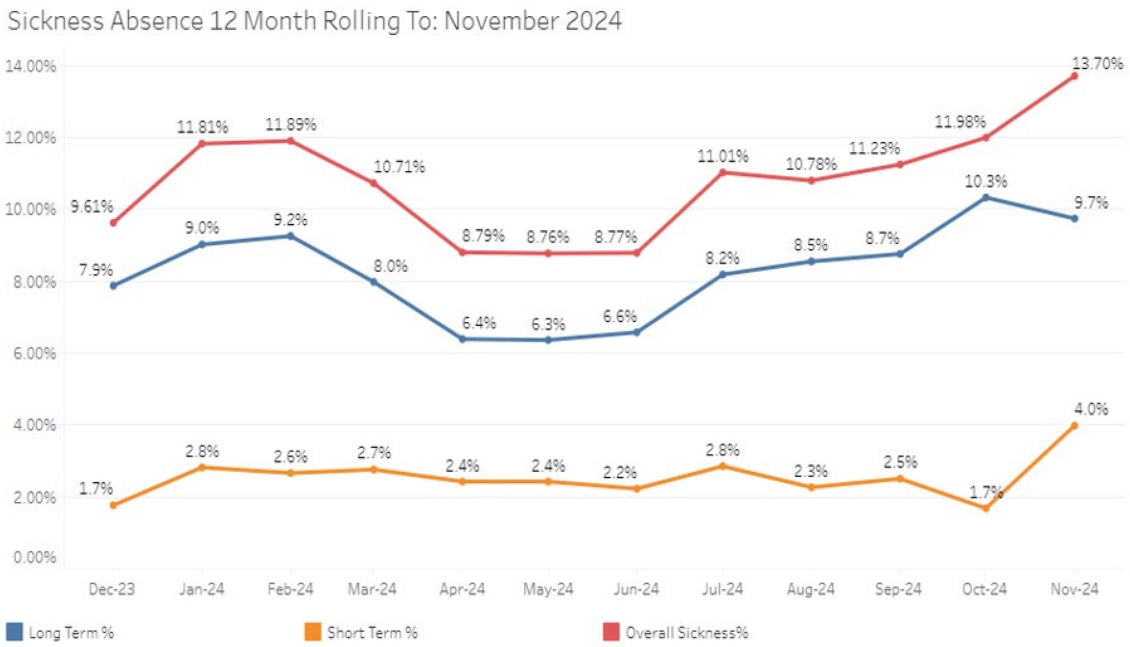
a) ATTENDANCE MANAGEMENT

(i) TSH Sickness Absence (Dec 23 to Nov 24)



Small reduction of 0.36%, with long term falling by over 1%, but short term absence increasing.

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



Nursing Sickness absence increased by 1.72%, with long term absence falling as short term absence increased.

(iii) Attendance Management Observations

Patterns/Trends:	Slight reduction in total absence (small decrease in long, small increase in long term). Spike in Nursing (long term) is main contributory factor.
Areas of Concern:	Arran Ward 1, Skye Centre – Administration, Lewis – Ward 3
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 November, 9 staff were invited to a Stage 1 meeting and 1 member of staff were invited to a Stage 2 and no staff were invited to a Stage 3 meeting. Of the 101 people who have been on a Stage 1 in the past 12 months, 86 remain on an active monitoring period. 14 are currently on active Stage 2 monitoring and 1 on Stage 3.
Benchmarking:	Rowanbank: Orchard Grove:

b) RECRUITMENT

TIME TO HIRE	75 days (KPI of 75 days)	Only 3 vacancies
SUMMARY OF VACANCIES:	Currently 8 wte Band 5 Registered Nurse vacancies and 1 planned leaver	5 OU students awaiting PIN, therefore 4 Band 5 RN Vacancies
EMPLOYABILITY:	MA awaiting start date. Support for Demonstrator Programme with South Lanarkshire Council is ongoing	

c) SUPERNUMARY STAFFING

OT & EXCESS	48.89 WTE	Down from 52/67 WTE
NURSING	30.94 WTE	Down from 31.52 WTE
SSR	9.92 WTE	Down from 11.06 WTE

d) EMPLOYEE RELATIONS

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	0	2	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 November.

e) LEAVERS

Leavers

- No leavers in November 2024: YTD total is 37.
- Turnover YTD is 4.98% compared to last year which was 5.44%

Exit Interviews

- Exit interviews continue to be offered to all staff on leaving the organisation at the time of resignation letter received to HR.
- Circa 30% Exit Interviews completed April to November

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

Status / Progress

Progress in December

- In December four new Job Descriptions were received.
- Four outcomes were given (completed within 14 weeks target timeline).
- During December two Quality Check panels took place.
- JM panels were cancelled due to not being required.

Status

- At end December there are 3 posts which remain active as outlined in the slide deck.
- Of the 3, two require to be reviewed to ensure they are panel ready and one is the outstanding JAQ. Following the Quality Check process this post is required to be

returned to the original JAQ panel to progress responses provided to queries raised by the QC panel. Dates are being sought.
- The review requested in October as outlined in the slide deck also remains outstanding due to awaiting paperwork, this is not included in the active posts. It will be re-added once paperwork is received.
- The JE Leads continue to meet monthly to ensure timely progression of posts.
- January, February and March 2024 panel dates are being scheduled.

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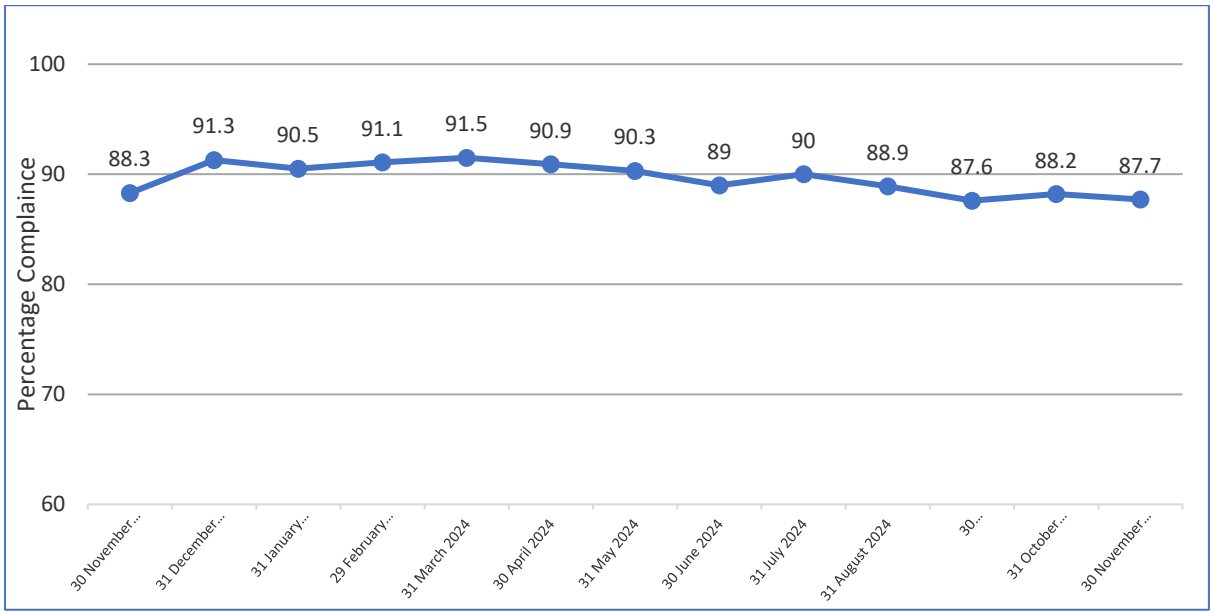
- January, February and March 2024 panel dates are being scheduled.

Job Evaluation Steering Group

- Unfortunately, due to low numbers able to attend the December in person meeting, this was cancelled. However, a communication was issued by the JE Leads thanking all involved for their support in securing a positive turnaround with Job Evaluation work. Appreciation and thanks for the continued support during 2024 was expressed.
- A January meeting date is being scheduled.
- Further to previous agreement around local training resources for managers to develop their skills in writing Job descriptions and understanding of the JE process, work is in progress and will be available for the State Hospital in the next 12 months. This work is progressing and will be discussed at a future meeting.
- The JE Leads will create a succession plan for the JE practitioners, due to the reliance on key individuals and risk to the organisation should they become unavailable, noting also the risk due to unavailability of national training which is required to participate in the process.

g) PDPR COMPLIANCE

A small decrease in month to 87.7%, but still above the national target of 80%.



4 RECOMMENDATION

Members of the Board are asked to note the update on overall workforce performance.

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.	Information in 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:	19 December 2024
Agenda Reference:	Item No: 17
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Whistleblowing Report Quarter 2 - 2024/25
Purpose of Report:	For Noting

1 SITUATION

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

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

2 BACKGROUND

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

3 ASSESSMENT

The Quarter 2 update is from 1 July to 30 September 2024. No formal Whistleblowing cases were raised during this quarter either direct to The State Hospital or indirect via the INWO.

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

4 RECOMMENDATION

Members of the Board are asked to note the nil return for Quarter 2 of 2024/25.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	For noting
Workforce Implications	For noting
Financial Implications	N/A
Route To the Board Which groups were involved in contributing to the paper and recommendations.	Staff Governance Committee
Risk Assessment (Outline any significant risks and associated mitigation)	
Assessment of Impact on Stakeholder Experience	Ensuring that staff feel secure to raise any Whistleblowing concerns.
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	As detailed previously – providing a safe and secure environment to raise any issues.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ✓ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE COMMITTEE **SGC(M) 24/03**

Minutes of the meeting of the Staff Governance Committee held on Thursday 15 August 2024

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

Chair:	
Non-Executive Director	Pam Radage
Present:	
Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	Cathy Fallon
In attendance:	
Associate Director of Nursing	Josie Clark [Item 12]
POA Representative	Colin Cruikshank
Head of Organisational Learning and Development	Sandra Dunlop
Chief Executive	Gary Jenkins,
Corporate Planning, Performance & Quality	Monica Merson
Board Chair	Brian Moore
RCN Representative	Richard Nelson
Head of HR	Laura Nisbet
Head of Corporate Governance	Margaret Smith
Director of Workforce	Stephen Wallace

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Ms Radage welcomed everyone to the meeting. There were no formal apologies, and it was noted that Mr Cruickshank would attend for this meeting on behalf of the POA.

2 CONFLICTS OF INTEREST

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

3 MINUTES OF THE PREVIOUS MEETING

The Committee received the minute of the previous meeting held on 16 May 2024.

Ms Fallon requested an update on the 'Get to know the Board' videos. Mr Jenkins advised that the Communications Team had attended training in this regard, and ordered equipment to allow this to be taken forward. Mr Wallace added that the Communications Team had advised that they were progressing this presently, and were hoping to be in a position to commence the making of videos in early 2025.

The Committee:

1. Approved the minute of the meeting held on 16 May 2024.

4 MATTERS ARISING AND ROLLING ACTIONS LIST

Ms Radage noted that the actions on the list would be covered during the course of the meeting.

The Committee:

1. Noted the progress of the Rolling Actions List.

5 OCCUPATIONAL HEALTH 12 MONTH REPORT

The Committee received the Occupational Health (OH) 12 Month Report. Ms Nisbet presented a summary of the report in the absence of Ms Keenan of NHS Dumfries and Galloway, who was unable to attend the Committee today.

Firstly, Ms Nisbet noted the information in the report detailing staff attendance at OH clinics, which were nurse led for matters like health clearance or immunisations. These appointments had shown a higher rate on Did Not Attend (DNAs) which indicated a need for further awareness among staff about the importance of these. From 1 July, the service had changed process so that following a DNA, staff would not be offered a second appointment routinely. It would then be for the line manager to consider whether a second appointment should be booked. This aligned to the position across NHSScotland generally. She also advised that case management reviews had increased, and these were a helpful mechanism through which to support staff. The report also provided background in terms of the reasons for management referrals being made, which may be related to wider issues relating to home life.

Ms Nisbet also noted the work progressed through OH in relation to infection control as well as the integration of the physiotherapy service for staff. Ms Nisbet noted the development of the OPAS-G2 Health Management Software within NHS Dumfries and Galloway, and that the aim would be for TSH to adopt this in the future. This should give line managers greater access to information, rather than the existing practice of raising queries with OH. Ms Nisbet noted the cyber-attack which had occurred, confirming that this had not been as impactful on TSH staff as had first appeared, but that it did represent an opportunity for organisational learning.

Lastly, Ms Nisbet referred to the recommendations in the report, detailing the main areas of focus for the coming year.

Ms Radage noted the range of information in the report, and opened the discussion from the Committee. Ms Fallon acknowledged the number of positives, particularly the work around case reviews, and the contribution made by physiotherapy. She noted concern that this report appeared to be an interim update, rather than providing the basis through which assurance could be taken in terms of assessing the value that the service offered to TSH. At the same time, she could link to the workforce reporting, also on the agenda for the meeting, to make sense of progress. It was difficult to link the information to the existing Key Performance Indicators (KPIs) to gauge success in each area and see the added benefits for TSH, and to make a clear assessment based on the costs of the service. She noted that it would be helpful for the recommendations in reporting to be clear in respect of what the Committee was being asked to do.

Mr Jenkins noted that the key was to be able to make an evaluation of the service, and if these were tailored to the needs of TSH, and thus beneficial compared to the investment being made. He referred to the attendance rates for clinics as outlined, and thought it would be helpful to benchmark these to experience in other NHS Boards, to ascertain if these were capable of further improvement. He also noted the factors related to sickness absence caused by stress, and the causes shown to be non-work related, and how to tailor a response to that to offer staff support.

He also provided an update in relation to the cyber-attack, confirming that following notification to the relevant authorities, this was essentially closed for TSH with no further action required. The Head of eHealth was scheduled to deliver a presentation to the Corporate Management Team (CMT) in the next month on any possible learning from the incident.

Mr Moore noted the number of DNAs as part of the pre-employment process, and the need for clear messaging about expectations in that respect. He also asked for an update on the Time for Talking Service, which was not part of the Service Level Agreement. He asked for further clarification on the detailed information within Appendix 1 of the report.

Mr Wallace thanked the Committee for their comments, and recognised the need to reflect on these for future reporting, especially around the KPIs and better demonstrating the impacts of the service taking an evidence led approach. He noted that report did highlight the activity in this area, and the proactive approach, which did bring benefit to TSH. He would consider how to evidence that is a different way going forward. He referenced experience of OH service more widely, and offered the view that what was on offer here would compare positively. It would be essential to review the service as a whole, in order to assess the continuation of the service level agreement.

Ms Radage commented that this was helpful, and agreed that reporting showed that different approaches had been tried in terms of engaging staff, and to improve attendance rates. She noted the discussion being helpful, in helping to show the activity in the service, but that this had perhaps not been evidenced as clearly within the confines of the report, especially for assurance on meeting KPIs. Ms Nisbet acknowledged that the reporting could provide more assurance, but that that there had been progress made in the delivery of the service itself which was beneficial to staff.

Mr Currie reflected on the core purpose of OH services, in supporting staff in their working lives and helping them back to work following an absence. It should be a positive contribution to the organisation. Reporting should provide a full picture, so that the service could be evaluated especially in the current financial climate. Ms Fallon followed up on the previous point made about pre-employment checks, and asked about any possible detriment for TSH. Ms Nisbet confirmed that contracts of employment would only be issued if there was reassurance on health clearance. The key was good administration to ensure that this essential process took place without impacting timescales for recruitment.

The Committee noted that they were being asked to endorse these recommendations, rather than to note the update. Ms Smith noted that this could be considered in the context of the framing of reporting more generally. This could help separate reporting around operational decision-making within day-to-day services, and the need to provide the Committee with an appropriate level of assurance reporting. Mr Jenkins provided assurance that reporting mechanisms were under review presently through the CMT, and the aim was to make improvements where required, focusing on the key information required in the context.

Ms Radage summed up for the Committee, noting that the report contained a range of helpful information. The Committee asked for the approach to reporting to be re-framed to lend more focus on performance metrics as well as comparator data to other NHS Boards. There was a need to contextualise the information being presented to enable the Committee evaluation of the metrics presented.

Action – Mr Wallace

1. Noted the Occupational Health 12 Month Report.
2. Requested a refreshed approach to reporting, as discussed and outlined.

6 CORPORATE RISK REGISTER – STAFF GOVERNANCE RISKS

The Committee received the Corporate Risk Register - Staff Governance quarterly report presented by Mr Wallace, detailing the current position on the four risks that sit under the Workforce Directorate.

Mr Wallace provided an overview of the paper and the actions underway to mitigate each risk. In particular, he highlighted the risk relating to the job evaluation process, and the need to recognise the potential impact of the review of Agenda for Change Band 5 Nursing posts that was underway. Within TSH, this process had begun with the provision of advice to staff about the process itself.

This was being taken forward in partnership, and it was important to ensure that staff were aware of the challenging nature of this process. At the same time, it should be possible to understand the level of response from nursing staff within TSH fairly quickly as well as to estimate the level of capacity available within current resources. Presently, it was an open-ended process so it may be a risk that presents into the future for the organisation. Ms Radage thanked Mr Wallace for the update and opened up for questions.

Mr Nelson commented on the positive work that had gone on to reduce the risk rating for compliance with Level 2 PMVA training to low, and there was agreement around the table.

Ms Fallon noted that the risk rating for deliberate leaks of information had reduced, and Mr Wallace agreed that this was the result of a focused workstream in this area. She also asked whether the job evaluation targets were local or national, and Mr Wallace advised that this was a local target within TSH and that it was a stretch target compared to other NHS Boards. Mr Jenkins acknowledged that the job evaluation process had been unacceptably lengthy in the past, adding that this was mainly from trying to match specialist roles. He recognised the impact that this had had on staff, but also credited the efforts of HR in terms of reducing this to meet the current target.

There was also discussion on the layout and content of the report compared to the reporting that came to the Clinical Governance Committee. It was agreed that Mr Wallace would liaise with the Risk Department in terms of aligning reporting.

Action – Mr Wallace

It was noted that an update on the Workforce Plan would be provided later in the meeting, and that a three-year plan was currently being developed.

Ms Radage summed up for the Committee, noting that there had been great improvement in the job evaluation process and a reduction of the risk rating. She also noted the potential impact of the Band 5 review process for TSH, and that this was something that would come back to the Committee. Lastly, she noted that it would be helpful to standardise reporting across committees as suggested.

The Committee:

1. Agreed that the Corporate Risk Register – Staff Governance update represented an accurate statement of risk.
2. Requested that the Corporate Risk Register reporting should be reviewed to align across the governance committees.

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

The Committee received and noted the Workforce (HR, Learning & Wellbeing, & OD) Report. Ms Nisbet presented the report, highlighting that focus remained on attendance management, which had shown an increase in sickness absence, both long and short term in July, particularly within nursing, but also within non-clinical areas. In relation to short-term absences, there had been higher instances of covid in the community and this had been a contributory factor. There had been focus on training for line managers, and there had been a higher take-up by managers for this. She also summarised activity in recruitment and retention, and noted the low rate of staff turnover. Ms Nisbet summarised the number of timescales for employment relation cases which was included as part of reporting. Lastly, she highlighted the work progressed on exit interviews, and reflected that the rates of return on this were positive compared to other NHS Boards.

Ms Dunlop then provided an overview of activity and compliance for PDPRs, which was at 90% approximately. She provided assurance on the support offered to any departments that had fallen short of the target of 80% to gain improvement. She also noted that TSH performance in this area compared positively to other NHS Boards.

Mr Nelson noted the number of Return to Work (RTW) interviews that were being reported as outstanding, as a concern, and indicated the need to improve on this. He also asked about the two employment relations cases that were over six months, and what actions were being taken to conclude these. He asked about consistency of contact with staff on long-term sick leave by line managers. He asked for an indication as to whether there had been a higher level of absences due to injury at work. He also noted that it would be helpful to see the feedback collected from exit interviews.

Ms Nisbet noted that work was progressing on how to report completion of RTW interviews. She would link with the team, and Mr Nelson as to consistency across the organisation. On the employee relation cases, each case was taken on its own merits and it may be due to individual factors such as illness. In respect to contact with staff on long terms sick leave, the policy position was for contact every four week and this was recorded and monitored. Managers would make contact on other occasions more informally, depending on each individual case. In terms of absence through injury, a higher incidence of absence through industrial injury had been noted. HR were linking in with line managers in respect of the appropriate support. She confirmed that she would share the exit interview information. Mr Nelson thanked Ms Nisbet for this, and added that the concern about support for staff on long-term sickness leave was a possible lack of support for staff, if there was lack of contact within the regular cycle of contacts arranged every four weeks. He would link in with Ms Nisbet on any particular cases, as appropriate.

Mr Cruikshank commented that he had taken part in the “Open Day” for nursing recruitment recently, and that it had been a really positive and engaging experience.

Mr Currie noted that importance of engagement and having valuable conversations, taking the valuable opportunity that RTW interviews, and PDPRs, especially for general wellbeing. He echoed the point around supporting staff when they were absent from work, to be able to identify what other support that the staff member may need. The person who will be best placed to give feedback were staff themselves. Ms Radage echoed this, underlining the importance of the contributions that managers could have in these contexts.

Mr Connor highlighted the reported timelines in employee relations cases, and the particular problem that it may take a number of weeks to actually start the process, and whether this was being measured. He also asked about reporting of industrial injuries, as these previously were recorded separately. He thought that the high levels of sickness absence being seen were very concerning, and asked about the key actions required to reduce this.

Mr Jenkins agreed with this, and advised that work was being focused within Nursing and Operations in terms of front line resourcing. The Task and Finish Group had been stood down, and it may be something to be considered again going forward. However, even without the impact of short-term absence due to respiratory illness and a spike in covid, sickness absence rates were concerning. He also agreed that there should be a review of compliance rates for RTW interviews, as well as contact with staff during absences. Further that the initiation process for investigations in employment relation cases should also be reviewed, to see if there was a need for improvement. There was agreement for reporting to reflect these points.

Action - Mr Wallace

He acknowledged the increase in assaults, and outlined some of the clinical acuity that lay behind this, and the work being done to review this. He also noted that the metrics may show particular areas of concern within some departments, and it would be helpful to have local engagement through the Heads of Department.

Ms Fallon also asked whether it was correct that staff would not be offered overtime shifts, following an absence unless the RTW interview had been completed.

Mr Wallace recognised that it would be essential to bring the level of sickness absence down. After the Task and Finish Group was concluded, the approach had moved to a focus on maximising attendance and a managerial approach to managing attendance appropriately. This

means reviewing that whole absence process, to identify possible gaps in the process and put in pathways. He advised that Ms Nisbet and Ms Dunlop would take this forward through the Workforce, Wellbeing and OD Delivery Group.

He underlined the need for there to be relationships of trust between staff and managers, especially for managing contacts with staff, and compliance in RTW interviews. It was about establishing a clear, quick, transparent process to get the help to the people as quickly as possible. He noted that these issues would also be reflected in the next item on the agenda, in relation to the Workforce Governance Group. Ms Nisbet added that she was collating data on employee relations cases, in terms of the stages within the process, to try and trouble shoot where the issues were in managing the timescale and noted that this could come back to the Committee, once completed.

Action – Ms Nisbet

Ms Radage summed up the discussion, which had been detailed and covered a number of areas. She noted the positives to be taken in terms of the low turnover rates, and the combination of initiatives that may be contributing to staff choosing to remain at TSH. She added that it may be interesting to take forward an initiative in respect of why staff stayed, in the same way as exit interviews. Finally, that the Committee wished to see reporting come back on the points raised in discussion.

The Committee:

1. Noted the Workforce (HR, Learning & Wellbeing and OD) Report.
2. Requested updates within reporting, as outlined.
3. Requested update on ER case timelines.

8 WORKFORCE GOVERNANCE GROUP REPORT

The Committee received a report on the Workforce Governance Group, to provide an update on its activity. Mr Wallace advised that the role of the group was to underpin delivery of the Workforce Plan, through the key pillars of plan, attract, train, employ and nurture.

In particular, there was a theme around resilience in a small organisation, and linking that to the need for succession planning. Further, work was progressing on how recruitment and vacancies approvals were managed, and the report highlighted the recent activity in this area. He indicated that it would be helpful to refresh the approach of the group, and the process in place presently, to ensure control.

Mr Wallace noted that the aim was to make this group more focused on compliance and quality elements in terms of workforce issues which should help to be able to highlight where services may be struggling in particular areas e.g. PDPR or absence management. Although the group had progressed a lot of good work, it would be good to reflect on how to get the best from this forum. Mr Jenkins supported this and noted the helpfulness to have a linear route, as well as giving transparency for decision-making.

Ms Fallon commended the work being progressed, and asked about how many staff were accessing Open University courses that then went on to substantive courses at TSH. It was confirmed that up to 12 students per year took this route.

Mr Moore asked about taking the opportunity to always consider the utilisation of resources, when vacancies arise, and whether a different approach could be taken. This would be essential in the challenging financial landscape for NHSScotland. Mr Wallace agreed, and thought that a vacancy approval group could be effective in this way. Mr Jenkins added that this would be essential, and also that this should be considered across the organisation as a whole, especially in roles which may be currently aligned to one directorate, but which could offer expertise more widely. This may also help to build development routes for staff within TSH.

Ms Radage asked for clarification on the eHealth roles, which had been made substantive through use of Scottish Government strategic funding. Mr Jenkins advised that this was the case, to give a level of certainty for a small number of roles, which had previously been offered only on temporary contracts. It was a small element of risk, but this was an important and developing area and it would be beneficial in the longer term to have consistency in staffing. There was agreement around the table on this point.

The Committee:

1. Noted the Workforce Governance Group Report.

9 WORKFORCE PLANNING AND REPORTING

The Committee received a report to outline progress in a number of workstreams being taken forward presently. Mr Wallace provided an overview in this regard including the Wellbeing Strategy, as well as a new strategy on Organisation Development. The key would be to take an integrated approach across workstreams, and give concrete milestones to measure progress. The aim was to bring these different workstreams together, to help build the medium term Workforce Plan moving forward.

Mr Jenkins added that the key would be to bring cohesion to the different strands, and the value that this would bring to the organisation as a whole.

There was agreement with this approach, and the need to get the right product from this process especially through such wide engagement.

The Committee:

1. Noted the Workforce Planning and Reporting Report.

10 HEALTH AND CARE STAFFING QUARTERLY REPORT

The Committee received quarterly reporting in relation to the Health and Social Care Staffing, and Mr Wallace provided a summary of the key points. This related to Quarter 1 of the current year, and there were no areas of concerns to note. He confirmed that if approved by the Committee, the report would be submitted to Health Improvement Scotland.

Ms Fallon was pleased that there were no areas of concern, and noted the mental health, learning, disability workload tool – it would be helpful to get further feedback on this going forward.

The Committee:

1. Noted the Health and Care Staffing Quarterly Report.
2. Approved the content for submission to HIS.

11 eROSTERING PROJECT CLOSURE

Mr Wallace provided a verbal update on the close of the eRostering Project Team, noting that a business as usual approach was now in place based on ensuring compliance in all areas using the systems and applications. Further that action plans would be in place to monitor this. There were planned points of review in September of this year, as well as at the end of the year.

The Committee:

1. Noted the position.

12 NURSE PRACTICE DEVELOPMENT 6M UPDATE

The Committee received a report in relation to Nurse Practice Development presented by Ms Clark who highlighted the main six key priorities and the progress made within these workstreams. In particular, she noted the implementation of the Clinical Care Policy in May 2024, and the agreed routes for monitoring this within its first year. She noted that in relation to clinical supervision, training being rolled out to supervisors, and a short life working group had been established to promote and build on this. In terms of the first year support programme, there had been fantastic feedback from newly qualified staff following their first year, as well as comments on how the programme could be improved even further, and this work was being taken forward. A wider staff survey was also being developed for nursing staff. She noted that work continued to link with schools and higher education establishments to promote forensic services as a career choice.

It was noted that the Annual Report would return to the Committee in February 2025, and this would also set out the plan for the following 12 months.

The update was received very positively, with agreement on the strength of the initiatives on recruitment and retention of nursing staff. Further, the support given in the transition period from their first year was noted as an area of good practice. Mr Jenkins commented on the TSH staff turnover rate, as it was very low, and wondered if there was any linkage from that to these initiatives.

Mr Currie also noted the innovative ways of working, and asked about the support in place to take these forward. He also noted that sometimes there may be a challenge in trying new initiatives with higher educational establishments, to create a partnership with them. Ms Clark noted that there were good relationships in place, and so these challenges were not being faced in reality.

Mr Jenkins noted the need to collate and triangulate different staff surveys, through organisational development, so that learning could be taken effectively. Ms Clark agreed and gave assurance that this would be the case to take this forward.

The Committee:

1. Noted the Nurse Practice Development Update.

13 WHISTLEBLOWING REPORT

The Committee received and noted the Quarter 1 update which confirmed that there had been no new cases. Mr Wallace advised that work was progressing for Speak Up week which would take place on the week beginning 30 September. This would link to a re-launch of the overall process, to ensure independence from the HR team in line with the national guidance.

Mr Currie noted the need to evaluate the position on Whistleblowing i.e. with low numbers of cases and what the implications of that was, and how to measure success in this area. He added that there was a difference in terms of what Whistleblowing was, compared to a Speak Up culture. Mr Wallace reflected that the important aspect was to ensure that the organisation had a culture which enabled staff to have the confidence to speak up and raise any concerns they may have. At the same time that it was essential to have a robust and established process for Whistleblowing in place and that he would link into any national discussion in this area in terms of direction of travel.

Mr Jenkins also noted the engagement of joint staff side, and the partnership approach being taken which had a beneficial impact as well, especially as a route for discussion and resolving issues as they may arise.

The Committee:

1. Noted the Q1 Whistleblowing Report.

14 PARTNERSHIP FORUM

The Committee received and noted the approved minutes from the Partnership Forum meetings which had taken place in April and June 2024.
Ms Fallon asked for clarity around mention of an unsafe practice form, and it was noted that this was a staff side form to raise any concerns about unacceptable practices to senior nursing colleagues, with the aim of resolving any issues identified. This was reviewed through the Operational Sub Group. Ms Fallon also noted the work progressed on the reduction of the working week (RWW) and management of overtime in terms of the Working Time Directive, and the governance route for reporting these issues.

Mr Connor noted that the issue on managing overtime had been raised at the Partnership Forum, and referred to the point made previously about staff returning from a period of sickness absence. It was the case that staff should not be offered overtime unless a RTW interview had taken place. In respect of the working time Directive, this had become an increasing issue, with some staff working longer periods from back shift to night shift. Mr Nelson echoed concerns on this point and also voiced concerns about the RWW, and how agreements were being taken forward in particular areas.

Mr Jenkins noted this and provided assurance on the route available to escalate any concerns. He also noted the concerns raised about shift working within nursing, and gave assurance that action was being taken to identify where this was occurring and to ensure that this was not accepted practice.

Mr Wallace advised that in relation to the RWW, the majority of agreements had been put in place, but a short life working group was progressing the position in relation to nursing - a proposal had been developed for nursing for the first 30 minute reduction. It would be a greater challenge for the further reductions towards the 36-hour week. He also noted the need to ensure that there were no unsafe practices, and ensuring adequate staffing. This was being taken forward in partnership. Mr Connor commented that the process had been followed in relation to the RWW, and that joint staff side had been involved in the short life working group set up.

The Committee:

1. Noted the approved minutes.

15 AREAS OF GOOD PRACTICE / AREAS OF IMPROVEMENT

The following areas were highlighted:

- Development of the first year support program to nursing staff.
- Open Day.

16 ANY ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTIEES

Ms Radage noted that complaints reporting would usually come through the Clinical Governance Committee, and that the internal audit report was being shared for information and awareness.

Ms Smith provided an overview, noting that in implementing the complaints policy and managing complaints, the team relied very much on colleagues across the organisation. In doing so, it was important to recognise the potential impacts on staff. She provided a brief overview of the internal audit, which had recently been taken forward, and the changes made in terms of engaging patients. She highlighted the further work being developed within directorates, to support staff opening up conversations within a safe place. The aim was to help to build confidence within staff about the way they approached efforts to resolve complaints. This was in addition to the approach taken within the corporate induction, to raise awareness of complaints and to link this to NHS Values and Behaviours. Lastly, Ms Smith noted that there could be long term relationships with

patients and carers given the unique nature of the care provided at TSH, and that there was awareness of this with focus on how best to support patients, carers and staff through the complaints process.

Ms Fallon noted that these were issues that were also considered by the Clinical Governance Committee, and that there was awareness of the impacts on staff within that forum as well. She noted the positive result of the audit, which had indicated that substantial assurance could be taken by the organisation on complaints management.

There were no other issues raised at today's meeting that should be shared with other committees.

17 ANY OTHER BUSINESS

No other business was presented by the Committee members.

18 DATE OF NEXT MEETING

The next meeting would be held on Thursday 21 November 2024 at 0930 hours via Microsoft Teams.

The meeting concluded at 1225 hours

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2024
Agenda Reference:	Item No: 18
Report Author:	Head of Corporate Governance
Title of Report:	Staff Governance Committee – Summary Report
Purpose of Report:	For Noting

This report provides an update on the key points arising from the Staff Governance Committee meeting that took place on 21 November 2024.

1	Corporate Risk Register Quarterly Update	The Committee received the quarterly report detailing the corporate risks assigned to the Workforce Directorate. This was agreed as an accurate statement of risk, and that work would continue with the Risk Team in respect of the reporting format. There would also be a review around workforce risks, and how to best capture these on the register.
2	Staff & Volunteer Health and Wellbeing Strategy	The Committee received a detailed update on the work progressed, and the offer available to staff through wellbeing initiatives. There was consideration on how to continue to embed this, and how to develop bespoke packages for teams and directorates across the hospital, and how to further empower managers and teams.
3	Staff Governance Monitoring Return	The Committee was asked to consider and approve the Staff Governance Monitoring Return, noting that it had been shared with partnership colleagues and would be presented to the Partnership Forum in the following week (due to timing of meetings). Approval was confirmed on this basis.
4	Equalities Update	The Committee was asked to note the establishment of a Workplace Equalities Group to support good governance in this area. It was agreed that this would as acting as the catalyst to creating an inclusive environment by supporting the priorities developed in the Equalities Monitoring for 2025/29. This will developing yearly action plans, and an anti-racism strategy.
5	Workforce Governance Group	The Committee noted the further progress made in this area of governance, and that this group was taking forward consideration of change and had a sharp focus in taking forward its remit in a

		supportive way alongside operational delivery.
6	Whistleblowing Report	Reporting for Quarter 2 of 2024/5 confirmed that there had been no new cases for consideration. The Committee highlighted Speak Up Week, as well as the national guidance provided by the INWO about the importance of accredited investigators and that this may require to be external for a small organisation. The Committee received an update from the Whistleblowing Champion in respect to the Whistleblowing Network. There was detailed discussion on linking this agenda to that of the wellbeing workstream in TSH, building trust and embedding open routes for raising concerns.
7	OD Strategy – Health and Performance	The OD Lead provided a detailed update on the progress made, and the refreshed focus on organisational health and performance, and how these align across TSH. This was received very positively, and emphasised the need to take forward organisational development with the organisation i.e. not something than can be top down. The Committee endorsed the way forward, and the plan for 2025 placing this within the overall context of what can be done within the financial framework.
8	iMatter Annual Update	Reporting provided comparison between the results for the TSH survey, and that of NHSScotland as a whole. There was agreement on the usefulness of the data. The issue of Board Member visibility was considered, and how more could be done in this regard especially around linking Non-Executives to key events on the organisation, particularly with patient involvement.
9	Workforce Report	Reporting provided the Committee with updates across the full range of activity across the directorate including Human Resources, Organisational Development, Learning and Wellbeing. This included metrics across workforce data. There was consideration of the continuing challenge on sickness absence rates, and how to lead improvement. There was also discussion of the arrangement for Staff Awards, and how to make this inclusive across stakeholders.
10	Once for Scotland Policy Launch – Update	The Committee received an update on the continued roll out of this policy framework, and how this is being implemented within TSH.
11	Areas of good practice / Concerns	The Committee agreed that the engagement with staff for the development of the Medium Term Plan was an example of good practice, and a positive way of gaining ownership across the organisation. The Committee also reflected on the meeting, and the positive improvement made in reporting received, with a meaningful and concise agenda and papers, which demonstrated links across workstreams and had supported discussion and decision-making within the Committee.

RECOMMENDATION

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

MONITORING FORM

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

Paper No. 24/111

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date:	19 December 2024
Agenda Reference:	Item No: 19a
Sponsoring Director:	Acting Director of Security, Resilience and Estates
Author(s):	Head of Estates and Facilities
Title of Report:	Annual Climate Emergency and Sustainability Report 2023/24
Purpose of Report:	For Decision

1 SITUATION

Health Boards are required to report on an annual basis against the aims of DL (2021) 38 (A Policy for NHS Scotland on the Climate Emergency and Sustainable Development).

2 BACKGROUND

Scottish Government Health and Social Care Directorates supplied an approved template requesting Health Boards to submit their annual return for 2023/24. The template contains the following sections:

- Leadership and governance
- Greenhouse gas emissions
- Climate change adaption
- Building energy
- Sustainable care
- Anaesthesia and surgery
- Respiratory medicine
- Travel and transport
- Greenspace and biodiversity
- Sustainable procurement, circular economy and waste
- Environmental stewardship
- Sustainable construction
- Sustainable communities

The purpose of the report is to focus on the environmental performance of our organisation and allows the hospital to reflect on its performance against the standards and allows any outstanding actions or forward planning to be highlighted.

Throughout the report data is requested in tabular form, or by questions around 'what we did last year' and 'what are we doing this year' for each section.

3 ASSESSMENT

Completed Annual Climate Emergency and Sustainability Report for 2023/24 is attached.

The tables below contain the current modelling report for TSH's Net Zero performance on a BAU scenario.

As a Board the emissions have decreased by a massive 83.7% against the baseline year 1993/94, which is within the 5-year 1990 Kyoto window.

Prior to 1993/94, the site was operated and maintained by the Department of Environment (DoE) on behalf of the UK Government and Scottish Executive.

NHS State Hospital							
CO2e Emissions Targets		**1993/94**	**2023/24 Reported Figures**	**2025 Interim Target**	**2030 Interim Target**	**2035 Interim Target**	**2040 Net Zero Target**
The New % Pathways to a 2040 Net Zero Outcome	CO2e Emissions Targets	Baseline	-63.6%	-65.5%	-75%	-87.5%	-100%
Target – Our Current Usage Trend will have to follow these trajectories	Tonnes	10,678	3,887	3,684	2,670	1,335	0
Actual and Predicted CO2e Emissions from now to 2040	Tonnes	10,678	1,739	1,653	1,446	1,332	1,264
CO2e Emissions – Current Pathway based on current anticipated energy use	Based on 1993/94 usage levels	-	-83.7%	-84.5%	-86.5%	-87.5%	-88.2%
Potential Shortfall			-20.1%	-19.0%	-11.5%	0.0%	11.8%

To meet the decarbonising of heat sources target, TSH will require to commission a feasibility study to explore the use of new technologies such as ground source/air source heat pumps, and any emerging technologies that would be suitable for the site. With the target year being 2038, this will require to be completed over the next 5/6 years.

Electrical renewable technology to be explored for the site includes wind (turbine) and solar PV. This work will coincide with the feasibility study for the decarbonising of heat sources over the next 5/6 years.

During the next 5/6 years, as Net Zero plans are developed, funding sources will also have to be identified to allow TSH to implement the technology for Net Zero to be achieved.

Focus for this year will be to develop and implement a high-level waste route map, move forward with an active travel agenda, increase biodiversity/greenspace awareness and fully implement an EMS for The State Hospital.

4 RECOMMENDATION

To approve the content of the Annual Climate Emergency and Sustainability Report for 2023/24 for submission to Scottish Government.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support the Climate and Sustainability Strategy and allow measurement towards our objectives in line with Scottish Government Objectives
Workforce Implications	N/A
Financial Implications	There are no financial implications related to the publication of this report.
Route To CMT and Board Which groups were involved in contributing to the paper and recommendations	Climate and Sustainability Group
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

Annual Climate Emergency and Sustainability report 2023/24 for

The State Hospitals Board for Scotland

SUSTAINABILITY ACTION
Our NHS | Our People | Our Planet

NHS SCOTLAND

Contents

DATE OF ISSUE – NOVEMBER 2024

1. Introduction

This is The State Hospitals Board for Scotland's annual Climate Emergency and Sustainability Report.

The State Hospitals Board is very much an integral part of NHS Scotland and one of eight National Boards providing specialist services. It has a unique function in Scotland of providing high quality forensic mental health assessment, care, treatment and rehabilitation for male patients who require a high secure environment. The Hospital has 140 beds and admits patients from Scotland and Northern Ireland. It is based in South Lanarkshire and employs around 650 people.

The State Hospital operates from 15 buildings and manages land and buildings covering an area of 63 hectares.

2. Leadership and Governance

- The Board Sustainably Champion is Cathy Fallon, Non-Executive Director.
- The Executive lead is David Walker, Director of Security, Estates and Resilience. (This is correct for the reporting period)
- Within organisational governance, the Climate Change and Sustainability Group has the lead responsibility and is accountable to the Security, Resilience, Health and Safety Oversight Group through the Director of Security, Estates and Resilience. Its purpose is to ensure that the principles of sustainability are embedded in The State Hospital's strategic programme. The Group will ensure an integrated approach to sustainable development, harmonising environmental, social and economic issues.
  The Group provides assurance to the Security, Resilience, Health and Safety Oversight Group that robust arrangements are in place for monitoring and review of the effectiveness of management arrangements within the Board.
- Corporate and Operational Management Teams are responsible for operational delivery of services. The Climate Change and Sustainability Group focus on issues of strategic or corporate significance, with reports by exception from CMT as required.

The Group are currently working on the update of The State Hospitals Corporate Strategy, organisational values, mission statement, vision and principles that explicitly reflect our commitment to all aspects of sustainability.

In addition to the leadership and governance arrangements outlined above The State Hospital commissioned an independent audit in regard to Environmental, Social and Governance Review by external auditors RSM. The purpose of the audit was to benchmark our progress against the Policy for NHS Scotland on the Global Climate Emergency and Sustainable Development - DL (2021) 38.

The findings of the audit against TSH's progress towards the 68 DL 38 requirements, the audit identified that given the resource and financial restrictions faced in terms of sustainable development, TSH is in a position to fulfil the requirements by 2040. We evidenced that TSH has already reduced its emissions by 81% since 1990, established a strong governance structure and is meeting its various reporting requirements set out by NHS Scotland.

Recognised positive progress was identified against the requirements of DL 38 but, through benchmarking across the RSM client base, opportunities were identified to implement sustainable structures to drive continuous improvement and oversight. The State Hospital and the Climate and Sustainability Oversight Group have taken on board the recommendations made and will look to deliver, where possible. In particular, the development of a Sustainability Co-ordinator and the development of a sustainable action plan which could incorporate the recommendations from the Net Zero Route map and set out SMART sustainable targets that are accompanied by corresponding timelines, interim targets, KPIs and financing options.

3. Summary of Impacts

The State Hospitals Board for Scotland aims to become a net-zero organisation by 2040 for the sources of greenhouse gas emissions set out in the table below. The table sets out the amount of emissions produced annually by The State Hospital.

Greenhouse gas emissions 2022-2023 & 2023-2024, tonnes CO2 equivalent					
Source	**2022/23 emissions (tCO2e)**	**2023/24 emissions (tCO2e)**	**Percentage change – 2022/23 to 2023/24**	**2023/24 – target emissions**	**Percentage difference between actual and target emissions – 2023/24**
Building energy	1547.62	1569.22	1.39% Increase	No target set	No target set
Non-medical F-gas	Was not available	8.33	First year recording information	Not applicable	Not applicable
Medical gases	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Metered dose inhaler propellant	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
NHS fleet travel	8.63	20.47	137.2% Increase	No target set	No target set
Waste	43.95	52.72	19.9% Increase	No target set	No target set
Water	2.67	3.74	40.1% Increase	No target set	No target set
Business travel	4.08	3.42	16.2% Decrease	No target set	No target set
Total emissions	**1606.95**	**1657.90**	**3.17% Increase**	No target set	No target set

Carbon sequestration	Not recorded	Not recorded	Not applicable	Not applicable	Not applicable
Greenhouse gas emissions minus carbon sequestration	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable

The table below sets out how much of key resources we used over the last two years

Source	2022/23 Use	2023/24 Use	Percentage change – 2022/23 to 2023/24
Building energy (kWh)	9,582,640	9,131,167	4.7% Decrease
NHS fleet travel (km travelled)	Not recorded	60,542	Not applicable
Waste (tonnes)	125	111	11.2% Decrease
Water (cubic metres)	12,232	18,225	48.9% Increase
Business travel (km travelled)	14,838	12,750	14.1% Decrease

4. Climate change adaptation

Scotland's climate is changing faster than expected according to research published by the James Hutton Institute in December 2023. According to this research:

- "Between 1990 to 2019, February and to a lesser extent April have become wetter, particularly in the west, by up to 60%, exceeding the projected change by 2050 of 45-55%."
- "Scotland is on track to exceed "a 2°C increase in temperature by the 2050s, with the months from May to November experiencing up to 4°C of warming over the next three decades (2020-2049)."

- "The number of days of consecutive dry weather – an indicator for drought and wildfire risk – are also expected to increase in drier months, such as September."

Climate change exacerbates existing health risks and introduces new challenges, ranging from the spread of infectious diseases to the intensification of heatwaves and extreme weather events that will impact the health of the population, healthcare assets and services. NHS Scotland plays a pivotal role in safeguarding the life and health of communities by developing climate-resilient health systems capable of responding to these evolving threats.

The changing climate is increasing risks for health and health services. More information on these risks in the UK can be found in the UK Climate Change Committee's Health and Social Care Briefing available here: www.ukclimaterisk.org/independent-assessment-ccra3/briefings/

- *What are the main risks from climate change that the Health Board has identified through its Climate Change Risk Assessment?*

The State Hospital have identified the extremes of weather as the main risks and includes higher average temperatures with extended periods of hot weather, heavy rainfall, and cold spells. The main impacts would affect transportation, site access, delivery of essential supplies and disruption to the electrical supply.

- *What actions has the health board taken to reduce those risks – what has changed since the last report?*

The State Hospital are currently updating the associated adaption plan with assistance from NHS Assure. The adaption plan will specify equipment, buildings and processes that could be affected by the extremes of weather and increased weather events that the site could experience over the next 10 to 20 years. The State Hospital also have business continuity plans for an event involving loss of power, adverse weather etc., and also have internal resource to manage the power on-site for a protracted period of up to 7 days if required.

Since last years report all relevant business continuity plans have been reviewed, with particular attention placed on adverse weather conditions and the impact on transportation, site access and essential deliveries.

- *What are we doing to be prepared for the impacts of climate and increase the resilience of our healthcare assets and services?*

The State Hospital are working through a list of actions following completion of the adaption plan and taken forward through the Sustainability Group. There is an expectation that this will be presented during the next year.

5. Building energy

We aim to use renewable heat sources for all the buildings owned by The State Hospitals Board for Scotland by 2038.

The State Hospital site has 15 buildings including patient accommodation, off ward therapy areas, offices, carers' facilities, security buildings and estates buildings.

In 2023/24, 1569.21 tonnes of CO2 equivalent were produced by The State Hospital use of energy for buildings. This was an increase of 1.4% since the year before.

In 2023/24, The State Hospital used 9,131,167 kWh of energy. This was a decrease 4.7% since the year before.

In 2023/24, The State Hospital generated 1,819,670 kWh of energy from renewable technologies.

Building energy emissions, 2015/16, 2022/23 and 2023/24 – tCO2e				
	2015/16 energy emissions	**2022/23 energy emissions**	**2023/24 energy emissions**	**Percentage change 2015/16 to 2023/24**
Building fossil fuel emissions	832.7	1014.72	997.87	19.8% Increase

District heat networks and biomass	57.3	24.91	19.54	65.9% Decrease
Grid electricity	1425.3	507.99	551.80	61.3% Decrease
Totals	**2315.3**	**1547.62**	**1569.21**	**32.2% Decrease**

Building energy use, 2015/16, 2022/23 and 2023/24 – MWh				
	2015/16 energy use	**2022/23 energy use**	**2023/24, energy use**	**Percentage change 2015/16 to 2023/24**
Building fossil fuel use	3096	4530	4652	50.3% Increase
District heat networks and biomass	4342	2365	1819	58.1% Decrease
Grid electricity	2848	2686	2659	6.6% Decrease
Renewable electricity	0	0	0	0%
Totals	**10,288**	**9,582**	**9130**	**11.3% Decrease**

- *What did we do in 2023/24 to reduce emissions from building energy use?*

There was a greater focus to use the biomass boiler as the primary heat source for the site instead of LPG last year, however boiler faults resulted in greater 'down time' than expected. A project to update the Building Management System commenced during the year.

External lighting around various buildings has been changed to LED lighting, with further work to take place this year.

- *What are we doing in 2024/25 to reduce emissions from building energy use?*

The State Hospital were unsuccessful in obtaining a grant for all the lighting in 5 buildings to be changed to LED. We will now look at internal funding to allow the work to progress

- *What projects are we planning for the longer-term to reduce emissions from building energy use?*

Further information contained within the conclusion section.

6.1 Sustainable care

The way we provide care influences our environmental impact and greenhouse gas emissions. NHSScotland has three national priority areas for making care more sustainable – anaesthesia, surgery and respiratory medicine.

6.2 Anaesthesia and surgery

Greenhouse gases are used as anaesthetics and for pain relief. These gases are nitrous oxide (laughing gas), entonox (a mixture of oxygen and nitrous oxide) and the 'volatile gases' - desflurane, sevoflurane and isoflurane.

Through improvements to anaesthetic technique and the management of medical gas delivery systems, the NHS can reduce emissions from these sources.

The State Hospital does not have any emissions from these gases due to the nature of patient care that takes place within the Board. The Board has no operating theatres or treatment rooms where anaesthetics could be administered

6.3. Respiratory medicine

Greenhouse gases are used as a propellant in metered dose inhalers used to treat asthma and COPD. Most of the emissions from inhalers are from the use of reliever inhalers – Short Acting Beta Agonists (SABAs). By helping people to manage their condition more effectively, we can improve patient care and reduce emissions.

There are also more environmentally friendly inhalers such as dry powder inhalers which can be used where clinically appropriate.

The Scottish Government provide all territorial health boards with an assessment of emissions from medical gases and inhaler propellant annually. The State Hospital are not included in these figures for 2023/24 as no prescribing takes place within the health board for these purposes.

7. Travel and transport

Domestic transport (not including international aviation and shipping) produced 28.3% of Scotland's greenhouse gas emissions in 2022. Car travel is the type of travel which contributes the most to those emissions.

NHSScotland is supporting a shift to a healthier and more sustainable transport system where active travel and public transport are prioritised.

- *What did we do in 2023/24 to reduce the need to travel?*

As a single site Board there is no requirement for travel across various sites. Currently the level of business travel within the Board has reduced post Covid. This is quantified by a 61% drop in travelling expenses in 2023 compared to 2019, and then a further 14% this year.

The introduction of flexible / home working arrangements for existing and new employees, and the ongoing management of these arrangements, has also seen a reduction on staff having to travel to and from work.

- *What did we do in 2023/24 to improve active travel?*

Active Travel has been incorporated as an agenda item for Climate Change and Sustainably Group meetings. Alongside this, the Health and Wellbeing Strategy Group also have oversight of active travel within the groups standing agenda. This Wellbeing group looks at specific staff benefits, and opportunities in regard to active travel. The hospital has introduced cycle to work schemes and is also looking at options for salary sacrifice schemes for cars and other modes of transport. The hospital has also looked at enhanced options for staff around lease vehicles especially electric options. Both groups are still at the scoping stage of options to improve travel arrangements for staff looking at potential for hub pick up points for staff working shifts.

- *What did we do in 2023/24 to improve public and community transport links to NHS sites and services?*

We look to continue to look at development with transport links within our area. There are restrictions to what we can do to develop this due to the isolation of the site and access to public transport. We do offer pick-up services from local train stations as part of our carer interaction. This then allows for visitors to the hospital not being restricted to car travel opening up opportunity to travel by train. We will continue to offer this service, but will also continue to try to develop other options for travel and access.

- *What are we going to do in 2024/25 to reduce the need to travel?*

The State Hospital will continue to look at options to improve travel arrangements for staff. Most operational meetings are via Microsoft Teams to reduce the need for everyone to be on-site or to indeed travel to different locations or sites. We also encourage that our external partners use the teams format if meetings are required to take place. The hospital will continue to encourage this, and this practice along with flexible working options for staff, where possible, will allow us to continue to maintain a reduced need to travel.

- *What are we going to do in 2024/25 to improve active travel?*

The State Hospital will continue to look at options to improve active travel. Due to the remote location of the site, the Board will look to explore processes to make travel from various locations local or city locations more sustainable and reduce the need for staff, visitors and volunteers to use their own cars. The option to increase public transport to the area is difficult as we have no control of the third parties involved, but we may look to try to work with them to explore an option to seek reduced rail or bus fares to Carluke and then provide transport to bring staff from the station to the hospital, as an example.

- *What are we going to do in 2024/25 to improve public and community transport links to NHS sites and services?*

The location of the hospital makes it difficult to enhance public and community transport links, as these are dependent on third party interaction. The demand in the local vicinity is low therefore to promote better transport opportunities is limited. We currently offer visitor pick up and drop off services from the local train station using a local taxi service. This is mainly to support visitors who struggle with car transport, but we are looking at options to extend this service to offer to all, managed by the site transport. This will be reviewed, and where possible developed, by the Climate Change and Sustainability Group.

We are working to remove all petrol and diesel fuelled cars from our fleet.

The following table sets out how many renewable powered and fossil fuel vehicles were in The State Hospitals Board for Scotland's fleet at the end of March 2023 and March 2024:

	March 2023		**March 2024**		
	Total vehicles	**% Zero tailpipe emissions vehicles**	**Total vehicles**	**% Zero tailpipe emissions vehicles**	**Difference in % zero tailpipe emissions vehicles**
Cars	0	0	0	0	
Light commercial vehicles	7	2	7	2	No difference

Heavy vehicles	2	0	0	0	No difference (see note below)
Specialist vehicles	5	0	5	0	No difference

Specialist vehicles was not a category in last years return. The State Hospital have the following list of specialist vehicles, that are used on site for grounds maintenance.

- 2 tractors (these were reported last year as heavy vehicles)
- 2 sit-on grass cutting machines
- 1 quad bike

The following table sets out how many bicycles and eBikes were in The State Hospitals Board for Scotland's fleet at the end of March 2023 and March 2024:

	March 2023	**March 2024**	**Percentage change**
Bicycles	0	0	No difference
eBikes	0	0	No difference

The following table sets out the distance travelled by our cars, vans and heavy vehicles in 2023/24

Distance travelled, kms	**Cars**	**Light commercial vehicles**	**Heavy vehicles**	**Specialist vehicles**	**Total**

2023/24	0	60,542	0	Not Recorded	60,542

Business travel is staff travelling as part of their work in either their own vehicles or public transport. It covers travel costs which are reimbursable and doesn't cover commuting to and from work. The table below shows our emissions from business travel by transport type.

Business travel emissions, tCO2e	**Cars**	**Public transport**	**Flights**	**Total**
2023/24	3.41	0	0	3.41

8. Greenspace and biodiversity

Biodiversity

Biodiversity, or the wide variety of living organisms within an environment, has declined at a rapid rate in the last 50 years. Evidence demonstrates that these trends are attributed to human activities, such as land use change, habitat degradation and fragmentation, pollution, and the impacts of climate change. The State of Nature report published in 2023 has highlighted the decline of nature across Scotland, with 11% of species now classed as threatened with extinction.

Public bodies in Scotland have a duty under the Nature Conservation (Scotland) Act 2004 (Nature Conservation Scotland Act 2004) to further the conservation of biodiversity, taking care of nature all around us. Furthermore, the Wildlife and Natural Environment (Scotland) Act 2011 (Wildlife and Natural Environment Scotland Act 2011) requires every public body to summarise their activities to meet this duty, through the production of a publicly available report.

- *What actions have been taken to identify, protect and enhance biodiversity across your organisation?*

As we are a high secure site, our local community cannot benefit from the grounds space within. We encourage use of the land by staff and patients and maintain all areas of the grounds to a high standard. We have created inner garden areas for patients and families to enhance the visitor experience and have also created garden areas for staff to utilise during periods of good weather.

- *What actions have been taken to contribute to the NHSScotland Estate Mapping programme, or to develop an internal mapping programme?*

The State Hospitals land consists of trees, grass/scrubland and agricultural land which is classified as 'greenspace'. We formed part of the overall Estates Mapping programme highlighting available land for greenspace but again due to the nature of the High secure Environment, our estate can only be used by patients and staff housed within.

- *What actions have been taken to mainstream biodiversity across the organisation?*

The State Hospital has a climate and sustainability group which oversees areas of development. Nature and Biodiversity is also a featured topic of the National Sustainability Assessment, which scores health boards on their performance towards sustainability. The State Hospital has a valuable and significant outdoor estate. It also has a legal duty and responsibility to enhance and protect that for the benefit of nature and biodiversity. There is increasing evidence that therapeutic contact with nature has important health and wellbeing benefits.

- *How have nature-based solutions been utilised to address the climate and biodiversity emergencies?*

The State Hospital have not utilised any nature-based solutions, however, the site has approximately 32 hectares of unused land that is made up of mainly grassland and existing trees.

- *What actions have been undertaken to raise awareness, engagement and understanding of biodiversity and nature?*

The State Hospital encourage staff and patients to walk on the grounds and be part of the open space. We use communication and advertising to promote healthy outdoor time and have timetabled activities that involve time in the outdoors.

- *What surveys, monitoring or assessment of biodiversity have been undertaken? If you have – have systems been developed to continue monitoring long-term?*

The State Hospital have not undertaken any surveys, monitoring or assessment of biodiversity. This will form part of the work for future years, as all public bodies in Scotland are required to further the conversation of biodiversity when carrying out our responsibilities.

Greenspace

The design and management of the NHSScotland green estate for human and planetary health, offers an opportunity to deliver a range of mutually beneficial outcomes. These include action on climate change (both mitigation and adaptation), biodiversity, health and wellbeing for patients and staff, community resilience building and active travel.

Currently all greenspace is managed and maintained to a standard that meets the Security requirements of the site. The State Hospital have no current projects that have been implemented in relation to key greenspace within the site, but may look at this in the future

9. Sustainable procurement, circular economy and waste

Earth Overshoot Day marks the date when our demand for resources exceeds what earth can regenerate in that year. In 2024, Global Earth Overshoot Day is 1 August, a day earlier than in 2023.

For the UK, the picture is more worrying. In 2024, the UK's Earth Overshoot Day was 3 June. The current level of consumption of materials is not sustainable and is the root cause of the triple planetary crises of climate change, biodiversity loss and pollution.

We aim to reduce the impact that our use of resources has on the environment through adopting circular economy principles, fostering a culture of stewardship and working with other UK health services to maximise our contribution to reducing supply chain emissions to net-zero by 2045.

- *What did we do in 2023/24 to reduce the environmental impact and the quantity of the goods and services we buy?*

All regulated tenders have a Procurement Strategy document which includes a sustainability assessment using the Scottish Government Sustainability test. For non-regulated Quick Quotes we also assess sustainability as part of the Invitation to Quote process.

- *What are we doing in 2024/25 to reduce the environmental impact of the goods and services we buy?*

All regulated tenders have a Procurement Strategy document which includes a sustainability assessment using the Scottish Government Sustainability test. For non-regulated Quick Quotes we also assess sustainability as part of the Invitation to Quote process.

We want to reduce the amount of waste we produce and increase how much of it is recycled.

The table below sets out information on the waste we produce and its destination for the last three years:

Type	**2021/22 (tonnes)**	**2022/23 (tonnes)**	**2023/24 (tonnes)**	**Percentage change – 2021/22 to 2023/24**
Waste to landfill	**79**	**90**	**81**	**2.5% Increase**
Waste to incineration	**Not Applicable**	**Not Applicable**	**Not Applicable**	**Not Applicable**
Recycled waste	**26**	**28**	**26**	**0%**
Food waste	**Not Recorded**	**Not Recorded**	**Not Recorded**	**Not Applicable**
Clinical waste	**5**	**7**	**4**	**20% Decrease**

The State Hospitals Board for Scotland are not one of the health boards that have been included in the high-level waste route maps that are being developed in tandem with the Net Zero Route Map. The State Hospital will require to apply the learnings from this process when they are made available.

Once The State Hospital receives the learnings from the process, we will set targets to reduce the amount of waste we produce and be in a position to populate the tables below. This will focus on six priority waste streams (residual, cardboard, dry mixed recycling, food waste, confidential waste paper, plastics and high grade non-infectious plastics from healthcare) and be in a position to fully populate the tables below.

In 2012/2013 the recorded domestic waste sent to landfill was 191 tonnes.

Reduce domestic waste by a minimum of 15%, and greater where possible compared to 2012/2013 – by 2025	
Target – reduce domestic waste by	30 tonnes
Performance – domestic waste reduced by	84 tonnes
Outcome	ACHIEVED
Further reduction required	None

Ensure that no more than 5%, and less where possible, of all domestic waste is sent to landfill – by 2025	
Target – reduce waste sent to landfill by	70 tonnes
Performance – waste sent to landfill reduced by	0 tonnes
Outcome	NOT ACHIEVED YET
Further reduction required	70 tonnes

Reduce the food waste produced by 33% compared to 2015/16 – by 2025

Target – reduce food waste by	Currently not recorded
Performance – food waste reduced by	Currently not recorded
Outcome	Currently not recorded
Further reduction required	Currently not recorded

Ensure that 70% of all domestic waste is recycled or composted – by 2025	
Target – recycle or compost	83 tonnes
Performance – recycled or composted	26 tonnes
Outcome	NOT ACHIEVED YET
Further increase required	57 tonnes

- *What did we do in 2023/24 to reduce our waste?*

We continued to promote the recycling of waste at source within each department / building.

- *What are we doing in 2024/25 to reduce our waste?*

The State Hospital will look to develop our own high-level waste route map which will prioritise activity to meet national target requirements.

National Procurement have introduced a new framework for Recyclates and General Waste Management in April 2024. The State Hospital are required to use mini completion to be able to refine our individual service requirements for waste management, and this will include a focus on being able to reduce our waste and increase recycling.

10. Environmental stewardship

Environmental stewardship means acting as a steward, or caretaker, of the environment and taking responsibility for the actions which affect our shared environmental quality.

This includes any activities which may adversely impact on land, air and water, either through the unsustainable use of resources or the generation of waste and pollution. Having an Environmental Management System (EMS) in place provides a framework that helps to achieve our environmental goals through consistent review, evaluation, and improvement of our environmental performance.

- *What steps did we take in 2023/24 to develop and implement our EMS?*

The State Hospital continued to populate the EMS with relevant data to allow action plans to be produced. This has been a protracted process due to not being able to dedicate time to the tasks, and therefore unable to report any meaningful progress.

- *We have fully implemented EMS to ISO14001 standard at the following sites:*

The State Hospital only have one site within the board. For the reasons given above, we are still progressing a fully implemented EMS.

- *What steps will we take in 2024/25 to further develop and implement our EMS?*

The State Hospital will look at the feasibility of a dedicated resource to further develop and implement our EMS. Funding this resource may prove difficult in the current financial climate

- *What did we do in 2023/24 to reduce our environmental impacts and improve environmental performance?*

There was a greater focus to use the biomass boiler as the primary heat source for the site instead of LPG last year, however boiler faults resulted in greater ‘down time’ than expected. A project to update the Building Management System commenced during the year and is ongoing.

External lighting around various buildings has been changed to LED lighting, with further work to take place this year.

- *What are we doing in 2024/25 to reduce our environmental impacts improve environmental performance?*

We are working to remove all petrol and diesel fuelled cars from our fleet. The State Hospital were unsuccessful in obtaining a grant for all the lighting in 5 buildings to be changed to LED. We will now look at internal funding to allow the work to progress

- *What factors have prevented implementation of EMS to ISO14001 Standard for any sites in The State Hospital's estate which have not yet reached that standard?*

The State Hospital have been unable to provide a dedicated resource to further develop and implement our EMS.

11. Sustainable construction

Where there is a need for new healthcare facilities, we want both the buildings and grounds to be safe, nature-rich, sustainable, resilient and accessible. The State Hospitals Board for Scotland currently have no planned or ongoing building projects.

12. Sustainable communities

The climate emergency undermines the foundations of good health and deepens inequalities for our most deprived communities.

The NHS touches every community in Scotland. We have a responsibility to use our abilities as a large employer, a major buyer, and one of the most recognised brands in the world – an 'anchor' organisation – to protect and support our communities' health in every way that we can.

- *What are we doing to act as an anchor institution for our local communities?*

  Scottish Government have commissioned all NHS Boards to produce an Anchors Strategic Plan as an initial 3-year strategy to demonstrate how The State Hospital plans to take action to contribute to community wealth.

  The Anchors Strategic Plan includes data to provide a baseline in relation to workforce and local procurement.

  Initial themes that The State Hospital have focused on as part of the Anchor Strategic Plan include:

- Progressive Procurement - TSH can direct investment into the local region through procurement practices. It may be possible to consider giving local suppliers greater weight in procurement processes, which in turn can create new employment locally.

- Employment - TSH is a relatively large local employer within an area of deprivation. Development of recruitment practices to encourage community members to consider employment in TSH would be useful to consider.

- Sustainable use of land and property - consideration given to the use of land and sustainable practices.

- *What are we doing to improve the resilience of our local communities to climate change?*

There are no current areas of improvement that have been identified. The location and nature of the hospital makes it difficult to engage with the local community to improve resilience with regards to climate change.

13. Conclusion

The tables below contain the current modelling report for TSH's Net Zero performance on a BAU scenario.

As a Board the emissions have decreased by a massive 83.7% against the baseline year 1993/94, which is within the 5-year 1990 Kyoto window.

Prior to 1993/94, the site was operated and maintained by the Department of Environment (DoE) on behalf of the UK Government and Scottish Executive.

NHS State Hospital						
CO2e Emissions Targets	**1993/94**	**2023/24 Reported Figures**	**2025 Interim Target**	**2030 Interim Target**	**2035 Interim Target**	**2040 Net**

							Zero Target
The New % Pathways to a 2040 Net Zero Outcome	CO2e Emissions Targets	Baseline	-63.6%	-65.5%	-75%	-87.5%	-100%
Target – Our Current Usage Trend will have to follow these trajectories	Tonnes	10,678	3,887	3,684	2,670	1,335	0
Actual and Predicted CO2e Emissions from now to 2040	Tonnes	10,678	1,739	1,653	1,446	1,332	1,264
CO2e Emissions – Current Pathway based on current anticipated energy use	Based on 1993/94 usage levels	-	-83.7%	-84.5%	-86.5%	-87.5%	-88.2%
Potential Shortfall			-20.1%	-19.0%	-11.5%	0.0%	11.8%

From the data above, TSH are already 20% ahead of the Net Zero target with the reported figures in 2023/24.

To meet the decarbonising of heat sources target, TSH will require to commission a feasibility study to explore the use of new technologies such as ground source/air source heat pumps, and any emerging technologies that would be suitable for the site.

With the target year being 2038, this will require to be completed over the next 5/6 years.

Electrical renewable technology to be explored for the site includes wind (turbine) and solar PV. This work will coincide with the feasibility study for the decarbonising of heat sources over the next 5/6 years.

During the next 5/6 years, as Net Zero plans are developed, funding sources will also have to be identified to allow TSH to implement the technology for Net Zero to be achieved.

Focus for this year will be to develop and implement a high-level waste route map, move forward with an active travel agenda, increase biodiversity/greenspace awareness and fully implement an EMS for The State Hospital.

Paper No. 24/112

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2024
Agenda Reference:	Item No: 21
Sponsoring Director:	Chief Executive
Author(s):	Head of Corporate Governance
Title of Report:	Board Workplan 2025
Purpose of Report:	For Decision

1 SITUATION

The Board is asked to review its workplan for the coming year to identify the key considerations and actions required during 2025, and to provide assurance on planned areas of reporting.

2 BACKGROUND

The Board considers and approves a workplan annually, to ensure that each component part of the workplan is allocated to meeting(s) throughout the year. The workplan has been developed to encompass the key focus areas for the Board in the coming year, and is enclosed at **Appendix A**. The workplan is developed based on planned workstreams, and reporting will be stood up to reflect change that may occur throughout this period.

3 ASSESSMENT

The workplan sets out the Board's priorities, with a review of its Corporate Objectives for 2025/26 in February. This will be linked to the development of the Medium Term Plan, as well as the Annual Delivery Plan and the Workforce Plan (each of which will be routed through the Board meeting held in public, following the relevant approvals by Scottish Government).

The Board will continue to receive dedicated reporting around key areas of risk and resilience, with review of the Corporate Risk Register at each meeting, and dedicated reporting on the financial position and bed capacity within the State Hospital, and across the wider forensic estate.

The workplan includes evaluation of the clinical model at the two-year point, reflecting that the Clinical Governance Committee will take detailed oversight in this regard throughout the year. The Board will continue to receive reporting at each meeting summarising key aspects of Quality Improvement and Assurance, including Realistic Medicine. There will be presentations providing the views of patients and carers, giving the Board the opportunity to hear the lived experience of stakeholders.

The Board will continue to receive high level reporting on workforce reporting, with the Staff Governance Committee receiving more detailed reporting in this regard. The Annual Report on the

implementation of the Health and Care (Staffing) Act will come to the Board in April, prior to submission to Scottish Government.

The workplan includes a final report on the conclusion of the Perimeter Security and Enhanced Internal Security Systems Project in June 2025. There will be six monthly updates on progress in relation to the Network and Information Systems audit workstream, as well as annual reporting on the Climate Change and Sustainability framework.

The timings of annual reports have be reviewed to bring these forward where possible, making the updates more timely. The Board will also receive an annual report on progress on the Board Improvement Plan in April 2025, and it is expected that a new programme for self-assessment will also be led by the Board Development Team at NHS Education for Scotland (NES).

The Board has also scheduled a series of Board Development Sessions throughout the year, which will be held in person, allowing an additional framework through which to consider developing workstreams as they progress toward the formal Board.

4 RECOMMENDATION

The Board is asked to:

- Review the revised workplan and discuss whether this provides a robust structure for the consideration and scrutiny of the Board's business in 2025, advising whether any change or addition is required.

- Approve the plan as a basis for managing Board business in 2025.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP / Corporate Objectives	To support the Board's Corporate Objectives and strengthen reporting to and oversight by the NHS Board with planned reporting throughout year
Workforce Implications	There are no implications as a result of this report
Financial Implications	There are no impacts to consider.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Requested by the Board as part of workplan, and directed through the Corporate Management Team.
Risk Assessment (Outline any significant risks and associated mitigation)	The workplan is developed to provide assurance to the Board, and there are no additional risks to consider
Assessment of Impact on Stakeholder Experience	This is considered by the Board in setting its workplan
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not relevant
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND: BOARD BUSINESS 2025

February 2025	April 2025	June 2025	August 2025	October 2025	December 2025
• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report •	• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report
• Governance Committee Minutes/Summary Reports	• Governance Committee Minutes/Summary Reports • Clinical Forum Update • Board Improvement Plan Update	• Governance Committee Minutes/Summary Reports • Governance Committee Annual Reports	• Governance Committee Minutes/Summary Reports • Clinical Forum Update • Annual Schedule of Board/Committee meetings	• Governance Committee Minutes/Summary Reports • Board Improvement Plan Update	• Governance Committee Minutes/Summary reports • Clinical Forum Update • Annual Review Feedback (2024/25) • Workplan 2026
RISK AND RESILIENCE:					
• Corporate Risk Register • Finance • Bed Capacity	• Corporate Risk Register • Finance • Bed Capacity	• Corporate Risk Register • Finance • Bed Capacity	• Corporate Risk Register • Finance • Bed Capacity	• Corporate Risk Register • Finance • Bed Capacity	• Corporate Risk Register • Finance • Bed Capacity
CLINICAL GOVERNANCE:					
• Quality Assurance and Improvement	• Patient, Carer & Volunteer Stories • Quality Assurance and Improvement	• Quality Assurance and Improvement	• Patient, Carer and Volunteer Stories • Quality Assurance and Improvement • Implementation of Specified Persons Annual Report • Clinical Model 2 Year evaluation	• Quality Assurance and Improvement • Medical Appraisal and Revalidation Annual Report • Medical Education Report	• Patient, Carer and Volunteer Stories • Quality Assurance and Improvement • Patient Independent Advocacy Annual Report

February 2025	April 2025	June 2025	August 2025	October 2025	December 2025
STAFF GOVERNANCE:					
• Staff Governance Report • Whistleblowing Quarter 3 Report	• Staff Governance Report • Health and Care Staffing Annual Report • Whistleblowing Quarter 4 Report/ Annual Report	• Staff Governance Report • Workforce Plan 2025/28– *following SG approval*	• Staff Governance Report • Whistleblowing Quarter 1 Report	• Staff Governance Report	• Workforce Report • Whistleblowing Quarter 2 Report
CORPORATE GOVERNANCE:					
• Corporate Objectives 2025/26 • Performance Report Quarter 3 • Security Project	• Annual Review of Standing Documentation • Communications Annual Report • Network and Information Systems Report	• Annual Accounts Reporting • Medium Term Plan 2025/28– *following SG approval* • Performance Annual Report • Risk and Resilience Annual Report • Security Project Final Report	• Performance Report Quarter 1 • Complaints & Feedback Annual Report • Information Governance Annual Report	• eHealth Annual Report • Network and Information Systems Report	• Performance Report Quarter 2 • Climate Emergency and Sustainability Annual Report 2024/25 • Whole System Infrastructure Reporting

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2024
Agenda Reference:	Item No: 22
Sponsoring Director:	Chief Executive
Author(s):	Head of Corporate Planning and Business Support Corporate Planning, Performance and Quality Project Support Mgr
Title of Report:	Q2 2024/25 Corporate KPI Performance Report
Purpose of Report:	For Noting

1. SITUATION

This report presents a high-level summary of organisational performance through the reporting of Key Performance Indicators (KPI's) for Q2: July to September 2024. Trend data is also provided to enable comparison with previous performance. The national standards directly relevant to the State Hospital are Psychological Therapies Waiting Times and Sickness Absence. Additional local KPI's are reported to the Board and are included in this report. Board planning and performance are monitored by Scottish Government through the Annual Delivery Plan (ADP) for 2024-25 which was approved by the Scottish Government in June 2024.

2. BACKGROUND

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

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

3. ASSESSMENT

The following sections contain the KPI data for Q2 and highlight any areas for improvement in the next quarter through a deep dive analysis for KPI's that have missed their targets.

There is a total of 12 corporate KPI's. Seven KPI's have reached and / or exceeded their target this quarter, this is a decrease of one since Q1 and there are five KPI's which are off target, these are:

Reached and / or exceeded their target	Off target
• Patients will be engaged in psychologist treatment. • Patients will be engaged in off-hub activity centres. • Patients will undertake an annual physical health review. • Patients transferred/discharged using CPA.	• Patients have their care and treatment plan documentation reviewed at 6 monthly intervals. • Patients will undertake 150 minutes of exercise each week. • Patients will have a healthier BMI.

• Patients requiring primary care services will have access within 48 hours. • Staff will have an approved PDR. • Patients will commence psychological therapies <18 weeks from Referral.	• Patients have their clinical risk assessment reviewed annual. • Sickness absence rate.

Performance Indicator	Target	RAG Q3 23/24	RAG Q4 23/24	RAG Q1 24/25	RAG Q2 24/25	Actual	Comment
Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	R	R	R	A	91.97%	This indicator moves from the red to the amber zone.
Patients will be engaged in psychological treatment	85%	R	G	G	G	96.33%	This indicator remains in the green zone.
Patients will be engaged in off-hub activity centers *(This includes drop-in sessions which took place in hubs, grounds and Skye Centre)*	90%	G	G	G	G	96.67%	This indicator remains in the green zone.
Patients will undertake an annual physical health overview by the practice nurse	100%	G	G	G	G	100%	This indicator remains in the green zone.
Patients will undertake 150 minutes of moderate exercise each week	70%	R	R	G	A	62.67%	This indicator moves from the green to amber zone.
Patients will have a healthier BMI	25%	R	R	R	R	8.67%	This indicator remains in the red zone.
Sickness absence rate	5%	R	R	R	R	7.6%	This indicator remains in the red zone
Staff have an approved PDR	80%	G	G	G	G	88.8%	This indicator remains in the green zone
Patients transferred / discharged using CPA	100%	G	G	G	G	100%	This indicator remains in the green zone.
Patients requiring primary care services will have access within 48 hours	100%	G	G	G	G	100%	This indicator remains in the green zone.
Patients will commence psychological therapies <18 weeks from referral date	100%	G	G	G	G	100%	This indicator remains in the green zone.
Patients have their clinical risk assessment reviewed annually.	100%	G	A	R	A	94.03%	This indicator moves from the red to the amber zone.

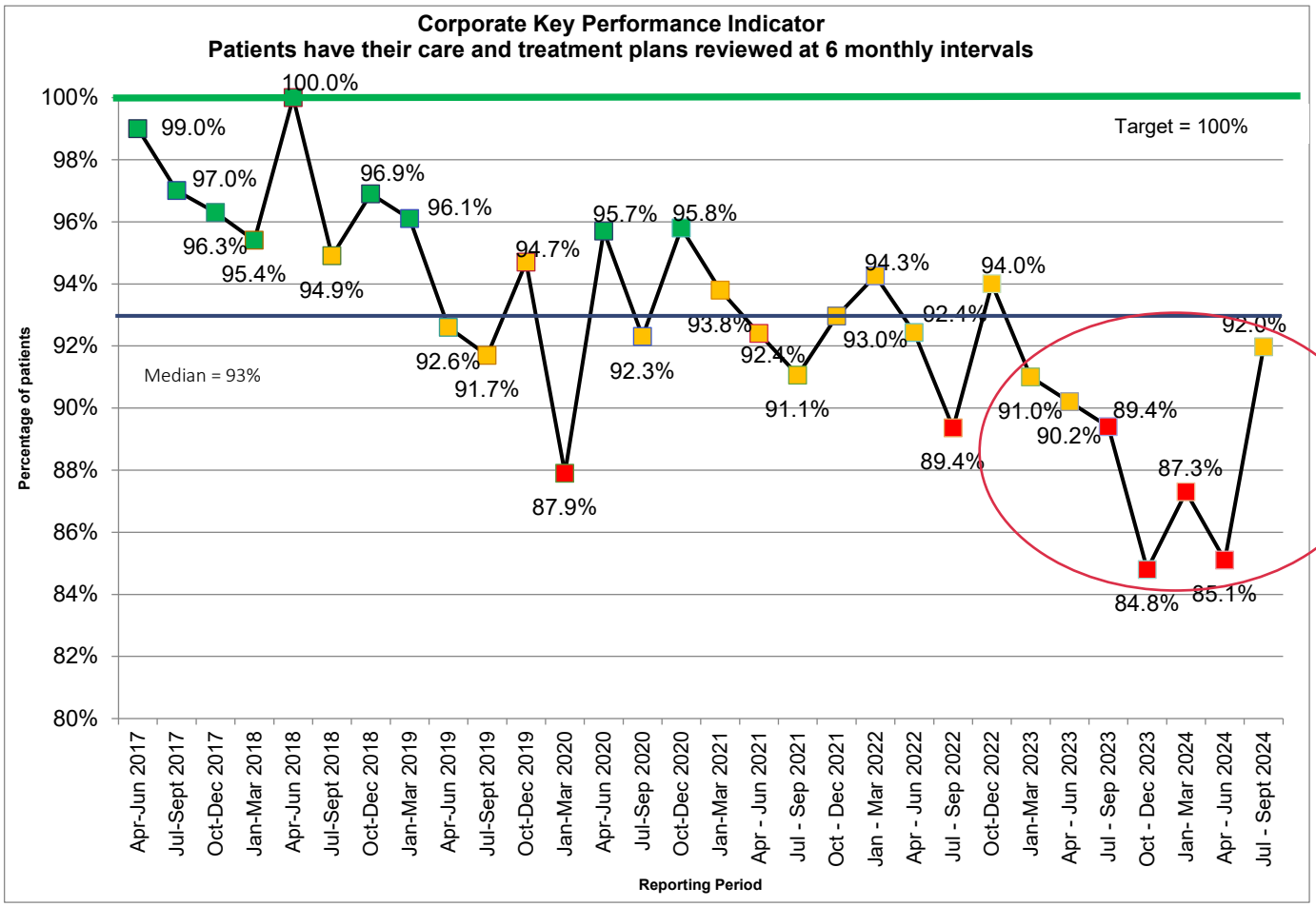
Definitions for red, amber and green zone:

- For all but items 6 and 7 green is 5% or less away from target, amber is between 5.1% and 10% away from target and Red will mean we are over 10% away from target.
- For item 6: 'Patients have a healthier BMI' green will be 3% or less away from target, amber will be between 3.1% and 5% away from target and red will be over 5% away from target.
- For 7 'Sickness absence' green is less than 0.5% from target, amber will be between 0.51% and 1% away from target and red will be over 1% and away from target.

No 1: Patients have their care and treatment plan documentation reviewed and uploaded to RiO at 6 monthly intervals

Target: 100%
Data for current quarter: 91.97%
Performance Zone: Amber

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



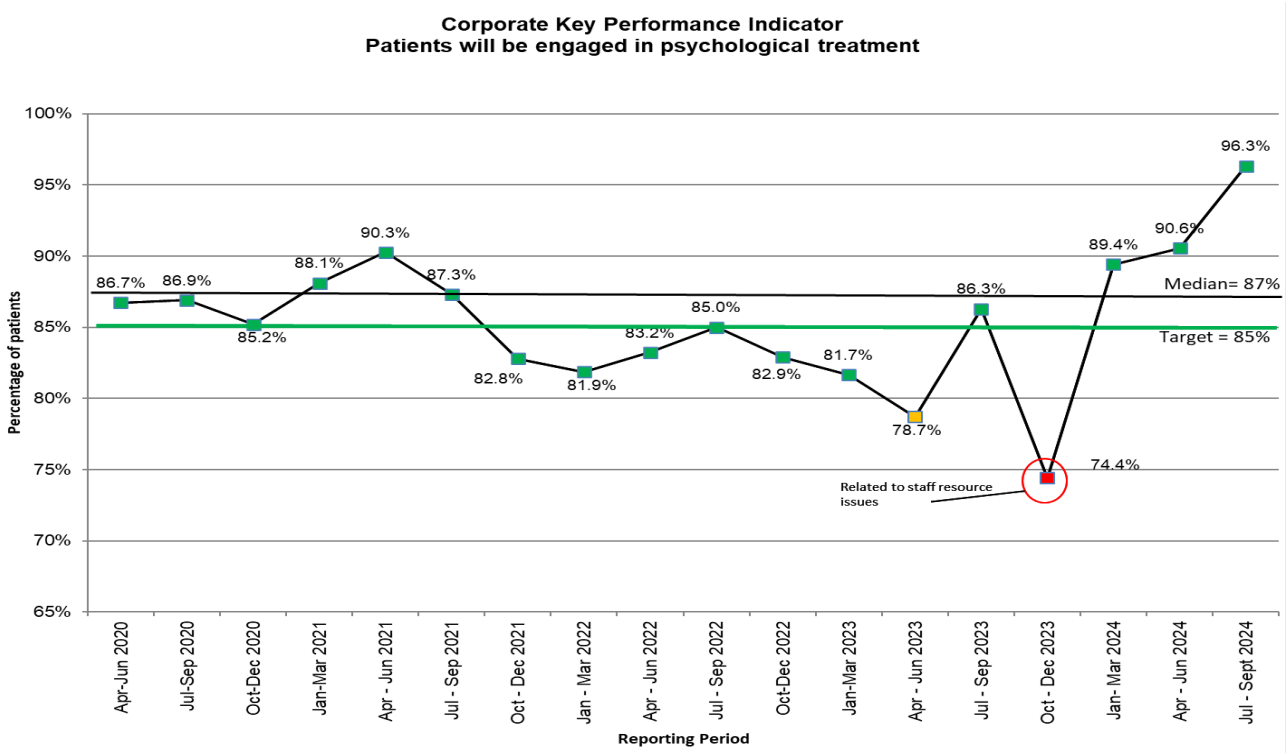
This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In July 2024 the compliance was 96.7% which is the highest monthly figure since February 2022. August 2024 was 87% and in September 2024 compliance was 92.2% giving a quarterly compliance of 91.97%. This has increased from last quarter's figure of 6.87%. This indicator therefore moved from the red to the amber zone. The median sits around 93%, the area circled in red shows a shift within run chart rules, therefore the pattern is likely to be attributable to something within the process and unlikely to just be a result of random variation.

As a result of this shift, a process mapping exercise has been completed to identify bottlenecks in the process, which are currently being investigated by the Business Admin team and Head of Psychology. The Corporate Planning, Performance and Quality Project Support Manager is providing a more detailed breakdown on a quarterly basis to the Medical Director for further investigation to reasons for the delays in uploading onto RiO.

No 2: Patients will be engaged in Psychological Treatment

Target: 85%
Data for current quarter: 96.33%
Performance Zone: Green

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

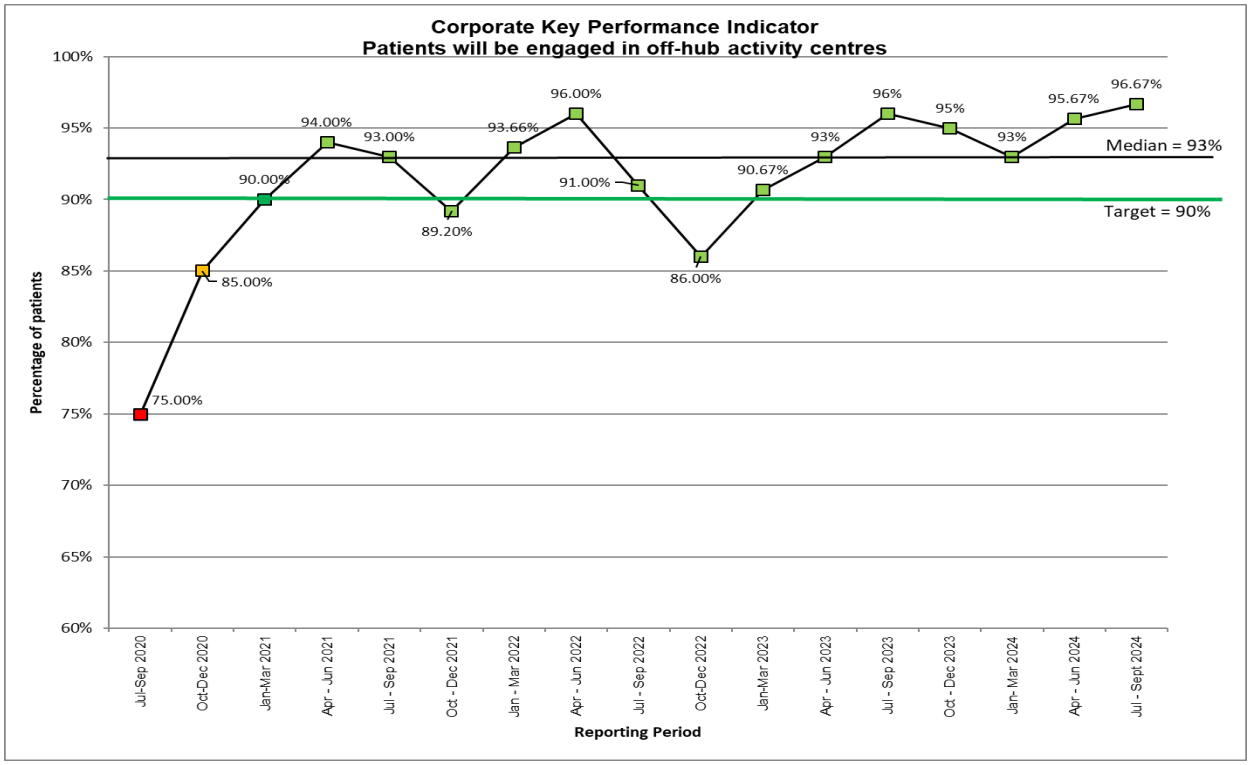


This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. This indicator has remained in the green zone and has increased by 5.77% since last quarter and above the target of 85% since Q4 2023/24. The median for this KPI sits around 87%, this shows random variation and will be monitored by the Corporate Planning, Performance and Quality Department through 2024/25 and reviewed with KPI Owner at their annual review meeting.

No 3: Patients will be engaged in Off-Hub Activity Centres

Target: 90%
Data for current quarter: 96.67%
Performance Zone: Green

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



This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. This KPI remains in the green zone, increasing by 1% since the last quarter and remained above the target of 90% since Q3 2022/23. The median for this KPI sits around 93%, using run chart rules shows random variation, the Corporate Planning, Performance and Quality Department will monitor through 2024/25.

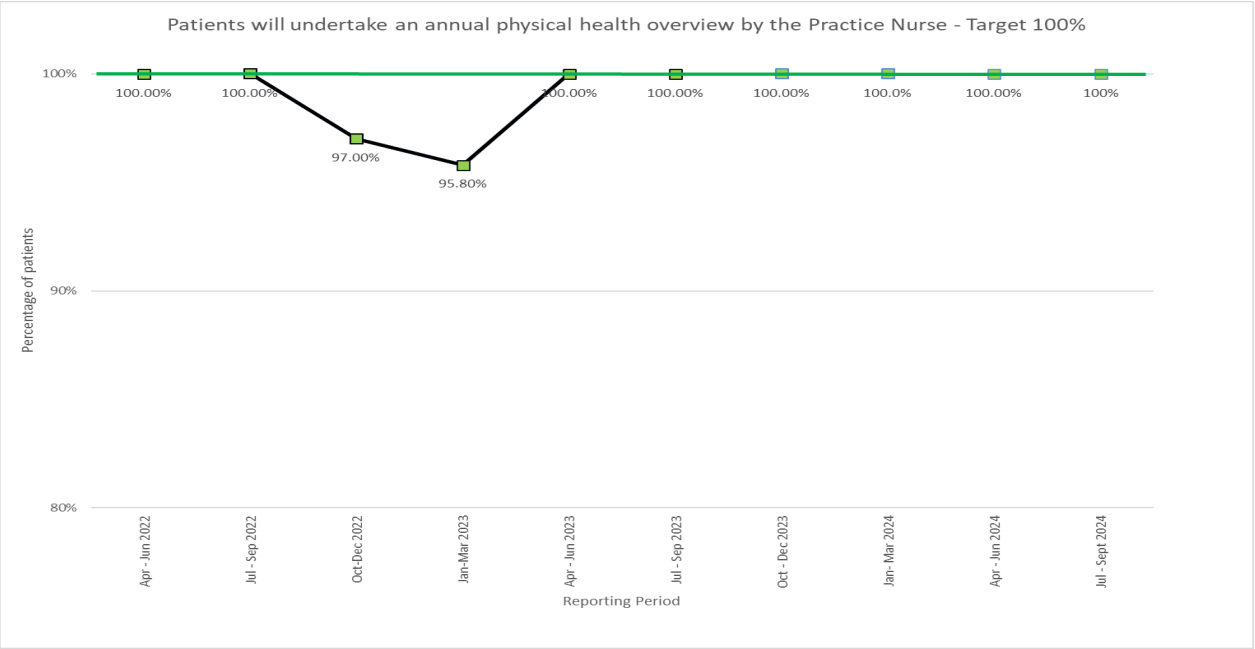
The Activity Oversight Group (AOG) commissioned a review of this KPI to include all activity within the hospital not just off hub activity. Clinical Quality are analysing the data being collected over a three-month period to ensure that the information being collected is accurate. Once the review process has been completed the AOG will discuss amending this KPI.

No 4: Patients will undertake an annual physical health overview by the Practice Nurse

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

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

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



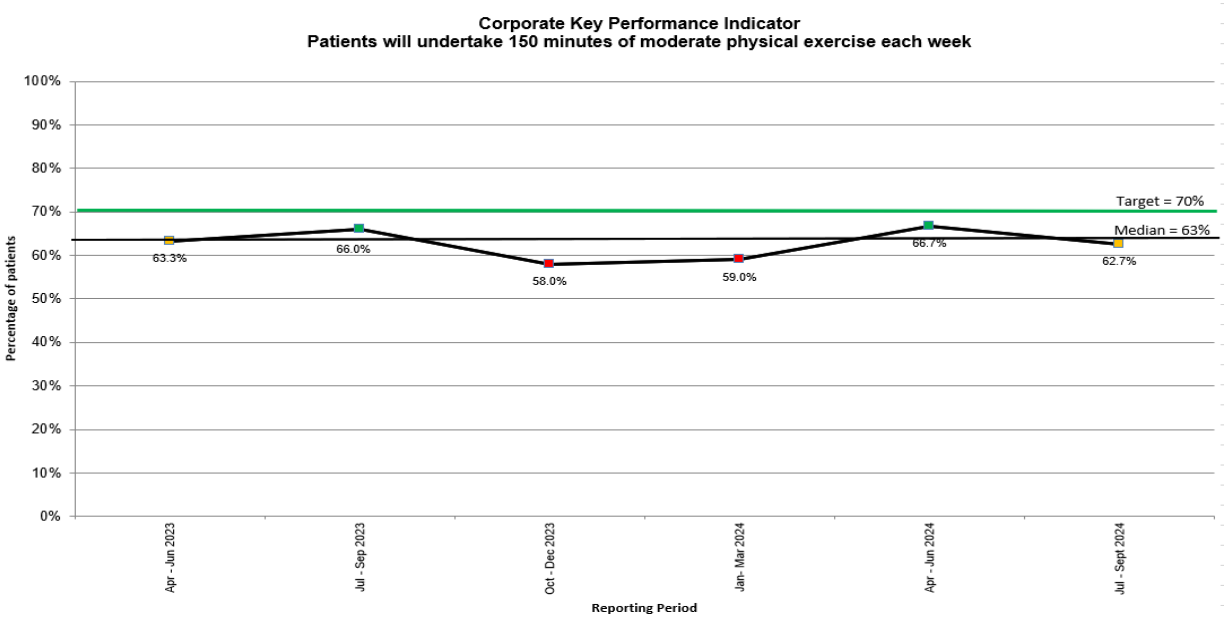
In Q2 2024-25 a 100% of patients who were eligible for an annual physical health review were reviewed by the Practice Nurse. This target has continued to be met and has done since Q4 2022/23 and has remained in the green zone since the change in target in Q1 2022/23.

No 5: Patients will undertake 150 minutes of moderate exercise each week

Target: 70%
Data for current quarter: 62.67%
Performance Zone: Amber

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

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



This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. Since the target was change in Q1 2023/24 there is insignificant data points to determine any improvement when using Qi run chart rules.

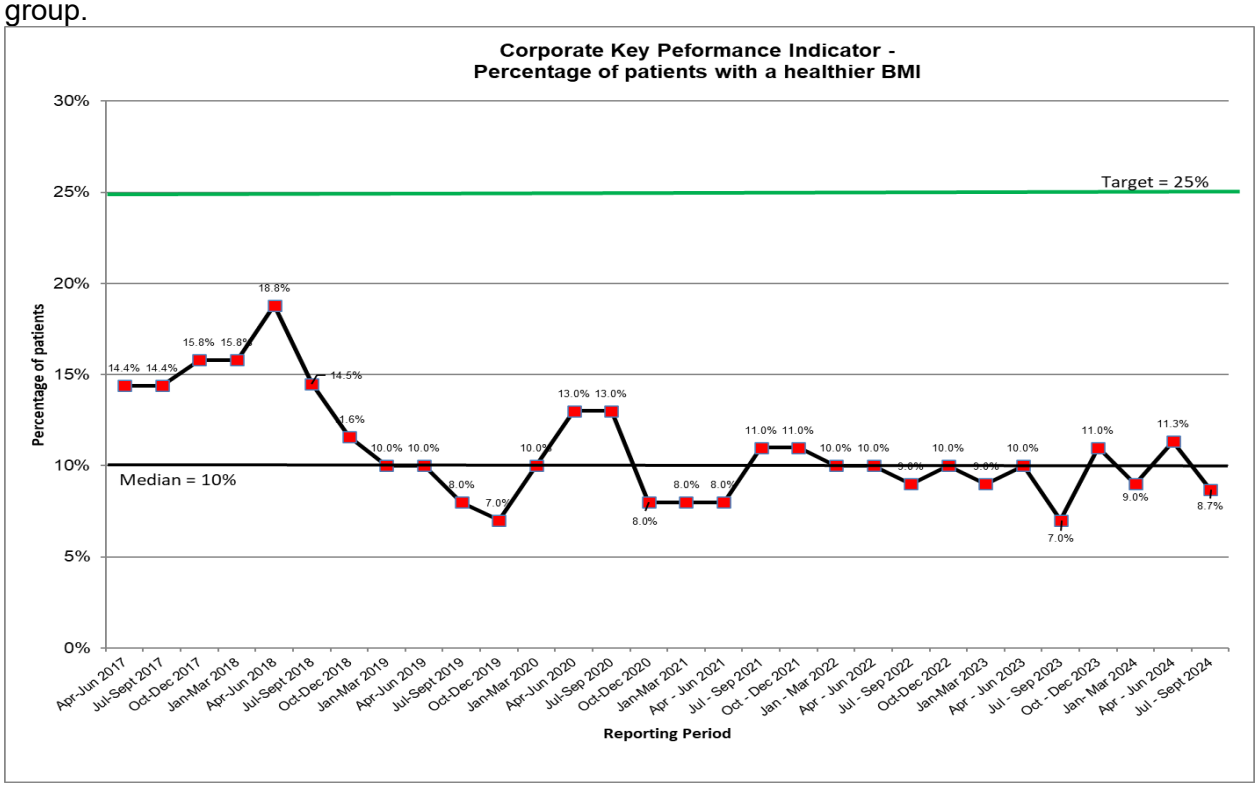
Target = 70%

Since Q1 there has been a decreased of 4% and moves from the green to amber zone in Q2. The monthly compliance data shows that there was 10% drop from July 2024 where the percentage was 67% to 57% in August 2024 albeit this increased in September data to 64%. During this review period various events were hosted by the Sports Dept and Skye Centre such as Euro 24 and Sports week whilst the running track was also reopened. The end time for patients to utilise grounds access has also started to decrease. The Activity Oversite Group is encouraging Service Leaders teams to have season plans in place to support activity

No 6: Patients will have a healthier BMI

Target: 25%
Data for current quarter: 8.67%
Performance Zone: Red

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



This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. This KPI remains in the red zone, decreasing by 6% since the last quarter. This KPI has never reached the agreed target of 25%. The median for this KPI sits around 10%, which is significantly lower than the agreed target of 25%.

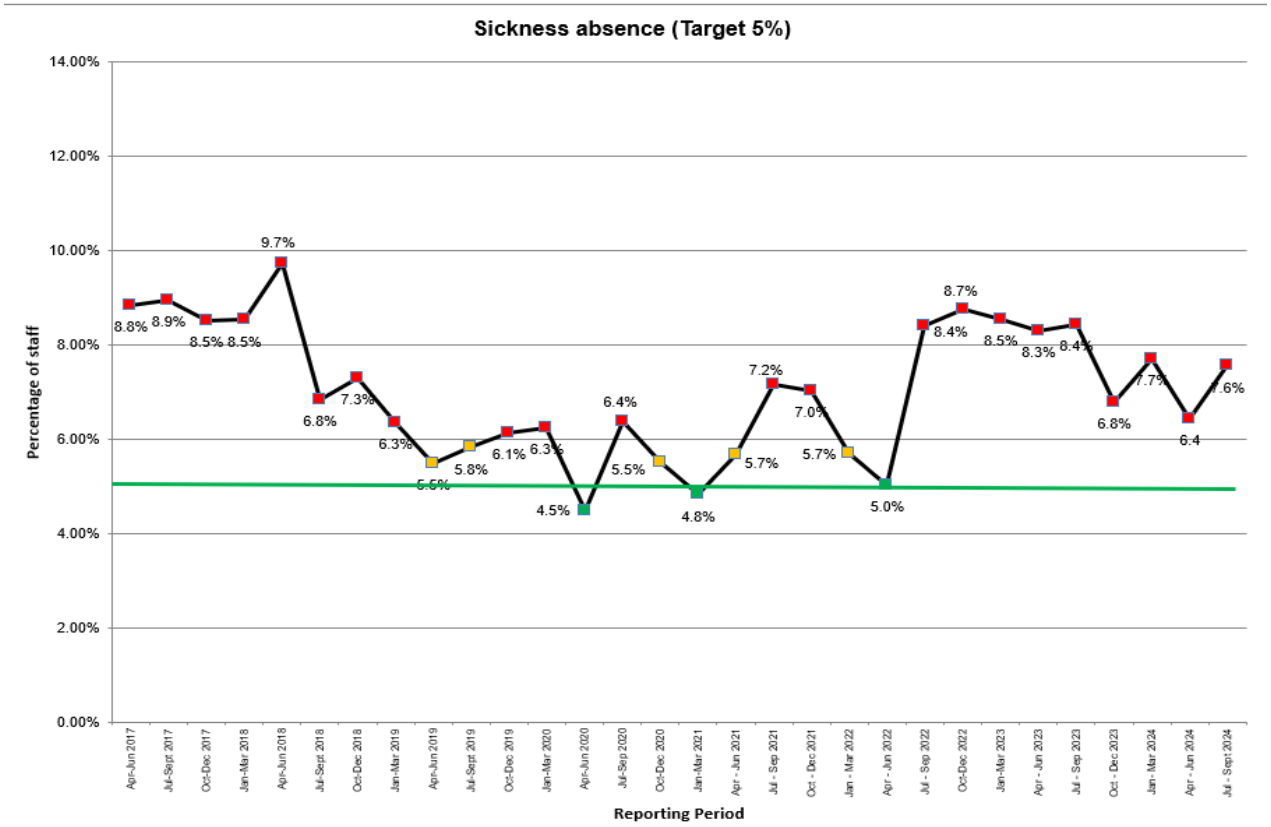
The monthly collections for the quarter are that in July 2024 9% of the patient population has a healthier BMI, in August 8% and in September 9%. Development of improvement projects via SHC is continuing.

One approach currently being tested by the Physical Health Steering Group is the adoption of a local KPI in April 2022 for newly admitted patients. This has the aim to limit weight gain of patients from admission to equal or less than 5% of admission weight over first 12 months following admission. Analysis of patient's weight 12 months following admission in TSH has revealed, 6 (23%) patients have met this target and remained under the 5% weight gain. Five of these were admitted during 2022/2023 and the remaining patient was admitted early 2023/2024.

No 7: Sickness Absence

Target: 5%
Data for current quarter: 7.55%
Performance Zone: Red

This relates to the National Workforce Standards and measures how many staff are absent through sickness. This now includes COVID-19 related absences, these had been measured / reported separately until 31st March 2024, and from 1st April 2024 these are now part of the overall absence figure. The State Hospital uses the data provided from SWISS for this KPI to align with all NHS Scotland Boards to ensure valid comparisons across Scotland can be achieved. The figures provided via SWISS data slightly differ from SSTS figures; this is due to the SWISS contractual hours being averaged over the 12-month period and the figures from SSTS are based on the contractual hours available within that month.



Levels of absence have remained inconsistent and higher than hoped throughout Quarter 2, with a further spike in September. This is largely attributable to significant rise in long term absence, principally between 29 days and 3 months.

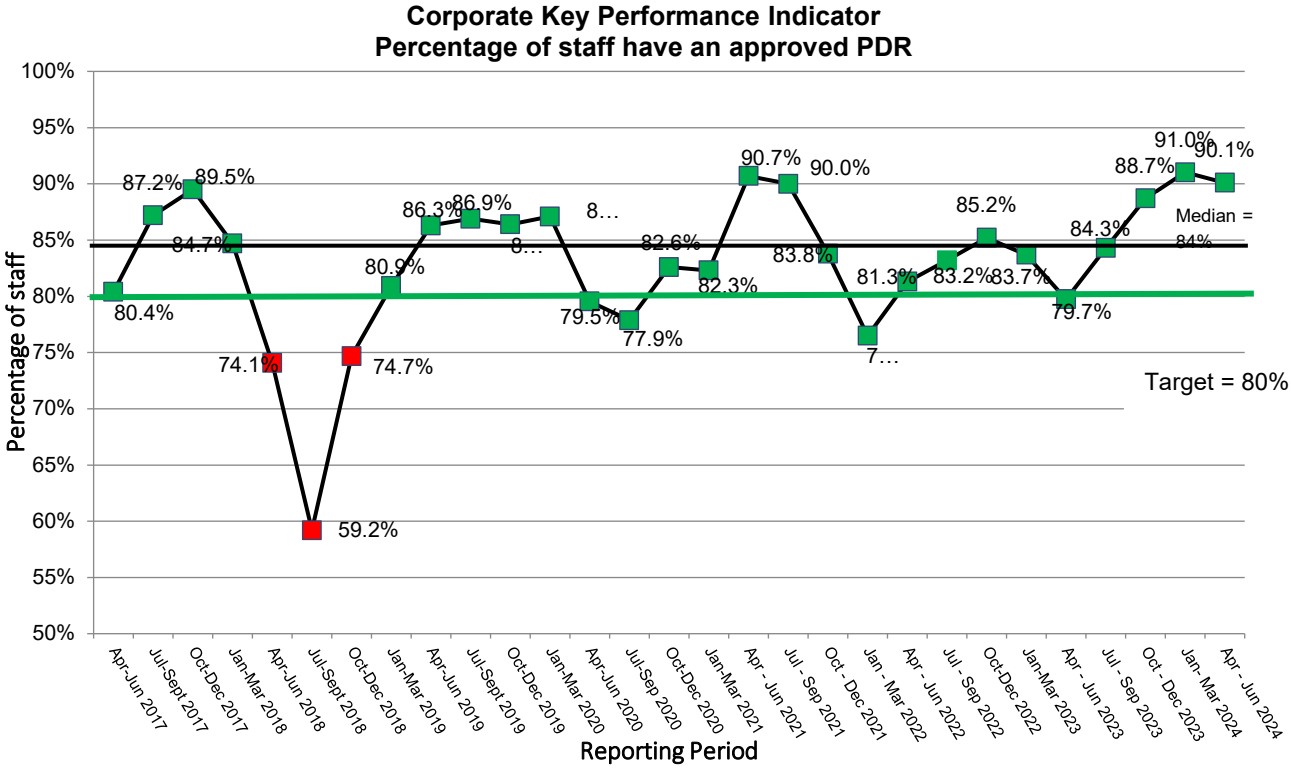
During this period, we have been focusing on selected Maximising Attendance Initiatives including management training on approach and dealing with difficult conversations, along with reviewing current absence pathways to shorten and streamline processes. We are working with service managers to ensure that there is strict compliance with the policy, but also identifying any other areas of support that may be required.

We continue to work proactively with Service Managers, Occupational Health and staff side representatives to proactively support and address all forms of absence, along with a focus on continuous improvement in terms of our processes.

No 8: Staff have an Approved PDR

Target: 80%
Data for current quarter: 88.8%
Performance Zone: Green

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

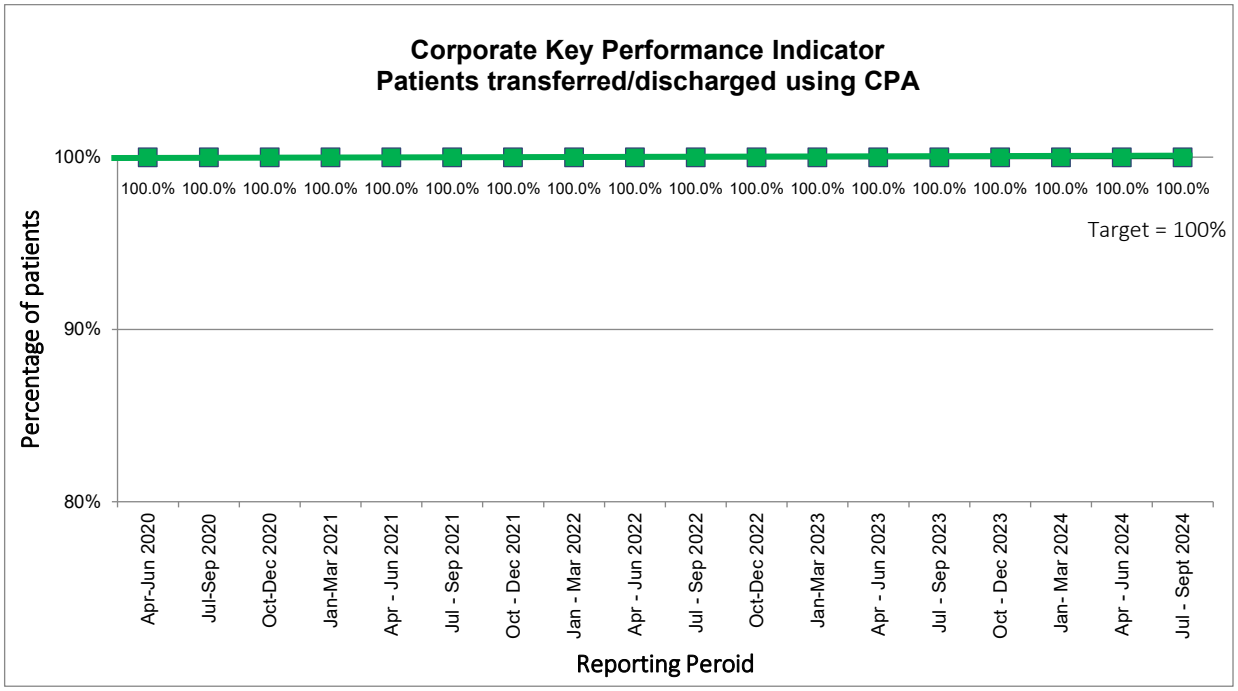


This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In July 2024 the compliance was 90%, August 2024 was 98.9% and September 2024 was 87.6% giving a quarterly compliance of 88.8%, which is a slight decreased from Q1 2024/25 of 1.3%. This indicator remains with the green zone and has remained above target since Q2 2023/24.

No 9: Patients are transferred/discharged using CPA

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

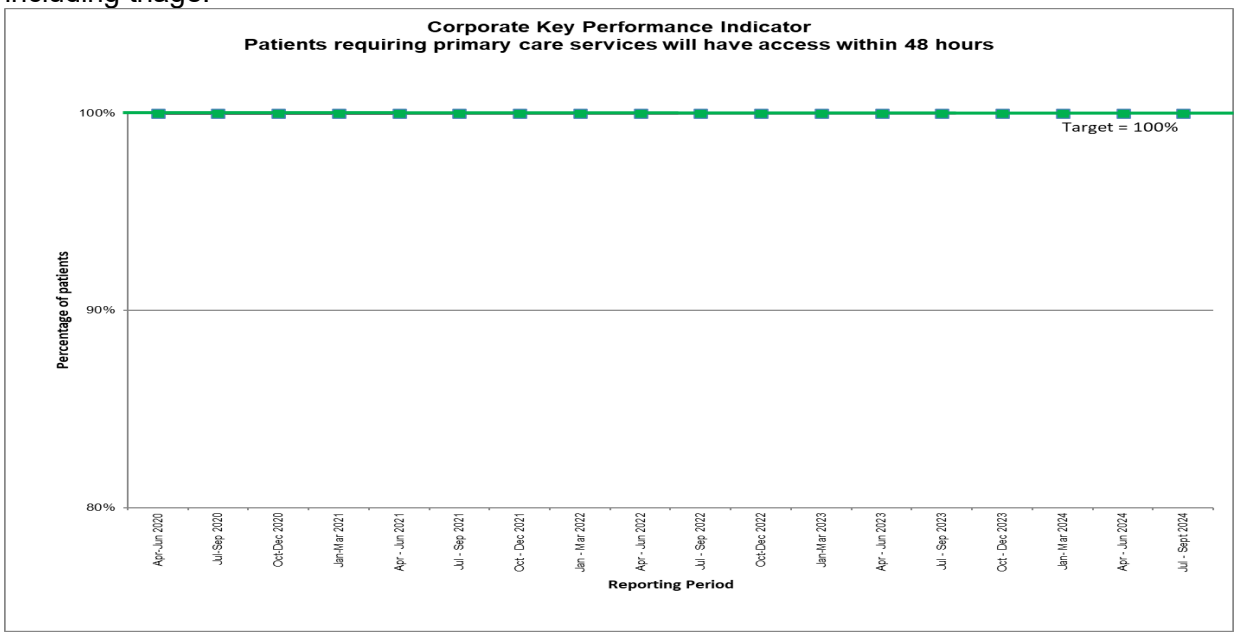
The indicator is linked to the Mental Health Act 2003 and the streamlining of discharges and transfers. The number of patients transferred out using CPA process are measured through this indicator.



No 10: Patients requiring Primary Care Services will have access within 48 hours

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

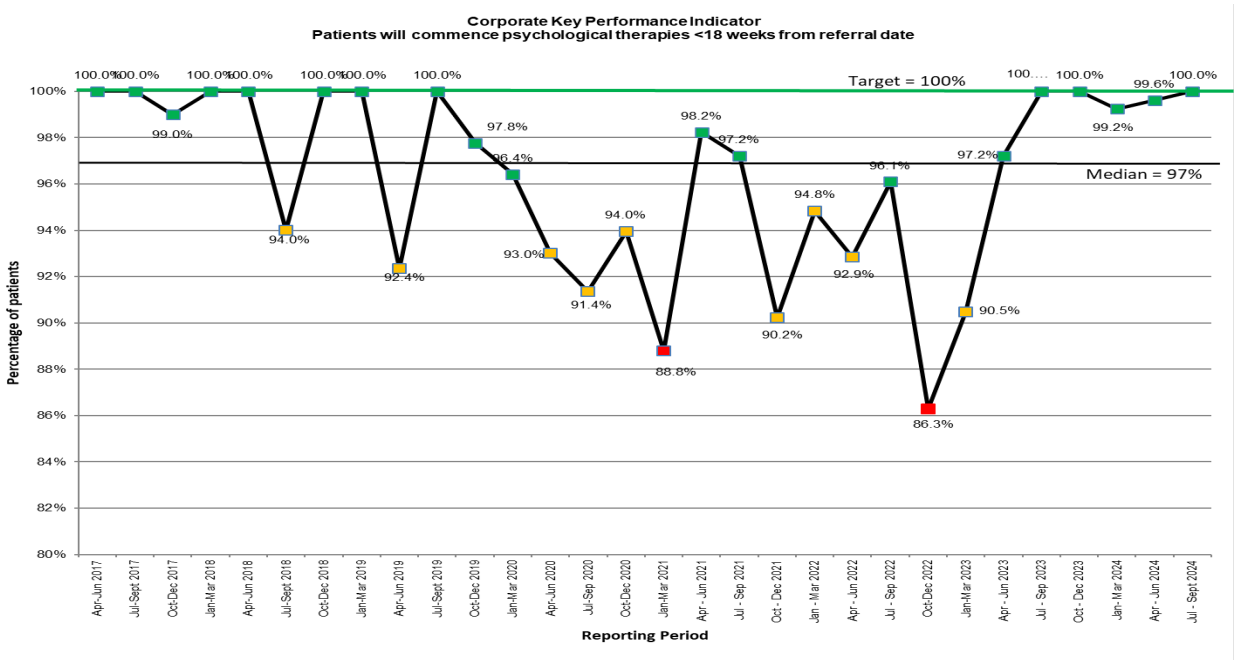
This indicator is linked to National Health and Social Care Standards as published by Healthcare improvement Scotland (HIS). Primary care services include any service at our Health Centre including triage.



No 11: Patients will commence Psychological Therapies <18 Weeks from referral date

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

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

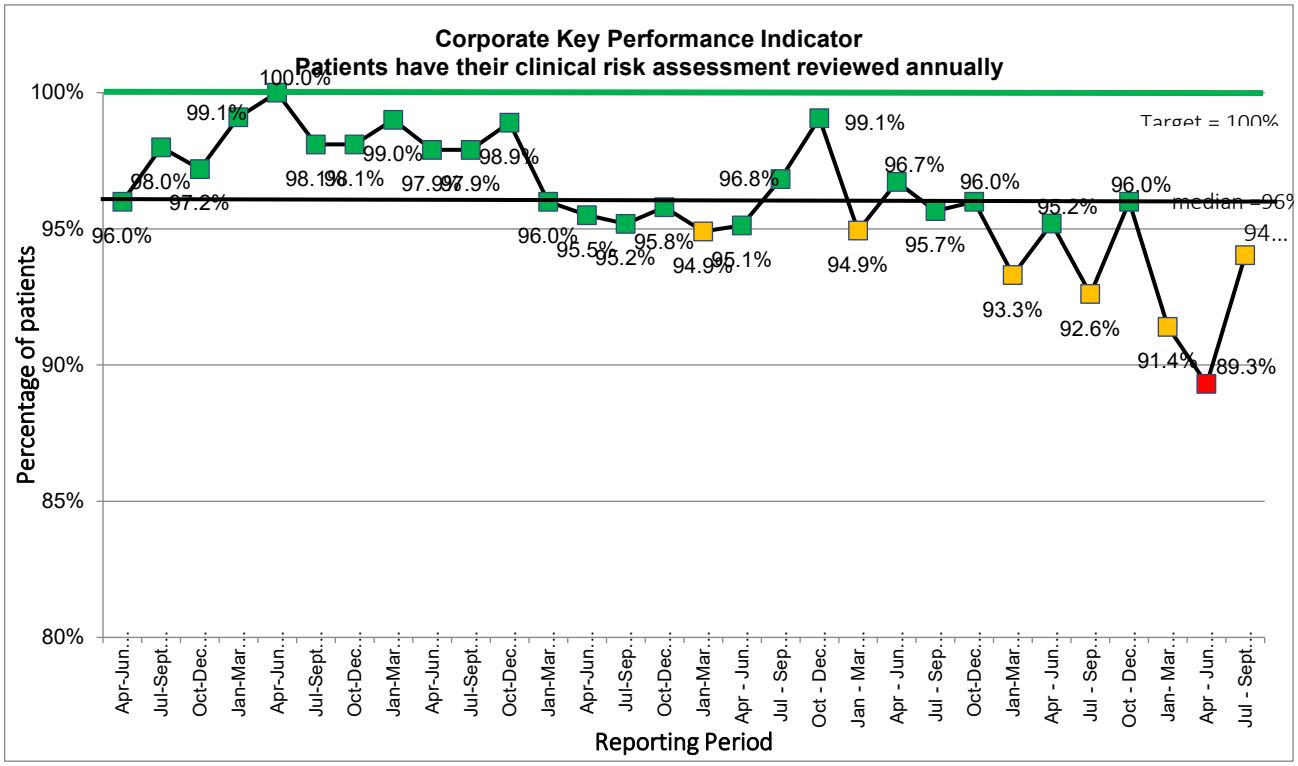


This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. This indicator has remained in the green zone since Q1 of 2023/24 and has increased by 0.38% since last quarter.

No 13: Patients have their Clinical Risk Assessment reviewed annually

Target: 100%
Data for current quarter: 94.03%
Performance Zone: Amber

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



The number of risk assessments which were not closed off within RiO by their expected submission date. In July 2024 the compliance was 96.7%, August 2024 was 95.4% and September 2024 was

90% giving a quarterly compliance of 94.03%, which is a 5% increase from Q1 2024/25. This indicator moves from the red zone to the amber zone. The Head of Psychology continues to monitor this KPI on a monthly basis to improve the target compliance.

No 15: Professional Attendance at CPA Review

Target: Individual for each profession

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

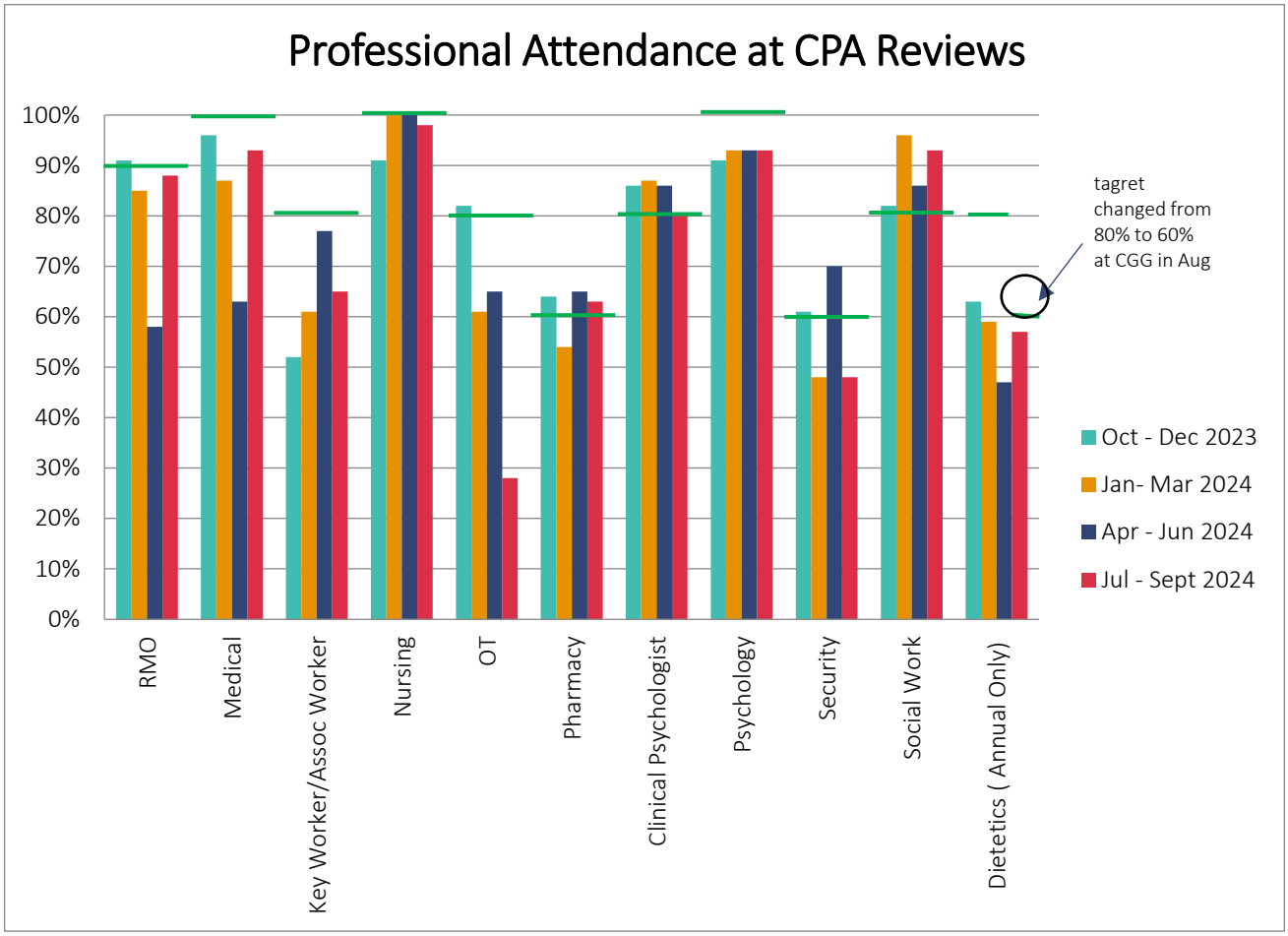


Table 1 shows Q2 broken down into months attendance

Profession	July 24 n=11	Aug 24 n=13	Sep 24 n=16
RMO	91%	100%	75%
Medical	91%	100%	88%
Key Worker/Associate Worker	82%	54%	63%
Nursing	100%	100%	94%
OT	9%	23%	44%
Pharmacy	73%	77%	44%
Psychologist	82%	92%	69%
Psychology	100%	92%	88%
Security	55%	31%	56%
Social Work	91%	85%	100%

	July 24 N=5	Aug 24 N=9	Sep 24 N=9
Dietetics (Annual Only)	60%	78%	33%

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

RMO (Target 90%) – attendance for this profession has increased from 58% in Q1 2024/25 to 86.33% in Q2 2024/25. This indicator moves from the red zone to the green zone. On two occasions the Trainee Psychiatrist/Speciality Doctor attended in their place. On one occasion there was no reason indicated for Consultant non-attendance and on one occasion the Consultant was on annual leave. On three occasions, the VAT form was not completed.

Medical (Target 100%) – attendance for this profession has increased from 63% in Q1 2023/24 to 93% in Q2 2024/25. This indicator moved from the red to the amber zone.

Key Worker/Associate Worker (Target 80%) – attendance figures decreased from 77% in Q1 2024/25 to 54.67% in Q2 2024/25. This indicator moved from the amber to the red zone. This is the lowest attendance recoded since Q3 2023/24

Nursing (Target 100%) – On one occasion no nursing rep attended as the Case Review was arranged at short notice reducing Q2 figures from 100% to 93%.

OT (Target 80%) – attendance has decreased from Q1 2024/25 from 65% to 28% in Q2 2024/25, this profession remains in the red zone. There is a combination of reasons recorded for this including staff not allocated due to staff vaccines and staff annual leave. This is the lowest percentage since data started to be collected.

Pharmacy (Target 60%) – attendance for this quarter has decreased slightly from 65% to 63% this profession remains in green and over target.

Clinical Psychologists (Target 80%) – this profession's attendance has decreased slightly from 86% in Q1 2024/25 to 80% in Q2 2024/25. This indicator remains in the green zone.

Psychology (Target 100%) – this professions attendance has remained at 93%, the same as Q1 2024/25. This indicator remains in the amber zone.

Security (Target 60%) - attendance from security has decreased this quarter by 22% in Q2 to 48% from 70% in Q1 2024/25. Security moves from the green zone into the red zone. There is a combination of reasons including staff annual leave, staff off duty, staff other commitments, Case Review date changed, and VAT not completed.

Social Work (Target 80%) – attendance has increased in Q2 2024/25 from 86% in Q4 2023/24 to 93% and remains in the green zone and over target.

Dietetics (Target 60%) – attendance is only recorded for annual reviews. This target was changed in August 2024 following approval at the Clinical Governance Group from 80 to 60%. Basing this profession results on the new target of 60% attendance it remains just under at 57%. Reasons are staff annual leave, staff off duty, Case Review date changed, no reason indicated, staff other commitments, staff sick leave and staff training (1).

4. RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of TSH Key Performance Indicators links to both the TSH corporate objectives and the Annual Delivery Plan 2024-2025. The KPI's provide assurance to TSH Board on key areas of performance. Some of the KPI's are national targets which TSH is held accountable for performance nationally, others are local priorities for TSH Board. The TSH Performance Framework proves an overview of how performance is managed across TSH. Scottish Government will receive this report following approval from TSH Board as an indicator of TSH performance.
Workforce Implications	No workforce implications - for information only.
Financial Implications	No financial implications - for information only.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Via Strategic Planning and Performance Group
Risk Assessment (Outline any significant risks and associated mitigation)	If KPI's are off target the improvement plan to address this is detailed in the paper
Assessment of Impact on Stakeholder Experience	Not formally assessed
Equality Impact Assessment	No implications identified.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2024
Agenda Reference:	Item No: 23
Sponsoring Director:	Finance and eHealth Director
Author(s):	Head of eHealth
Title of Report:	eHealth Annual Report
Purpose of Report:	For Noting

1 SITUATION

In order for the Board to have an overview of the work carried out by the eHealth Department, an annual report is provided for consideration.

The eHealth Annual Report highlights the activities of the department during 2023/24

- Information team
- Infrastructure team
- Project Management

2 BACKGROUND

The State Hospital's eHealth department builds on the national commitment to provide a suitable digital infrastructure for NHS Scotland, with a strong focus on delivering national initiatives and programmes. In addition, there are significant Board-specific projects which require to be addressed in order to maintain the desired level of provision for both staff and patient needs.

This report relates to the period April 2023 to March 2024 and provides an update in respect of the above work streams, in relation to contributing to the delivery of high quality service and developments based on identified needs in the short, medium and longer-terms.

3 ASSESSMENT

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

Key achievements include:

- Upgrade of remote access systems
- ServiceNow helpdesk
- Disaster Recovery Test plans
- Microsoft 365 additional functionalities
- Wireless Network Installation
- Core Network switch replacement
- Dragon Medical One Dictation system
- Patient Learning Centre Netsupport system
- Deployment of Windows Defender for Server and Unmanaged Devices
- TSH suite of Tableau dashboards
- New functionality in Rio EPR – CPA processes moved to EPR, and overall Rio upgrades
- Testing of the national phishing simulation product
- Successful submission of NIS reporting requirements

Some key actions currently identified for the next twelve months include:

- Disaster Recovery Test Plans:
- Upgrade of remote access system
- ServiceNow Helpdesk
- Microsoft 3675 Security Baseline Implementation
- Continuation of Wireless network Implementation
- Microsoft 365 Products (SharePoint) as required as part of the national programme

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 the eHealth Strategy
Workforce Implications	Not applicable
Financial Implications	No financial implications if approved
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	eHealth SubGroup
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).	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

eHEALTH ANNUAL REPORT

2023-2024

Responsible Director	Finance and eHealth Director
Lead Author	Head of eHealth
Contributing Authors	Senior Project Manager, Information & Data Lead, Infrastructure Operations and IT Security Manager
Approval Group	The State Hospitals Board for Scotland
Effective Date	April 2023
Review Date	April 2024
Responsible Officer	Finance and eHealth Director

Contents

1 Overview

The use of digital technologies continues to expand across many areas of operation within the Hospital, with the resultant significant reliance on the eHealth Department. From the helpdesk officer through to the information and data lead, all areas have seen demands on the department continue to grow.

The teams continue to prioritise projects appropriately and function effectively – working together across disciplines on such as the latest EPR update. Our eHealth infrastructure team provide the technical support for staff while maintaining all our digital information and reporting.

The integration between our EPR (Rio) and Pharmacy's HEPMA system continues to provide real time information on patient medication status. It had been hoped that we would have access to our own HEPMA data for use in our data warehouse, but while several options to achieve this goal have been investigated, further work is needed with support from our host Board (NHS Lothian) before this can be delivered. The varying priorities for eHealth support continue to be managed successfully by the heads of each team.

Home working continues to be the norm for our Project and Information and Data teams, with the availability of hot desking as required and maintaining health and wellbeing for all teams.

With funding continuing to be challenging, it was recently approved to use the funding for fixed term posts to fund permanent roles in support of the resilience of the department. Work is ongoing to review the roles affected (with support from HR and staff-side as relevant). Additionally, as software manufacturers change to subscription licencing, software that – for example – previously had a 5 year life at a cost of £360 per user has now increased in cost to £1,175. It is difficult to find reductions on software, but we continue to work with several licence suppliers to ensure we get the best prices that procurement routes allow.

While there were expectations of a full rollout of Microsoft 365 with new SharePoint site access, again this continues to be a challenge to deliver due to national delays (NSS). We do have significant unseen potential benefits from our M365 subscription such as Microsoft Defender and Advanced Threat Protection, and M365 provides a secure digital workspace for collaboration. Again due to the national position, we have been unable yet to rollout Microsoft's Advanced Data Loss Prevention or Information Protection Sensitivity Labelling and Retention capabilities - guidance being yet to be produced by the M365 ODG, and a date yet to be set for a national rollout.

We have successfully entered the world of Artificial Intelligence (AI) with new systems recently deployed. While uptake to date has been slow as the new technology is learned and understood, we continue to grow the list of available digital solutions that can be utilised and encourage staff where possible.

- Dragon Medical One (DMO) is an AI powered real time dictation system that converts voice to text automatically. This is supported by M365 and helpfully can be used directly with Microsoft word, Outlook and our EPR Rio.
- Smartbox AI is an AI powered document redaction system. This system automates a process that is typically carried out manually by searching for key words within documents. This process is a time consuming and Smartbox AI will significantly reduce the time staff spend on redacting documentation once it has been fully utilised.

The Network Information & Security Directive (NIS) is at the fore front of everything we do. This year's interim NIS submission will be an update on outstanding NIS points from last year's submission, aiming to progress to a compliance over 80% - with the next full review due in 2026.

Cyber security, backup recovery, disaster recovery, and post-recovery system testing have been planned, with the timing of this year's NIS interim management meeting review yet to be scheduled.

2 Information and Business Intelligence Team

The Information and Business Intelligence team continues to improve how TSH data is recorded and analysed, working with a wide range of stakeholders to help embed data in everyday practice.

The team's principle focus has been the development of new bespoke Rio modules. Highlights include Improved Observational Practice, Clinical Service and Psychological Therapies referrals, Grounds Access authorisation, Soft Restraint Kit monitoring, and a full redesign of the CPA process and Variance Analysis Tool. The feedback from clinical staff regarding these areas has been very positive, and the next upgrade (to V24.09) is scheduled to take place in October 2024.

The TSH suite of Tableau dashboards also continues to grow, again to a positive response from staff. Recent developments include new, improved Workforce, Physical Health, Service Leadership, and Incidents dashboards.

Other significant pieces of work in the year have included supporting Excellence in Care, and the rollout of eRostering, plus the regular requirements for decommissioning and replacement of legacy systems.

3 Infrastructure Team

The infrastructure team provide the support for day-to-day problems and incidents along with support for several projects within the hospital. They continued to monitor, maintain, and update the digital infrastructure, equipment and the operating systems relied on. This is a continual part of the work this team undertake while supporting the essential systems used to assist in delivering patient care.

A new remote access solution is currently being tested and is expected to go live in the new year.

Management of the organisation's M365 accounts has created additional volume of calls for the IT Helpdesk – and, as staff numbers have increased, the effective management of the scope of our M365 licences is crucial to mitigate additional licence costs.

Significant projects delivered by this team have included –

- Windows Defender products (Sever and Unmanaged devices)
- Upgrade to Virtual environment software
- Upgrade of Backup system software
- Upgrade of storage software
- Replacement of the Core Network switches (ongoing in-year)
- Replacement of the Organisation's edge firewalls (ongoing in-year)
- Proof of concept of NetSupport for PLC
- Upgrade to RiO
- Assisting with national projects
- Replacement the wireless network (ongoing in-year)
- Testing of national phishing simulation exercises
- Phase 1 of the Ricoh Multi-Function Device replacement (Phase 2 now started)
- Assisting national cyber security incidents and alerts while remaining vigilant to local incidents and alerts.

The team continue to provide essential and regular day to day support – critical to the organisation both onsite and remotely.

4 Project Management

The Project Team delivered a successful Digital Inclusion workshop in October 2023, which resulted in the publication of a fully costed Patient Digital Inclusion Roadmap. However, as discussed at Board level, this project is now unfortunately on hold due to a lack of funding under the national financial pressures.

National programme work continues, with much of the work undertaken this year being behind the scenes for the Microsoft 365 programme including security baseline, unmanaged devices, Teams cleanup and preparatory work for SharePoint online.

Other projects supported by the team this year have included:

- Phase 1 of Ricoh Multi-Function Device Replacement delivered, phase 2 being scheduled for October.
- Replacement of Video Visiting system with NearMe completed.
- Pilot of Dragon Medical One to replace Winscribe Digital Dictation, due to be completed in November.
- Pilot of Net Support software for Patient Learning Network in progress.
- Metacompliance refresh completed.
- Upgrade of Rio EPR to 24.09 is underway and expected to be completed in October 2024.
- Wireless Network Replacement, first stage complete in Harris and plan in preparation for rollout across site.

The Project Management Team continue to support colleagues through the Project Approval Process, maintain the Project Register and manage the Rio Oversight and Development Group (ROAD).

5 Key eHealth Project achievements 2023-2024

These include:

- Upgrade of remote access systems
- ServiceNow helpdesk
- Disaster Recovery Test plans
- Microsoft 365 additional functionalities
- Wireless Network Installation
- Core Network switch replacement
- Dragon Medical One Dictation system
- Patient Learning Centre Netsupport system
- Deployment of Windows Defender for Server and Unmanaged Devices
- TSH suite of Tableau dashboards
- New functionality in Rio EPR – CPA processes moved to EPR, and overall Rio upgrades
- Testing of the national phishing simulation product
- Successful submission of NIS reporting requirements

6 Cyber Security

The second incantation of the NIS audit process takes place in October 2024. The State Hospital did well in this assessment compared to our first year but there were some areas of improvement that we still need to meet before the next full review in 2026. Plans to achieve this were agreed, are underway, and will be delivered over the next two years.

Cyber security continues to be recognised as a high risk and concern for all Boards, with significant focus for the eHealth department and the hospital overall. All Staff have a responsibility to work safely in the digital world, but testing on recent guidance on email phishing revealed some lack of awareness when a test email phishing campaign was carried out. This will be followed up with further testing and raising of awareness, and education for staff is recognised as being key to reducing our cyber risks and exposure – with an ongoing focus on how we best share this information across the hospital.

As staff are aware, we were unfortunately impacted by the cyber-attack on NHS D&G. While D&G have now shared some of the lessons learned and they have been assessed against the cyber security previsions in place at the State Hospital, some concerns were presented to CMT with recommendations on how these items can best be addressed to mitigate risk. It was agreed that a simulated cyber attack should be carried out to test the hospital's digital resilience plans – and this is being planned for early 2025

7 eHealth Collaborative Working

Collaborative working has continued to be prevalent, and is an ongoing development. The eHealth department represents the hospital at several national eHealth groups, and works where possible with other National or Territorial Boards. We continue to have sight of national programs and projects within NHS Scotland, and benefit from national solutions wherever practical and applicable.

The groups on which State Hospital eHealth staff are represented include –

- eHealth Leads Group,
- National Information Leads Group,
- National Infrastructure Group,
- National IT Security Group,
- National Board Digital Group,
- West of Scotland Infrastructure Group,
- West of Scotland IT Security Group,
- 365 Project Group.
- M365 Renegotiation Team

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2024
Agenda Reference:	Item No: 24
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 December 2024; The next Project Oversight Board is scheduled for 16th January 2025. At the meeting of 17 December 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, the timescale has moved (see 3b for detail) and costs are projected to overspend (see Finance – Project Cost at point 3c below).

b) Project Timescales

Project completion as per the most recent accepted programme has moved and is now scheduled for 26th December 2024; the most recent proposed programme has a projected completion of 26th February 2025 & this programme has been rejected.

The installation of technology is complete. Key remaining works are final elements of commissioning, a quantity of minor works, Site Acceptance Testing (SATs) of the installation and the production of documentation. Difficulties in addressing CCTV issues remain the primary cause of recent programme delays; further information is supplied below 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 £820k. This has increased by approximately £37k since the October 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 January. Should the programme completion move to the end of February 2025 costs will increase by approximately £30k.

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

Project Start Date:	April 2020
Planned Completion Date:	December 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 14/12/24:	£9,612,030
Total costs to date (exc. VAT & retention) at 14/12/24:	£9,527,817
Total costs to end of project (Exc. VAT & retention)	£ 84,214

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 14/12/24 is:

Securitas	£ 7.298m
Thomson Gray	£ 1.181m
Doig & Smith	£ 0.008m
HVM	£ 0.192m
Staff Costs	£ 0.957m
Income	-£ 0.108m
Total	**£ 9.530m**

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.

Paper No. 24/115

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 December 2024
Agenda Reference:	Item No: 25
Sponsoring Director:	Chief Executive
Author:	Head of Corporate Governance
Title of Report:	Annual Review 2023/024
Purpose of Report:	For Noting

1 SITUATION

The Minister for Social Care, Mental Wellbeing and Sport led the Annual Review of the State Hospital (TSH) for the year 2023/24, which took place at the hospital on the 18 November 2024.

2 BACKGROUND

Since that date, a positive letter has been received from the Minister summarising the activity on the day, as well as outlining the actions required (Appendix A).

3 ASSESSMENT

The Minister thanked all of the staff involved in organising the event, and whom she met on the day. She has emphasised the positive nature of the visit, which demonstrated the person-centred care provided by TSH. The Minister also thanked the patients, especially those whom she met at the Patient Partnership Group, and noted the real sense of empowerment felt with patients being able to help to shape their experience of their care.

The letter highlights that TSH achieved its savings target with a break-even position for 2023/24. Further, that TSH was able to meet environmental targets in a meaningful way. The challenge in staff absence rates is noted, with a request for further detail on the plans in place to help staff to return to work. At the same time, the Minister recognised the way in which TSH prioritises staff wellbeing initiatives, including the Wellbeing Centre.

The Minister requested that a further update on patients' physical health, notably obesity rates, is provided at the end of the current financial year. Additionally, that the Scottish Government is kept advised of the impact of Daytime Confinement on patient care, and within the context of the overall staffing position.

The letter also references the development of a high secure female service at TSH as a key priority as well as the move to a single forensic mental health system, as part of a whole system approach. The Minister looks forward to working closely with TSH in this respect, noting that TSH has the governance in place to help to meet these new challenges.

4 RECOMMENDATION

The Board is invited to note this update, and the positive nature of the Annual Review 2023/24. All of the requested actions will be progressed in conjunction with our Sponsor Lead at the Scottish Government.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP / Corporate Objectives	This report provides direct feedback to the Board on the result of the Annual Review 2023/24, and the positive nature of the assurance taken by Scottish Government
Workforce Implications	There are no specific impacts, and the need to continue to report closely to Scottish Government will be taken forward as part of existing arrangements
Financial Implications	There are no financial impacts of reporting – reporting confirmed assurance taken.
Route To Board Which groups were involved in contributing to the paper and recommendations.	This is part of the Board's structured workplan.
Risk Assessment (Outline any significant risks and associated mitigation)	There are no additional requirements that need to be flagged. The actions refer to workstreams that are already on CRR or are under review for addition to the register.
Assessment of Impact on Stakeholder Experience	There are no impacts – but reporting underlines the positive engagement in place with patients, especially through PPG.
Equality Impact Assessment	This is 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).	This is not relevant to reporting.
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.

Minister for Social Care, Mental Wellbeing and Sport
Maree Todd MSP
Ministear airson Cùram Sòisealta, Sunnd Inntinn is Spòrs
Maree Todd BPA

T: 0300 244 4000
E: MinisterforSCMWS@gov.scot

Scottish Government
Riaghaltas na h-Alba
gov.scot

Mr Brian Moore
Board Chair
The State Hospitals Board for Scotland

Via Email:
brian.moore3@nhs.scot

2 December 2024

Dear Brian,

THE STATE HOSPITALS BOARD FOR SCOTLAND ANNUAL REVIEW: 18 NOVEMBER 2024

Thank you for attending The State Hospitals Board for Scotland (TSH) Annual Review with your Chief Executive and other members of the Executive Team on 18 November 2024. I am writing to express my deepest thanks and to also summarise the key discussion points from the Annual Review meeting.

Firstly, I would like to express my gratitude towards every member of staff I met on the day. The visit was highly informative, and I was pleased to see and learn first-hand the person-centred care that is delivered at TSH. I can see staff are dedicated and maintain a high degree of professionalism despite the challenges they face. I would also like to extend my personal thanks to the patients I met, particularly those in the Patient Partnership Group. I was keen to hear their experiences, and I felt there was a real sense of empowerment in terms of patients being able to help shape their experience of the care they receive.

Annual Reviews remain an important part of the accountability process for NHS boards. I look forward to hearing more about the developments TSH intend to take forward as we navigate through the various changes being made to the forensic estate.

FINANCE

I am glad that progress is being made on TSH successfully meeting environmental targets, and that the service is looking to seek additional funding to ensure this is met. I was also

pleased to note that despite the difficulties the service faces, TSH have achieved the necessary savings target for the 2023/2024 financial year. I understand this has been no easy task considering the pressure on budgets and I want to thank all those involved in ensuring these targets were achieved.

I understand the concerns and anxiety of staff members on the changes relating to the development of a high secure service for women, and the move to a single forensic mental health system. I appreciate there are financial implications, but I have been clear that this is the necessary direction to help improve forensic services as a whole and to meet our care obligations for some of the most vulnerable citizens in our country. My officials will continue to work with you, and the TSH Board, to ensure that we can deliver the best care for patients.

WORKFORCE

I note that staffing continues to be an issue at TSH with challenges due to absences and recruitment. However, I did hear that the task and finish group remains dedicated to understanding and seeking solutions to address this. Given the limited time we had on the day, I would be very interested in receiving more detail on the plans in place to help staff return to work and any other detail you can provide on how TSH expect to mitigate staffing issues.

I was pleased to hear as well that TSH continues to place staff wellbeing as priority. I know the effects of the Covid-19 pandemic are still being felt and have also impacted on staff wellbeing. I saw firsthand the Wellbeing Centre and I understand there is a high level of awareness and satisfaction for this service, which can only be commended. I hope this service continues to operate and I look forward to hearing how staff wellbeing has improved in the future.

PERFORMANCE/RESILIENCE IN PRIORITY AREAS

It remains disconcerting that such a high percentage of patients at TSH are obese, and this does not appear to have changed over several years. I do recognise there are a number of factors that have contributed to this position, and I understand overall the physical health needs of patients have been met. I would like to highlight that the improvement of patient physical health should remain a key priority for the Board, and I would be grateful for an update on this at the end of the financial year.

I also note that daytime confinement remains in place, despite plans to stop this in January 2024. I do appreciate staffing levels impact upon this and there are plans to recruit more staff to help manage the effect this has on patients. I ask that an update is provided to officials on this matter and that TSH make substantial efforts to minimise the impact this has on patients care, treatment and wellbeing.

STRATEGY

The development of a high secure female service at TSH is a key priority for this government. I understand preliminary work is due to begin shortly on the interim service and I look forward

to being kept up to date as this work progresses. In addition, the move to a single forensic mental health system is the way forward for all forensic mental health services in Scotland.

A whole systems approach is key to addressing the many challenges that exist across the forensic estate. I completely understand making the much-needed changes will be challenging, but we can do better. I believe once a way forward is clear, many of the issues across the forensic estate will be managed better under this approach.

I also want to touch upon patient KPI's that were not discussed in the review and that I noticed TSH did not meet. Regarding care and treatment plans being reviewed at every 6 monthly interval and patients participating in 150 minutes of moderate exercise per week, I would be keen to understand what work TSH are doing to address these targets. I would be grateful if you could engage with my officials in the sponsorship team to provide this information.

LOOK FORWARD

Looking forward, I understand that there are challenges that TSH must face in the coming years as well as the potential landscape for uncertainty and change within the forensic estate around the work that is being addressed via the Forensic Governance Advisory Group and the development of high secure female care at TSH. I am content that TSH has the governance in place to face and overcome these challenges, however, I ask that you maintain a good level of dialogue with officials to ensure that focus and assurances are maintained.

CONCLUSION

I would like to reiterate my thanks to the Board, the Chief Executive, the Executive Team and the staff at TSH for their efforts and commitment over the last year. I look forward to being kept appraised of developments.

As I said during the meeting, my door is always open, and I would be willing to discuss any of the issues highlighted on the day further. Please contact my officials who would be able to arrange an opportunity for these discussions to take place.

Yours sincerely,

MAREE TODD MSP

Taigh Naomh Anndrais, Rathad Regent, Dùn Èideann EH1 3DG
St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot