THE STATE HOSPITALS BOARD FOR SCOTLAND
BOARD MEETING

THURSDAY 20 JUNE 2024
at 12.30pm
Hybrid Meeting: in Boardroom and on MS Teams

A G E N D A

12.30pm			
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 25 April 2024	For Approval	TSH(M)24/03
4.	**Matters Arising:** **Rolling Actions List: Updates**	For Noting	Paper No. 24/37
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
1pm	**RISK AND RESILIENCE**		
7.	**Corporate Risk Register** Report by the Director of Security, Resilience and Estates	For Decision	Paper No. 24/38
8.	**Annual Report 2023/24: Risk and Resilience** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 24/39
9.	**Cyber Security: Incident Report** Report by the Director of Finance & eHealth	For Noting	Paper No. 24/40
10.	**Finance Report – to May 2024** Report by the Director of Finance & eHealth	For Noting	Paper No. 24/41
11.	**Bed Capacity Report:** **The State Hospital and Forensic Network** Report by the Medical Director	For Noting	Paper No. 24/42
1.40pm	**CLINICAL GOVERNANCE**		
12.	**Annual Report 2023/24: Clinical Governance Committee** Led by the Committee Chair	For Decision	Paper No. 24/43
13.	**Section 22: Approved Medical Practitioner** Report by the Medical Director	For Decision	Paper No. 24/44

14.	**Quality Assurance and Quality Improvement** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 24/45
15.	**Clinical Governance Committee:** - **Approved Minutes 9 February 2024** - **Report of Meeting 23 May 2024**	For Noting	CGC(M)24/01 Paper No. 24/46
2.10pm	**BREAK**		
2.20 pm	**STAFF GOVERNANCE**		
16.	**Annual Report 2023/24: Staff Governance Committee** Led by the Committee Chair	For Decision	Paper No. 24/47
17.	**Annual Report 2023/24: Remuneration Committee** Led by the Committee Chair	For Decision	Paper No. 24/48
18.	**Workforce Plan – Annual Review** Report by the Director Of Workforce	For Noting	Paper No. 24/49
19.	**Staff Governance Report** Report by the Director of Workforce	For Noting	Paper No. 24/50
20.	**Annual Report 2023/24: Whistleblowing** Report by the Director of Workforce	For Noting	Paper No. 24/51
21.	**Staff Governance Committee:** - **Approved Minutes 16 February 2024** - **Report of Meeting 16 May 2024**	For Noting	SGC(M)24/01 Paper No. 24/52
3pm	**CORPORATE GOVERNANCE**		
22.	**Annual Report 2023/24 – Audit and Risk Committee** Led by the Committee Chair	For Decision	Paper No. 24/53
23.	**Report on the Annual Accounts 2023/24** Report by the Director of Finance and eHealth	For Decision	Paper No. 24/54
24.	**Patient Funds Accounts** Report by the Director of Finance and eHealth	For Decision	Paper No. 24/55
25.	**Annual Report 2023/24: Performance** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 24/57
26.	**Digital Inclusion Strategy** Report by the Director of Finance and eHealth	For Noting	Paper No. 24/58
27.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 24/59

28.	**Audit and Risk Committee:** Approved Minutes of meeting held 21 March 2024	For Noting	ARC(M) 24/02
29.	**Any Other Business**		Verbal
30.	**Date of next meeting:** 12.30pm on 22 August 2024		Verbal
32.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
33.	**Close of Session**		Verbal

Estimated end at 3.50pm

THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 24/03**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 25 April 2024.

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

Chair:	Brian Moore

Present:

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

In attendance:

Mental Health Manager, Social Work	David Hamilton
Head of Planning, Performance and Quality	Monica Merson
Head of Corporate Governance/Board Secretary	Margaret Smith [Minutes]
Director of Security, Resilience and Estates	David Walker
Director of Workforce	Stephen Wallace

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

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

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 February 2024 was noted to be an accurate record of the meeting subject to minor amendment

<u>The Board:</u>

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

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

There were no matters arising for discussion, from the previous meeting minute. The action list was noted as having no outstanding items.

The Board:

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

5 CHAIR'S REPORT

Mr Moore advised that the NHS Chairs Group had met three times, including two meetings with the new Cabinet Secretary for Health and Social Care, Mr Neil Gray. These meetings had focused on the non-pay element of the Agenda for Change (AfC) pay agreement for 2023/24, as well as the emerging reform agenda for NHS Scotland, which acknowledged the need for fundamental reform and the need for collaborative working to strengthen service delivery. The Chair noted the indication that forensic mental health services would be included within this approach.

Mr Moore highlighted that the Board had held two development sessions since it last met formally. The first session had allowed a detailed review of the draft budget for 2024/25, as well as enabling a longer term focus on the financial challenges in the ensuing years. On 7 March, the Board held a focused session on the recent self-assessment survey arising out of the Blueprint for Good Governance, and this helped to develop the Board Improvement Plan included as part of the meeting agenda at this meeting.

On 23 April, Mr Moore along with Professor Thomson had attended a national Realistic Medicine event, looking at large scale implementation of this approach. He had also been delighted to attend the State Hospital's (TSH) Sports Award Week along with Ms McCaffrey to help celebrate the work and achievements of patients.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins advised that NHS Board Chief Executives meetings had also included discussion in relation to fundamental reform, and the Cabinet Secretary had attended a meeting with Board Chief Executives on 13 March. The Chief Executives for the national boards had also met, reviewing collaboration models, and the need for further work to assess high impact models which would yield greater synergies and identify opportunities to do so.

In respect to the budget setting process for 2024/25, the Board had held a development session as described by the Chair. This provided an opportunity to detail the financial plan including the risks and assumptions made. and for the Board to record agreement with the financial plan. TSH had received correspondence from Scottish Government to indicate that the plan had been accepted. This would marry with the Annual Delivery Plan, and an update in this respect was part of the agenda for this meeting.

Mr Jenkins confirmed that it had now come to light that the cyber attack experienced by Dumfries & Galloway impacted their Occupational Health Services. Due to the Service Level Agreement (SLA) in place, this meant that there had been an impact on staff within TSH. An incident command structure had been stood up within TSH to manage this situation, as well as to link with the Gold Command at NHS Dumfries & Galloway. TSH had informed the Information Commissioners Office (UK) as well as the Competent Authority for Network Information Systems of this within the defined timeframes. He confirmed that the planned drop in staff workshops had taken place this week, and it was anticipated

that the incident command structure could be closed this week, moving to business as usual governance. He confirmed that a briefing paper would be presented to the Board at its next meeting in this regard. The Chief Executive also thanked service leaders for their work in this respect, especially within Information Governance and Human Resources.

Action – R McNaught

He advised that he had met with the Minister for Social Care, Mental Wellbeing and Sport along with civil service colleagues on 22 April to discuss the potential model for high secure female forensic services within Scotland. As this was in initial development stage, a further update would be provided privately to the Board.

Mr Jenkins noted that the Quarterly Sponsorship with the Mental Health Directorate took place on 23 April, and all items were favourably received and no concerns were raised in relation to the yearend performance of the organisation.

He also provided the Board with a proposed update to the leadership structure for the Security, Estates, Risk and Resilience Directorate. This was underway and working its way through due process in terms of workforce governance. He noted that the impacts of the AfC pay deal for TSH would be covered later in the agenda within the staff governance update. He also advised that there had been a review of the SLA for pharmacy services with NHS Lothian, and this had been agreed and signed off.

Mr Jenkins had been able to make visits to both Rowanbank Clinic and Hope House to see at first hand the services offered there, and offered his thanks to the teams there who had made this possible.

Finally, Mr Jenkins advised that the final version of the Mental Welfare Commission Report following the unannounced visit in February was now awaited, and would be published in due course.

Mr Moore thanked Mr Jenkins for this detailed update, and opened the discussion by noting in particular the support that TSH staff had received in respect of the cyber incident.

Mr Currie commented on the helpfulness of collaborative working where possible across NHS Boards, and also asked about the potential for structural change and if so, how this would impact on the delivery of patient care and bring improvement. He noted that Audit Scotland colleagues had attended a recent session with Scottish Ambulance Service. Mr Moore noted that the emphasis was on initiatives supporting collaboration rather than structural change, though this type of change may still impact on governance. He agreed that the reform agenda for NHS Scotland would be a useful topic for the next Board Development Session in the autumn, including the possibility of inviting Audit Scotland colleagues.

Action – M Smith

Mr Jenkins also referred to the work ongoing through the National Planning and Development Board for a Scotland wide approach for services under pressure. Professor Thomson also noted the need for a solution to the national approach for forensic mental health services, and highlighted the impact across forensic services presently until this was reached.

<u>The Board:</u>

1. Noted the update from the Chief Executive.

7 PATIENT STORY

Ms McCaffrey introduced a story from a current patient, relating to his experiences moving from the Admissions to the Transitions Service within TSH, and how taking part in a range of sports had been central to the progress that he had made. Ms Garrity joined the meeting, and explained that she would play a recording of a patient talking about his journey. The genesis of this had been through discussion

at the Patient Partnership Group (PPG) when Supporting Healthy Choices had been part of the meeting agenda, and this patient agreed to tell his own story. He had been admitted in February 2022, and then as part of his care had taken part in sports placements. Prior to admission to TSH sports, running had been part an important part of his life, including marathons. By 2023, he had achieved Sports Leadership at Level 5, and was undertaking a Sports Volunteer role meaning that he actively helped his peers, encouraging and supporting them to take part in physical activities. One great achievement had been walking football, which was hugely popular.

The patient recording included the patient talking about how he had moved from hub activities following admission to TSH, to being able to take part in placements at the Skye Centre. He thought that the opportunities he had to do so contributed to his own recovery journey, and being able to transfer to the Transitions Service. He particularly enjoyed his volunteer role, and helping others. He described the way that patients from the Intellectual Disability Service particularly enjoyed walking football, taking part with great enthusiasm. He also described taking part in a badminton tournament, and how much he had enjoyed delivering a speech to his peers as part of the Sports Leadership Programme.

He explained how running had always been something he valued and said that he felt that it did take a long time to get clearance for taking part in running in the hospital grounds. He expressed his frustration that even when this was granted, it was difficult to do so because of the poor state of the patient running track. This could mean that patients would lose their motivation, and make it harder for them to improve their physical health without access to a running track. Following this, Ms Garrity explained that the patient had taken part on the "Couch to 5K" challenge, and was encouraging others to do so. Ms McCaffrey added that it was really positive to see the change within the patient, especially the growing capacity to recognise needs in others, and the desire to help them.

Ms Radage offered her thanks to the patient for being willing to tell his story, as it was incredibly helpful for Board Members to hear directly from patients. Ms Fallon thought that this was a really heart-warming story, and placed it within the context of improvement of patients' physical health and the reduction of obesity levels. She asked about the situation with the patients' running track, and Ms Garrity confirmed that the request had been made to Estates for the necessary repairs. Mr Walker advised that this was on the agenda for the Capital Group, with an understanding of the benefit to patients. Professor Thomson added her support for this, and that it was part of the Supporting Healthy Choices agenda as well, and that access to running facilities was a really important aspect of this. Ms McCaffrey asked for the Board's thanks to be passed to the patient and to the PPG, and Mr Jenkins supported this advising that he would write to patient personally. The importance of the repairs to the track was underlined and a progress update requested in this regard.

Action – Mr Walker

Mr Moore referred to the great enthusiasm that had been evident at the recent Sports Awards, and that this story helped to emphasise what an important dimension physical health was to overall care and treatment for patients within TSH.

<u>The Board:</u>

1. Noted the presentation from the patient, and the importance of physical activity, and the Sports Leadership Programme
2. Requested a further update in relation to repairs to the patent running track.

8 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 24/21) from the Director of Security, Resilience and Estates, which provided an overview of the Corporate Risk Register including movement on risk gradings. Mr Walker confirmed that all risks had been reviewed, and highlighted the significant changes made. He summarised the three risks which were graded as high, and also noted the continuing work to develop the Corporate Risk Register.

Mr Jenkins referred to the Board Development Session that took place earlier this week, focused on the 2024/25 budget within a challenging financial landscape in relation to risk FD90, relating to failure to implement a sustainable long term model, there would be a clear need to continue to monitor this closely across the year. Mr Currie commented on the continuing uncertainty across forensic mental health services in terms of strategic leadership; and how this may impact the organisation especially in retention of staff, and attracting new recruits should there be any instability. He noted the difficulty of planning within an uncertain landscape. Mr Moore agreed with this particularly around staff awareness and the importance of communicating with staff across NHS Scotland about the financial pressures likely to be experienced in the longer term. For TSH, there was the added complexity of the need for clarification on the national position around forensic mental health services generally. Mr Jenkins underlined the importance of ensuring staff engagement, should there be any change nationally, as this would bring greater positivity and would build staff confidence. Professor Thomson commented on the attractiveness of TSH as an employer to attract clinical staff, given its unique role.

Ms Fallon spoke positively on the control measures detailed within the FD90 risk assessment, as being good practice. She asked for further clarification around increased controls at Director level especially around use of overtime. Mr Jenkins advised that the greatest area of risk was on the need for overtime within nursing to meet clinical need, and the requirement to set clear management controls.

Mr Moore noted the Board's agreement to the paper being an accurate statement of risk; especially the review of risk FD90, relating to financial risks.

The Board:

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

9 FINANCE REPORT TO 31 MARCH 2024

The Board received a paper (Paper No. 24/22) from the Finance and eHealth Director, to provide the detailed financial position as at 31 March 2024.

Mr McNaught summarised the content of the paper, advising that it presented the indicative draft financial position to month 12. There was a small variance at this date, with a year-end break-even position anticipated. He advised that work was still ongoing for some final review processes for year-end adjustments to be completed. The external audit was underway and would begin its full scope review in early May.

He confirmed that the most recent finance meeting with Scottish Government noted that they were happy with the current position and forecast for TSH for 2024/25. Individual directorate budgets were now in place, aimed towards meeting the 2024/25 increased savings target. Further, that the capital resource budget was fully utilised for the year-end, and the TSH Capital Group had begun prioritising the capital demands for 2024/25 against a much constrained year in terms of lack of availability of any additional funds. At the same time, the situation would be monitored, should any future opportunity arise.

Mr Currie noted that it was unsurprising that there was a lack of available capital funds, and referred to the slippage involved in funding capital projects as costs continued to increase. He remarked on the achievement for TSH in an anticipated break-even for 2023/24, and that financial management in the coming year would require clear tracking of change in the balance between recurring and non-recurring funding streams, and related savings. Mr McNaught agreed and confirmed that there was close monitoring of this position would continue, identifying any movement. Ms Fallon asked about the residual Covid-19 costs, now recognised through directorate budgets; and whether further changes could be considered that may bring savings. Mr Jenkins agreed, and confirmed that this would be under active review.

The Board:

1. Noted the content of the report.

10 BED CAPACITY REPORT

The Board received a paper (Paper No. 24/23) from the Medical Director, which detailed the position for bed capacity within TSH for the period ending 31 March 2024, in the context of the wider Forensic Network. Professor Thomson highlighted that this had been a busy period clinically, and also asked the Board to note the position in terms of patient movement across services within TSH. The Intellectual Disability (ID) Service remained an area of pressure with 14 patients, in excess of the patient allocation for ID of 12, but this was managed by dividing the patients across two wards. Further that the surge bed contingency plan had not been required for patients with Major Mental Illness (MMI).

Professor Thomson also advised that there were 11 patients on the transfer list to move from TSH, seven of whom been fully accepted as ready to do so clinically. Capacity across the network continued to be tight; and an update from the Orchard Clinic, providing medium secure services within NHS Lothian, that the refurbishment works required within the facility had not yet commenced. She provided assurance that clinical services within TSH were manageable, and that the revised clinical model demonstrated progression for patients across service with an increase in patients being discharged from the Transitions Service.

Mr McConnell referred to the patient transfer list, noting that the number waiting transfer had reduced, and asked for further background around that. Professor Thomson confirmed that there had been improvement in medium secure capacity in Rowanbank Clinic, in NHS Greater Glasgow and Clyde; but that there were pressures across the system particularly in the transfer of patients from medium to low secure, and then onwards to community services. Mr Moore commented on the impact on long term forecasting on capacity and planning service delivery even with 80% occupancy rate within TSH itself, and Mr Jenkins added that a more coordinated approach to planning patient flow across forensic mental health services could bring improvement. On this point, Professor Thomson noted that even with an occupancy rate of 80% within TSH, there was a continuous need for careful planning of patient flow due to clinical acuity, meaning that review of patient placement could be complex and difficult.

On behalf of the Board, Mr Moore noted the concern about capacity across the forensic estate, and in particular the reduction in capacity in the Orchard Clinic, with the required refurbishment works still to commence.

The Board:

1. Noted the content of report.

11 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 24/24) which provided update reporting on quality assurance and improvement activities. Ms Merson presented the paper to the Board, and highlighted that the Quality Strategy was currently under review and an update would be brought to the next Board Development Session on 2 May.

Ms Merson summarised the report, including two clinical audits that had been completed, one of which was a re-audit of medical trolley practice after changes had been introduced. The audit evidenced improvement in compliance in this respect. She also noted good compliance in Variance Analysis Tool (VAT) compliance; but that there had been decreases in MDT attendances across staff groups. The report also highlighted a decrease in Positive and Negative Syndrome Scale (PANSS) completion.

Ms Merson also noted key developments in Quality Improvement, especially the work to continue to build capacity locally within TSH. In respect to Realistic Medicine, she also commented on the Realistic Medicine conference that had taken place, and the innovative ideas and work progressing in this area.

This helped the team within TSH link in with the national framework and implement positive ideas within the hospital.

In respect of Evidence for Quality, Ms Merson asked the Board to note the progress being made in the Evaluation Matrix Summary with the new Clinical Care Policy scheduled to go live on 1 May, and the related work on the use of seclusion.

Mr Moore commented that it was positive to see some complex work being brought to finalisation. He also noted that the use of BRAN questioning was an interesting development as included within the Realistic Medicine Plan. This was noted as meaning considering benefits and risks of treatment or considering alternatives or doing nothing. Ms Fallon thought that this plan was helpful, and asked about how the outcomes coming out of that work would be tracked and how the impacts would be reported. It was agreed that it would be helpful for the Board to add Realistic Medicine to its agenda for the next Board Development Session.

Action – Ms Smith/Ms Merson

Ms Fallon also asked about the one ward that had not improved compliance in relation to the medication trolley audit; and Ms Merson advised that the issue highlighted had been resolved.

Mr Moore thanked Ms Merson and her team for consistently detailed and helpful reporting in this area.

The Board:

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

12 STAFF GOVERNANCE REPORT

The Board received a report from the Director of Workforce (Paper No. 24/25) which summarised the key aspects of workforce performance across a range of metrics. Mr Wallace provided a high level summary of the report, and asked the Board to note the changes made in format to ensure that the key points were reported, and that more detailed reporting would be submitted to the Staff Governance Committee on 16 May.

Mr Wallace noted the continued improvement in sickness absence levels; although levels of long term absence were still a considerable challenge, especially within nursing. However, there was focused activity to support staff and lead to improvement going forward. The Task and Finish Group continued to meet, and the Staff Governance Committee would receive a detailed update and proposal to bring this to a conclusion and move to business as usual management. He also highlighted the positive work around recruitment especially within nursing; and that there had been a requirement to utilise supplementary staff due to increased clinical acuity involving supporting patients to be outboarded from TSH for acute care.

He noted the very positive rate of PDPR compliance for PDPR at 91% which was a testament to all the hard work progressed in this regard. He also confirmed that the evaluation work of wellbeing activities had been concluded and an analysis of this was underway.

Ms Radage commended the positive direction of travel in relation to sickness absence; and commented on the investment made in wellbeing initiatives and the need to ensure that the organisation got the right return from this. Ms Fallon asked if it had been possible to obtain comparative data for sickness absence rates with other high secure hospitals. Ms McCaffrey advised that this had been sought but had to date not been made available. Mr Jenkins offered the view that it was likely that TSH rates of absence would compare positively with other secure institutions including prison staff. Mr Moore noted that it appeared that only one case had been escalated to stage 3 in terms of the attendance management, in the past year which appeared to be low. Mr Wallace agreed to review these points and include in reporting at the next Staff Governance Committee.

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

The Board:

1. Noted the content of the report

13 HEALTH AND CARE STAFFING (SCOTLAND) ACT/e-ROSTERING

The Board received a report (Paper No. 24/26) to provide an update on the implementation of the Health and Care Staffing (Scotland) Act 2019 (HCSA) and e-rostering within TSH. This report was sponsored by the Director of Workforce, and the Director of Nursing and Operations. Mr Moore noted that this would represent the final update for the Board on the implementation of HCSA, with annual reporting in the future.

Mr Wallace presented the paper, summarising the key points, and confirming that TSH was in a strong position in respect of all the requirements for implementation of the HCSA. In terms of e-rostering, the project teams was coming to a conclusion and work was underway to integrate this workstream into business as usual practice. Ms McCaffrey referred to the need for an abridged version of the workforce tool that could be used within TSH, and also to the observational study which could help to get the next iteration of the tool which would work better for TSH. She also provided assurance that Scottish Government had given positive feedback about the implementation within TSH and had suggested that TSH should be considered an exemplar organisation.

Mr Moore noted the positive position, and commented on how this should help to support staff as it bedded in. It was agreed that in terms of reporting, the next report due would be the first annual report in 2025, but that any issues of concern that arose throughout the year should be escalated to the Board.

Mr Moore summed up for the Board, offering thanks to Ms McCaffrey and Mr Wallace and their teams for the considerable work that had been progresses in this regard.

The Board:

1. Noted the content of this update.
2. Agreed to move to annual reporting for HCSA, with any areas of concern being escalated throughout the year.

14 WHISTLEBLOWING QUARTER 4 REPORT / ANNUAL REPORT

The Board received a paper to report any developments during Quarter 4 (Paper No. 24/27) as well as to provide a draft of the Annual Report for 2023/24. However, the Chair noted that the Whistleblowing Champion was not able to be present at today's meeting, and that Mr Wallace has just recently commended in his role. The Board noted that there had not been any new cases during Quarter 4, and that it would be beneficial to bring the Annual Report to the next meeting of the Board, as well as including in the Board Development Session on 2 May 2024 to consider any future actions in this area.

Ms Fallon also asked for further clarification around how the whistleblowing standards related to sub-contractor employees working within TSH, and it was agreed that an update would return in this respect.

The Board:

1. Noted the content of the report.
2. Agreed for a further update to return to the Board in respect to Annual report.

15 ANNUAL REVIEW OF STANDING DOCUMENTATION

(a) STANDING FINANCIAL INSTRUCTIONS (SFIs) AND SCHEME OF DELEGATION

The Board received a paper (Paper No. 24/28) from the Finance and eHealth Director, to review the Standing Financial Instructions and Scheme of Delegation. Mr McNaught advised that there were no significant changes implemented or required by the Governance statement, Scottish Public Finance Manual or NHS Finance manuals. Some small amendments had been made to reflect committee title revision and job title changes, and a minor change to SFIs to reflect more accurately procedures in place.

These amendments had been made, and then reviewed by the Audit and Risk Committee who had recommended that these be presented to the Board for final approval.

The Board:

1. Approved the Standing Financial Instructions and Scheme of Delegation

(b) STANDING ORDERS AND MEMBERS CODE OF CONDUCT

The Board received a paper (Paper No. 24/29) from the Head of Corporate Governance, to review the Board Standing Orders and Members Code of Conduct. Ms Smith presented a summary of this and confirmed that there were no changes to note. The Audit and Risk Committee had reviewed these documents, and recommended that they be presented to the Board for approval.

The Board:

1. Approved the Standing Orders and Members Code of Conduct.

16 BLUEPRINT FOR GOOD GOVERNANCE – BOARD IMPROVEMENT PLAN

The Board received a paper (Paper No. 24/30) from the Head of Corporate Governance, to outline the Board Improvement Plan, which had been developed as part of the NHSScotland Blueprint for Good Governance.

Ms Smith summed up the key points including that the Board had held a dedicated session on 7 March, to review the outcomes of its self-assessment questionnaire. This session had been led by colleagues in NHS Education for Scotland's Board Development Team, and had helped to identify areas of existing good practice, as well as any areas for improvement. The draft plan had been circulated to Board Members, and was now being presented to the Board for approval. The format of the plan aligned to the template recommended by Scottish Government, and it was due to be submitted to government on 26 April 2024. Ms Smith also noted the governance arrangements, to take this forward with an update returning to the Board in six months.

There was agreement around the table on the content of the plan and that it should be submitted to Scottish Government, and for the governance arrangements proposed. Mr Moore thanked Ms Smith for the work progressed in this regard.

The Board:

1. Approved the Board Improvement Plan,

17 ANNUAL DELIVERY PLAN (ADP) 2024/25

The Board received a paper (Paper No. 24/31) from the Head of Planning, Performance and Quality, as an update on the ADP for 2024/25.

Ms Merson confirmed that the draft ADP was submitted to Scottish Government on 7 March 2024, as required. She advised that although a formal letter had not yet been received from Scottish Government accepting the plan, feedback had been positive to date. She confirmed that once the approval had been received, the plan would be published on the website, and that there was a communications plan in place to engage staff and ensure awareness.

The Board:

1. Noted the content of this update.

18 COMMUNICATIONS UPDATE

The Board received a paper (Paper No. 24/32) from the Head of Communications in respect of the redevelopment of the intranet site, and the business case for rebranding, with a State Hospital variant of the NHSScotland logo. The report also provided an update on staffing resources within the Communications Team. Mr Jenkins presented the paper reflecting the key areas of work progressed, and the Board were content to note this update.

The Board:

2. Noted the content of the report.

19 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report from the Director of Security, Resilience and Estates (Paper No. 24/33) in relation to this project. Mr Walker confirmed that the project was in its final stages, and that at the last meeting of the Project Oversight Board on 18 April it had been agreed that a Post Project Review would be taken forward, based on the requirements of the August 2018 Gateway Review and the Full Business Case Service Benefits Evaluation Plan. The TSH Board were now asked to consider this as the way forward. In addition, Mr Walker also provided an update on the key technical aspects which now required to be resolved, as well as the timescale for overall completion.

The Board were content to note this update and to approve the Post Project Review.

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. Approved the Post Project Review as outlined.

20 AUDIT AND RISK COMMITTEE

The Board received the approved minute of the meeting, which had taken place on 25 January 2024; as well as a summary report (Paper No 24/34) of the key areas of reporting and discussion at the meeting that took place on 21 March 2024.

As Chair of the Committee, Mr McConnell highlighted that external auditors had presented the external audit plan, and that the Committee had reviewed standing documentation as had been presented at today's meeting.

The Board:

1. Noted the content of the approved minutes ARC(M) 24/01.
2. Noted the update from the meeting held on 21 March 2024.

23 ANY OTHER BUSINESS

The Board discussed the format of reporting, and the inclusion of the monitoring report in terms of whether it would be useful to review this, and bring back a suggested improvements. It was agreed that Ms Smith would take this forward.

Action – Ms Smith

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

24 DATE AND TIME OF NEXT MEETING

The next public meeting would take place at 12.30pm on Thursday 20 June 2024.

25 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.

26 CLOSE OF MEETING

The meeting ended at 12.05pm

ADOPTED BY THE BOARD _____

CHAIR _____

DATE _____

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	February 24	Bed Capacity Report	Include longitudinal reporting of this to the Board	L Thomson	April 2024	**April 2024:** Longitudinal data added to report – on agenda **CLOSED**
2	February 24	Quality assurance and quality improvement	Further focus on closing outstanding actions as reported in the evaluation matrix and provide update at next Board meeting	M Merson	June 2024	**April 2024:** Update in report on agenda There has been some progress with closing some of the outstanding actions within the evaluation matrix GAP analysis meeting is being arranged for mid May to discuss the SIGN Stroke guideline with a view to submitting to the Physical Health Steering Group in July/August 2024. **June 2024:** Due to the size and complexity of the SIGN Stroke Guidance as series of GAP, analysis meetings are required. These are in progress with a view to submitting to the Physical Health Steering Group in August 2024. The IOP and seclusion Gap analysis have been reviewed and are currently with clinical colleagues for consideration.

3	February 24	Performance Report Quarter 3	Revise reporting to reflect a longer period	M Merson	June 2024	**April 2024:** Data within this report is being redesigned and wherever possible trend analysis will be incorporated in next report. **June 2024: on agenda** Trend analysis where possible is included in reporting for the annual report
4	April 24	CEO Update	Update on Cyber Security Incident to be brought to next Board meeting	R McNaught	June 2024	**June 2024: on agenda**
5	April 24	CEO Update	Board discussion on NHS Reform Agenda	M Smith	October 24	**Added to Board Development Session for 3rd October 2024** **CLOSED**
6	April 24	Patient Story	Update on progress on maintenance and use of running track / wander paths within grounds	D Walker	June 24	**June 2024:** Annual ground maintenance is being taken forward as part of existing budget (including remedial works). Overall upgrade is funding is not available in current capital allocation, and would require funding application to Scottish Government should the opportunity to do so arise.
7	April 24	Quality assurance and quality improvement	Presentation on Realistic Medicine	Clinical Lead / M Merson	October 24	**Added to Board Development Session for 3rd October 2024** **CLOSED**

8	April 24	HCSA/ e-Rostering	Final report noted in respect of implementation, amend workplan to move to annual reporting save for any issues requiring escalation	M Smith	Immediate	**Workplan amended** **CLOSED**
9	April 24	Whistleblowing	Revise annual report engaging with PF and CMT, include advice on sub-contractors and prepare for change in how managed.	S Wallace	June 24	**June 2024 Update:** Report on agenda Reviewed as part of Board development Session on 2 May, to highlight development routes which are now underway.
10	April 24	A.O.B	Reporting template review around the monitoring report, and to include sustainability	M Smith	August 24	**June 2024:** Review underway to be shared /agreed through Exec Directors and then brought to the Board.

Last updated – 13.06.24 M Smith

Paper No: 24/38

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item No: 7
Sponsoring Director:	Director of Security, Estates and Resilience
Author(s):	Risk Manager
Title of Report:	Corporate Risk Register Update
Purpose of Report:	For Decision

1 SITUATION

A corporate risk is a potential or actual event that:

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

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

2 BACKGROUND

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

3 ASSESSMENT

3.1 Current Corporate Risk Register - See appendix 1.

3.2 Out of Date Risks

All risks are in date.

3.3 Update on Proposed Risks for inclusion on Corporate Risk Register

N/A

3.4 Corporate Risk Register Updates

No changes since April 2024.

3.5 High and Very High Risk – Monthly Update

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

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

Monthly Update:

- 87% patients were overweight in April '24 (with only 3% data missing).
- Weight recording guidelines are not being followed consistently and these are being reviewed and updated to support staff with this, in addition to the lead nurse supporting communication around this.
- SHC work continues with the completion of the 'Whole systems approach to managing obesity' guidelines being completed and the action plan being development.
- Loss of project manager at the end of May 2024. Delivery of the weight management group has not commenced due to staffing issues.
- Health psychology post is anticipated to be made substantive from later this year.
- Physical activity continues to be addressed via the AOG in conjunction with the PHSG.
- Patient pathway re use of GLP-1 agonists in place and now being utilised on a named patient basis.

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

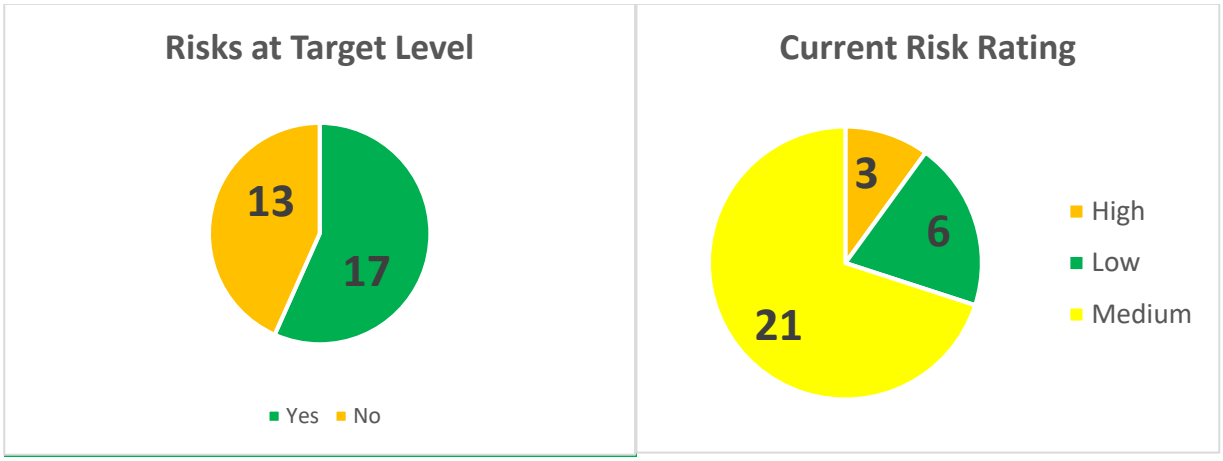
Monthly Update:

- Staffing Resource incidents continue to be monitored on Datix. Some fluctuation in incident numbers in the last month but figures have steadily decreased moving in to June 24. Full closures remain low ensuring staffing is being optimised to ensure excellent patient care where possible.
- ND70 currently being reviewed and will be shared with relevant groups when complete. The risk will be fully refreshed taking into account new data sources including activity levels and RAG Status to ensure an accurate picture of the hospitals situation is available at each review.
- Review of risk has started and is awaiting changes to the recording of staff resource issues to be implemented to ensure data can be monitored accurately and risk levels understood.
- Risk remains High until review complete and impact levels of risk are agreed.

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 focussing on expected funding shortfalls and significant budget restrictions for 2024/2025

3.6 Risk Distribution



Currently 17 Corporate Risks have achieved their target grading, with 13 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	MD30	
Possible			CE12, SD57, FD91, FD99. HRD113, ND71	FD90	
Unlikely			MD33, HRD110, FD96, FD98, CE11	MD34, SD51, SD50, SD54, HRD111	
Rare		CE14	FD97, CE13, ND73 SD52, HRD112	MD32, SD56,	CE10, SD53, CE15

Review Periods:

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

3.7 CRR Development

Progress has been slower than expected as the Risk and Resilience are working on five outstanding Category 1 and 2 Reviews, four of which have been recently commissioned. The team are looking to optimise their workloads to ensure progress is made on the below development.

The Risk management team are continuing to review and refresh the risk management process and a proposal on a new approach was presented and discussed with the Board Members at the Board Development session on 7 November 2023. Board Members were content with the approach being taken and Risk Management will now make a formal approach to CMT and the Board to ratify the way forward. This was presented to CMT in early January paving the way for a review to take place of the current Corporate Risk Register and ensure the risks are aligned to the Strategic Objectives. Work is ongoing within the Risk and Resilience Team to identify the first areas to be reviewed.

Current Progress:

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

4 RECOMMENDATION

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

Paper No: 24/38
MONITORING FORM

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

High Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	07/07/24	Clinical Governance Committee	Monthly	-
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Moderate x Possible	Moderate x Likely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	08/05/24	Clinical Governance Committee	Monthly	-
Corporate FD 90	Financial	Failure to implement a sustainable long term model	Major x Almost Certain	Major x Possible	Moderate x Rare	Finance & Performance Director	Finance & Performance Director	12/06/24	Finance and Performance Group	Monthly	-

Medium Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	12/09/24	Corporate Governance Group	Quarterly	-
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Moderate x Unlikely	Moderate x Rare	Chief Executive	Head of Risk and Resilience	12/09/24	Clinical Governance Committee	Quarterly	-
Corporate CE 12	Strategic	Failure to utilise appropriate systems to learn from prior events internally and externally	Major x Possible	Moderate x Possible	Moderate x Unlikely	Chief Executive	Head of Risk and Resilience	12/09/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate CE15	Reputation	Impact of Covid-19 Inquiry	Extreme x Likely	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	12/09/24	Covid Inquiry SLWG	Quarterly	-
Corporate MD 32	Medical	Absconsion of Patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Associate Medical Director	15/07/24	Clinical Governance Committee	Quarterly	-

Corporate MD 33	Medical	Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Medical Director	Associate Medical Director	15/07/24	Clinical Governance Committee	Quarterly	-
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Unlikely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	15/07/24	Clinical Governance Committee	Quarterly	-
Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Major x Rare	Major x Rare	Security Director	Security Director	12/09/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	12/09/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Unlikely	Moderate x Rare	Security Director	Security Director	12/09/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 53	Service/Business Disruption	Serious security breaches (eg escape, intruder, serious contraband)	Extreme x Unlikely	Extreme x Rare	Extreme x Rare	Security Director	Security Director	12/09/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 54	Service/Business Disruption	Implementing Sustainable Development in Response to the Global Climate Emergency	Major x Likely	Major x Unlikely	Moderate x Rare	Security Director	Head of Estates and Facilities	12/09/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	12/09/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate ND 71	Health & Safety	Serious Injury or Death as a Result of Violence and Aggression	Extreme x Almost Certain	Moderate x Possible	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	12/09/24	Clinical Governance Committee	Quarterly	-
Corporate FD 91	Service/Business Disruption	IT system failure	Moderate x Likely	Moderate x Possible	Moderate x Possible	Finance & Performance Director	Head of eHealth	12/09/24	Finance and Performance Group	Quarterly	-
Corporate FD 96	Service/Business Disruption	Cyber Security	Moderate x Likely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth	12/09/24	Information Governance Committee	Quarterly	-
Corporate FD 98	Reputation	Failure to comply with Data Protection Arrangements	Moderate x Likely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth/ Info Gov Officer	12/09/24	Information Governance Committee	Quarterly	-

Corporate FD 99	Reputation	Compliance with NIS Audit	Major x Likely	Moderate x Possible	Moderate x Rare	Finance and Performance Director	Head of eHealth	12/09/24	Information Governance Committee	Quarterly	-
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Unlikely	Minor x Rare	HR Director	HR Director	16/07/24	HR and Wellbeing Group	Quarterly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Moderate x Possible	Moderate x Unlikely	HR Director	HR Director	16/07/24	HR and Wellbeing Group	Quarterly	-
Corporate HRD 113	Service/Business Interruption	Job Evaluation and impact on services in TSH	Major x Possible	Moderate x Possible	Negligible x Unlikely	HR Director	HR Director	16/07/24	HR and Wellbeing Group	Quarterly	-

Low Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate CE 13	Strategic	Inadequate compliance with Chief Executive Letters and other statutory requirements	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Chief Executive	Board Secretary	12/08/24	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	07/12/24	Corporate Governance Group	6 Monthly	-
Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Rare	Moderate x Rare	Director of Nursing & AHP	Director of Nursing & AHP	15/07/24	Clinical Governance Committee	Quarterly	-
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	27/07/24	Security, Risk and Resilience Oversight Group	6 monthly	-
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	06/09/24	Information Governance Committee	6 Monthly	-
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Possible	Moderate x Rare	Moderate x Rare	HR Director	Training & Professional Developm	16/07/24	Clinical Governance Group	6 Monthly	-

							ent Manager				

Paper No: 24/39

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item No: 8
Sponsoring Director:	Director of Security, Estates and Resilience
Author(s):	Risk Manager / Head of Risk and Resilience
Title of Report:	Risk & Resilience Annual Report 2023/24
Purpose of Report:	To update The Board on Risk and Resilience activity

1 SITUATION

The Risk and Resilience Annual Report provides The Board with details of the activity undertaken within the Risk and Resilience department over period 1 April 2023 until 31 March 2024.

2 BACKGROUND.

The Risk and Resilience Department, part of the Security Directorate, is involved in a range of functions including:

- The development and maintenance of Local and Corporate Risk Registers
- Risk assessments for identified risks
- Development and review of Resilience Plans,
- Incident Reporting and Enhanced Reviews (Cat 1 & 2)
- Health & Safety
- Duty of Candour
- Administration of Datix System
- Training

The Audit Committee has overall responsibility for evaluating the system of internal control and corporate governance, including the risk management strategy and related policies and procedures.

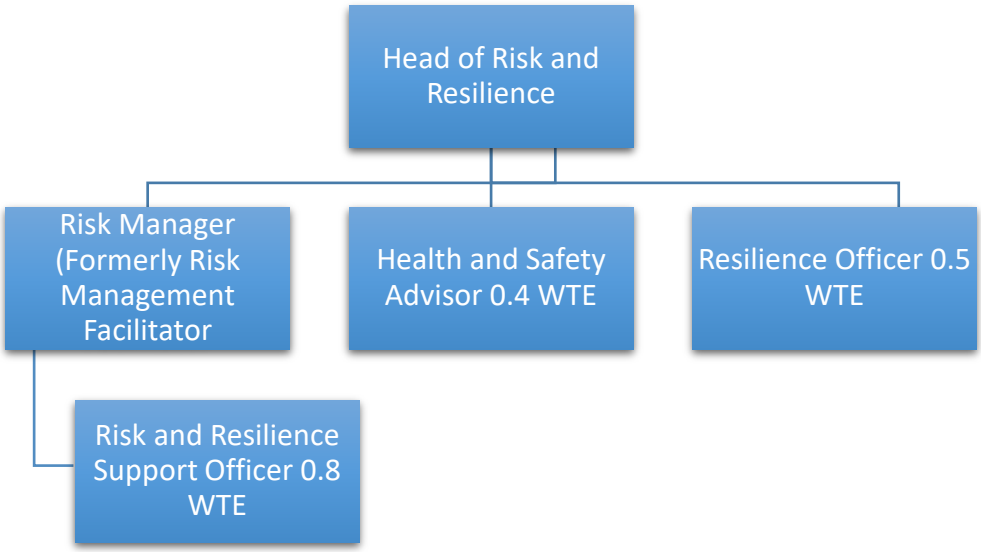
Report is provided to The Board each year prior to publication.

3 ASSESSMENT

In 2023/24 three new colleagues joined the Risk and Resilience Team and one member of the team changed roles. The Team is at full complement at time of report being published.

- A Health and Safety Advisor was recruited in January 2024. TSH now has its own Health and Safety Advisor 2 days per week, up from the previous 1 day per week.
- A new post was created to assist with resilience training and other resilience arrangements within TSH, this post is 2.5 days per week and was recruited to in January 2024.
- A Risk and Resilience Support Officer was recruited in December 2023 which was vacant for the majority of 2023.
- The role of the Risk Management Facilitator significantly changed in 2022/23 which resulted in the post being successfully evaluated to Risk Manager.

Current Model as of 2023/24



Areas of good practice within the risk management department include:

- Development of the Corporate Risk Register with risk owners has continued into 2023/24.
- Local Risk Register Development
- Department delivered training programmes across the hospital for resilience , H&S and Risk
- Continued adherence through Health and Safety Law, reporting of RIDDORs and management of Health and Safety
- Audit from RSM completed in March 23. Reasonable assurance achieved with minor actions.
- Datix Incident Reporting System internal development throughout 2023/24 including updating categories to capture better data for analysis.
- Continued development within the Risk and Resilience Team.
- Head of Risk and Resilience was able to build and maintain strong relationships with many external partners and provide training courses covering different aspects of resilience.
- Continued monitoring of incidents through reports and trend analysis, working alongside various groups to provide assurance
- Learning from adverse events within TSH continues through Cat 1 and 2 Reviews, Incident Reviews and Duty of Candour

Identified issues and potential solutions

- The Health and Safety Management System review mentioned in the 2022/23 Annual Report was delayed due to recruitment of H&S Advisor. The post holder in now in place and we will look to review this in 2024/25 alongside the Control Book Training arrangements which are currently paused.

- Work is underway to complete the agreed development work on the Corporate and Local Risk Registers as agreed with the board

Future areas of work and potential service developments

- National Procurement have agreed to purchase an Incident Management System known as InPhase that can replace our current system – Datix. In 2024/25 the team will work with InPhase and explore the system with a view to implementing the system at a suitable time in conjunction with the eHealth Team.

4 RECOMMENDATION

The Board is invited to note the Risk and Resilience Annual Report for the period 2023/24.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The Risk And Resilience Annual Report provides the board with an update of the activity of the department over the last year in line with governance arrangements.
Workforce Implications	There are no workforce implications related to the publication of this report. The report provides information on various workforce factors including Complaints, RIDDOR and Training.
Financial Implications	There are no financial implications related to the publication of this report. The report provides financial information on Claims.
Route To Board Which groups were involved in contributing to the paper and recommendations	Audit Committee
Risk Assessment (Outline any significant risks and associated mitigation)	There are no significant risks related to the publication of the report. Significant incidents over the financial year are highlighted.
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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Risk and Resilience Annual Report

2023-24

Prepared by: Risk Manager & Head of Risk and Resilience

Approved by: Director of Security, Estates and Resilience

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- 4.2 Identified Issues and Potential Solutions
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5. Next Review Date

1. Risk Management Department

1.1 Introduction

The Risk and Resilience Department, part of the Security Directorate, is involved in a range of functions including:

- The development and maintenance of Local and Corporate Risk Registers
- Risk assessments for identified risks
- Development and review of Resilience Plans,
- Incident Reporting and Enhanced Reviews (Cat 1 & 2)
- Health & Safety
- Duty of Candour
- Administration of Datix System
- Training

1.2 Aims and Objectives

- Development, implementation and review of Risk and Resilience policies and procedures;
- Proactive identification of risks potentially impacting on The State Hospital (TSH), with the subsequent management of these risks through recognised risk management tools and techniques.
- Implementation of Incident Review processes to ensure significant adverse events are adequately investigated with the development of Action Plans to enhance organisational learning.
- Supporting a "Quality" culture by developing staff competencies and improving risk management practices within TSH.
- Develop and maintain how we respond in times of crisis by maintaining a resilient hospital that can adapt and operate out with normal parameters.
- Develop and maintain relationships with our partner agencies, having a shared understanding and opportunity to learn.

2. Governance

2.1 Committees/Groups

The Audit Committee has overall responsibility for evaluating the system of internal control and corporate governance, including the risk management strategy and related policies and procedures.

The Risk Management process is embedded within TSH committees and group with members of the team present at the majority of the groups within the hospital. Regular reports on risk activity, incidents, adverse event actions and risk registers are presented to the relevant groups.

An example of some of the main groups Risk and Resilience report to are:

- **Health, Safety and Welfare Committee (HSW)**
- **Security and Resilience Group (SRG)**
- **Climate Change and Sustainability Group (CCSG)**
- **Security, Risk & Resilience, Health & Safety Oversight Group**
- **Audit Committee**
- **Organisational Management Team**
- **Corporate Management Team.**
- **Patient Safety Group**

In addition to the above Groups and Committees. Risk and Resilience also have a presence at other Hospital Groups including Infection Control, Information Governance, Corporate Governance and Clinical Governance among others.

3. Key Work Activities (2023-2024)

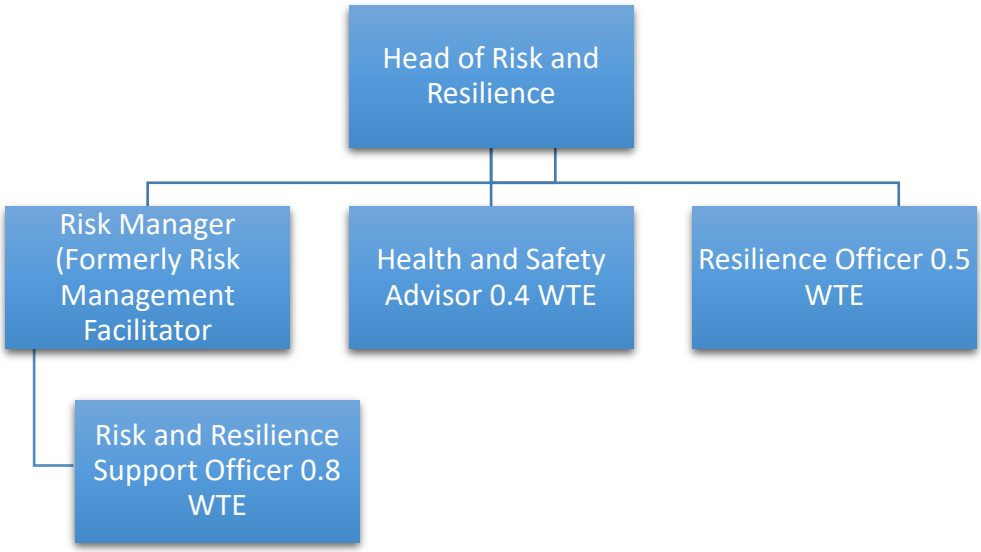
3.1 Risk and Resilience

3.1.1 Changes within Department

In 2023/24 three new colleagues joined the Risk and Resilience Team and one member of the team changed roles. The Team is at full complement at time of report being published.

- A Health and Safety Advisor was recruited in January 2024. TSH now has its own Health and Safety Advisor 2 days per week, up from the previous 1 day per week.
- A new post was created to assist with resilience training and other resilience arrangements within TSH, this post is 2.5 days per week and was recruited to in January 2024.
- A Risk and Resilience Support Officer was recruited in December 2023 which was vacant for the majority of 2023.
- The role of the Risk Management Facilitator significantly changed in 2022/23 which resulted in the post being successfully evaluated to Risk Manager.

Current Model as of 2023/24



3.1.2 Corporate Risk Register (Appendix A)

A corporate risk is a potential or actual event that:

- interferes with the achievement of a corporate objective/target; or
- would have an extreme impact if effective controls were not in place; or
- is operational in nature but cannot be mitigated to acceptable level of risk

Appendix A contains the current Corporate Risk Register containing 28 risks spread across the 6 Directorates. Risks are reviewed regularly throughout the year with updates shared with CMT and The Board. 4 of the risks were graded High with the rest following in the Medium and Low gradings.

A project is underway to update the Corporate Risk Register and ensure it aligns with the strategic aims of the hospital. This will be presented to the Board in 2023/24.

3.1.3 Department/Local Risk Registers

Department/Local Risk Registers contain risks that are particular to a specific department and are within the capability of the local manager to manage and are monitored and reviewed by the Head of Service. All departments are expected to develop a Local Risk Register, together with relevant risk assessments and action plans (if indicated).

The Head of Department will inform the relevant Executive Director of their departmental/local risks and indicate those risks to be reviewed (by exception) for inclusion to the Corporate Risk Register. This will include all current very high and high graded risks. The Head of Department is also responsible for developing, reviewing, and updating the local Risk Register.

The process for the Local Risk Register continued to be managed by the Risk Manager with each department within the hospital having an active register, which is reviewed frequently. The register continues to develop in response to changes within the hospital environment. This is managed by members of the Organisational Management Team.

CMT are updated on progress by the Director of Security, Estates and Resilience.

3.2 Resilience

The Head of Risk and Resilience has overall responsibility for the management of Resilience within TSH on behalf of the Director of Security, Estates and Resilience. The Director also chairs the Security, Risk and Resilience, Health and Safety oversight group and attends Security and Resilience Group chaired by the Head of Risk and Resilience / Head of Security. The Risk and Resilience Department also produces an annual report for the Boards' Audit Committee and regular Resilience Reports to the relevant groups.

3.2.1 Resilience Plans

Level 2 Plans

Level 2 Plans are primarily Loss of Service Plans and are handled by our internal operations. Normally return to normal operations is swift and is controlled within normal service functions and operations.

Currently, all level 2 plans are in date. Each plan has a review date of three years and within that time the plans will be tested to ensure they are fit for purpose. This will be co-ordinated by the Resilience Officer

Level 3 Plans

Our current level 3 plans remain fit for purpose and all agencies are content with current arrangements. Our level 3 plans are those of a multiagency joint working model. These plans involve input from our partner agencies, Police Scotland, Scottish Fire and Rescue, Scottish Ambulance Service, South Lanarkshire Council and the West of Scotland Regional Resilience Partnership. Work is ongoing to re-develop our Lv3 plans and a first draft have been shared with our partners for comment.

3.2.2 Resilience Related Incidents

In line with the approved Resilience Framework, all resilience related incidents are reported via Datix, with Level 2 and 3 incidents being reported directly to the Security, Risk and Resilience Group.

The Incident levels are defined within the Resilience Framework as follows:

> **Level 1**: Incidents which cause minor service disruption with one area/department affected which can be contained and managed within the local resources
>
> **Level 2**: Incidents which cause significant service disruption, interruption to hospital routine, special deployment of resources and affect multiple areas/departments.
>
> **Level 3**: A major/emergency situation which seriously disrupts the service and causes immediate threat to life or safety. These incidents will require the involvement of the Emergency Services

Over the year April 23 – March 24, there have been one Level 3 and zero Level 2 incidents out with the staffing issues recorded.

	2019/20	2020/21	2021/22	2022/23	2023/24
Level 2	2	0	19	8 (+ 3106 staffing resource)	0 (278, All staffing resource, only full closure)
Level 3	0	4	0	0	1

Level 2 incidents were only recorded relating to Full and Partial Closures of wards when there has been staffing resource issues. Although high, there is a significant reduction on the number of issues recorded in 2022/23. No other incidents that happened within TSH met the criteria for Level 2 and were all managed by their service.

One Level 3 Incident was recorded in 2023/24. Incident involved damage to a bedroom by a patient which resulted in the potential for weapons to be fashioned. This resulted in the Incident Command process being enacted and support required from Police Scotland. Incident is being investigated through the Category 2 Review Process.

3.2.3 Training and Exercising

Risk Management Training

Datix Training was provided to 19 staff in management roles. The training aims to teach staff how to use the Datix system, quality check all Datix entries, investigate Datix entries thoroughly and how to interrogate the system for data. Training for Datix runs continuously and is provided by the Risk Manager and in future the Risk Project Support Officer.

Resilience Training

Resilience training forms part of our overall strategy in developing and maintaining our resilience standards. Over the course of this year we have maintained our development by delivering a series of training events listed below

- Full Multi-Agency Live play training exercise with Full Incident Command in place. This event involved all partner agencies, Police, Fire, Ambulance and Local Authority. The event was a live play fire within a ward setting, with casualties missing. The hospital remained operational throughout and was managed by a full incident command operation. SFRS have 4 appliances in attendance with search teams deployed within the ward setting.

Police, ambulance and local authority along with SFRS formed part of the incident command structure and provided tactical advice to the silver command. Positive exercise with good learning and joint working, with positive de-brief following event.

- Level 3 PPE refresher and accreditation training completed.
- Critical Incident Communicator CPD events delivered for The State Hospital CIC's
- Delivery of Mental Health Awareness sessions to Police Scotland Negotiator Unit
- Silver Command Training and refresher events for on-call Directors
- Golden Hour training for our Operational Managers

3.2.4 Partner Agency Working

It is important to maintain and develop our relationships with our partner agencies, who at times we may rely upon to assist us during times of crisis. Our partner agencies include the following:

Police Scotland

Our relationship with Police Scotland remains strong. Over the past twelve months, the following milestones have been maintained and achieved:

- Police Scotland dedicated response team for the hospital. Close Liaison and working with Security Dept.
- Operational site visits to all new response inspectors and sergeants.
- Co-development of our level 3 and Multi Agency Incident Response Plan

Scottish Fire and Rescue

Over the last twelve months the following milestones were maintained and achieved:

- Operational familiarisation visits to the hospital with key departments.
- Development of Operational Intelligence for tactical interventions for an incident.
- Development of joint exercises
- Maintain and develop relationships and shared opportunities

Scottish Ambulance Service

Over the last twelve months the following milestones were maintained and achieved:

- Operational familiarisation visits to the hospital with key departments.
- Development of flow navigation to the hospital for patient care.
- Development of support resource for care options for patients.

South Lanarkshire Council

As part of the local LRP we work closely with South Lanarkshire Council. We have facilitated familiarisation visits for new to role staff to help them understand hospital activity and allow opportunity to develop shared learning of what we can both offer if required. This work will continue.

3.2.5 NHS Standards for Organisational Resilience

In May 2018, the Scottish Government updated its "NHS Scotland: Standards for Organisational Resilience document (2016), to reflect changes within the health and social care context, new policy imperatives and newly identified "Best Practice". This document specified minimum standards and related measure/performance indicator criteria for resilience within NHS Boards across Scotland.

TSH's Lead for Resilience (Director of Security, Risk Resilience and Estates) has responsibility for ensuring these Standards are achieved and are monitored by TSH Security, Risk and Resilience and Health and Safety Group.

Scottish Government(SG) are currently reviewing the resilience standards looking to develop and adapt new ones to work too. This remains an ongoing objective for SG. Risk and Resilience are working in line with these current standards where applicable.

Business Continuity Arrangements

In October 2023, EPRR published the following documents:

- Preparing for Emergencies: Guidance for Health Boards in Scotland.
- Business Continuity: Strategic Guidance for NHS Health Boards in Scotland.

This guidance is an updated version of the 2013 guidance and explains what should be done to enhance organisational resilience and capability. It is specifically aimed at Category 1 (core emergency response) and Category 2 (cooperating bodies) responders as defined by the Civil Contingencies Act 2004 (CCA). TSH are not classified as such however the guidance recommends compliance with the full CCA duties where applicable.

There are a total of eight sections contained within the guidance and the following sections have specific relevance to TSH and its plans for potential emergencies:

Section 2: Ensuring Preparedness
Section 4: Planning for Emergencies
Section 5: Essential Elements of Emergency Response
Section 6: Roles and Responsibilities
Section 7: Preparing for Specific Incidents

The preparation of plans in advance of any emergencies are overseen through the Security and Resilience Group.

Winter Preparedness

The Winter 2023/4 Checklist was submitted to Scottish Government on 21 September 2023. The return comprises of responses to statements of preparedness in four main areas as follows:

1. Overarching Principles/Resilience Preparedness
2. Planned Care
3. Primary Care
4. Workforce/Seasonal Outbreak

Whilst not all sections are relevant, those that are were given an appropriate response which sets out arrangements in place for TSH.

National Alerts

In April of this year the UK Government launched the new Emergency Alerts System. In order to manage this new system, The State Hospital has developed a mechanism to ensure that alerts are not missed. In the event of an alert being issued The State Hospital will review the alert and assess the impact to the operations of the hospital. The on-call Director, following consultation, will be responsible for invoking any operational resilience plans that are available to deal with the situation arsing.

3.3 Health & Safety

3.3.1 Control Book Audits

Health & Safety electronic Control Books (eCB's) provide the infrastructure to manage Health & Safety arrangements across TSH. The hospital currently operate around 30 eCB's which are audited within a 2-year cycle to ensure compliance with organisational and local policies/procedures.

7 Control Books were audited in 2023/24. 6 of the audits recorded green scores (> 80%) and will be re-audited again in 2 years. 1 book received an amber score and will be re-audited again in 1 year. All control books with the exception of 1 have received previous green scores and 1 remains amber from 2022/23. Control Book audits will continue in 2024/25 with the process currently being reviewed by the Health and Safety Advisor.

3.3.2 2023/24 Training Plan

A training plan was created for 2022/23 to target new and deferred control books. 29 staff were identified as a Control Book or Deputy Control Book Holder who required to attend their initial training. 4 training sessions were scheduled which 23 of the identified staff attended. The H&S Advisor left TSH in April 2023 when the SLA with NHS Lanarkshire ended and training was paused for the remainder of 2023/24.

Training service will be resumed in 2024/25 with the appointment of permanent Health and Safety Advisor.

3.3.3 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

RIDDOR requires employers to report incidents that 'arise out of or in connection with work resulting in: the death of any person; specified injury to any person or hospital treatment to non-employees; employee injuries resulting in over 7-day absence from work; dangerous occurrences and specified occupational diseases'. There has been an increase of 6 in reported RIDDOR incidents in comparison to 2022/23.

	Q1	Q2	Q3	Q4	2021/22	2022/23	2023/24
'Specified' Injuries*	0	0	1	1	**1**	**1**	**2**
Over 7 day lost time Injury	3	0	3	6	**4**	**7**	**12**
Total	3	0	4	7	**5**	**8**	**14**

All RIDDORs reported to HSE in line with the Health and Safety Act, individual incidents are monitored and reviewed by the Health and Safety Committee.

3.4 Fire

Three fire alarms occurred during the year to which all received a response from Scottish Fire & Rescue Service. No actual fires were present in TSH however 1 near miss was recorded.

3.5 Incident Reporting

Datix is the hospital's electronic incident reporting system, and is accessible to all staff via the intranet and a link from each computer desktop in the hospital.

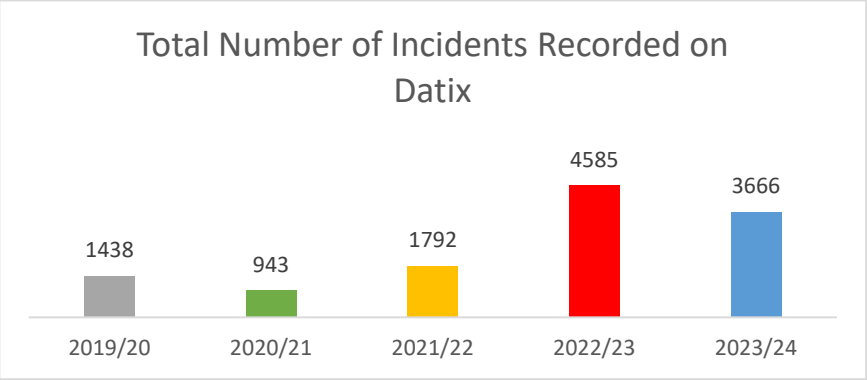
Each reported incident is investigated locally to ensure appropriate remedial and preventative steps have been taken. There are clear processes in place to identify incident trends or significant single incidents.

Datix classifies 7 overarching 'Type' of incident:

- Health and Safety
- Security
- Direct Patient Care
- Other
- Equipment, Facilities & Property
- Communication/Information Governance
- Infection Control

3.5.1 Datix Incidents

3666 incident reports were finally approved during 2023/24; a significant decrease in the number of incidents finally approved in 2022/23 (4585). The chart below shows the changes in the number of incidents reported within Datix over the last 5 years. The significant decrease is due to the reduction in the number Staff Resource Incidents reported on the Datix System, although many other categories did also show an increase:



3.5.2 Incident 'Type' Trends over last 5 years

Incident Type	2019/20	2020/21	2021/22	2022/23	2023/24
Staffing Resource	X**	X**	X**	3192	**2296**
Health & Safety	712	413	461	660	**554**
Security	138	93	139	277	**297**
Direct Patient Care	146	142	146	206	**232**
Equipment/Facilities/Property	106	78	75	105	**135**
Infection Control	82	55	60	77	**53**
Communication/Information Governance	32	48	65	51	**94**
Other	219	115	846	11	**5**
Totals	1435	943	1792	4585	**3666**
*Average Patient Population	106	114	115	110	102

* based on bed compliment at end of each quarter/4
** Staffing resource not recorded

Incidents are monitored by relevant groups who are responsible for taking forward any additional actions.

3.5.3 Risk Assessment

The process of Risk Assessment within TSH involves the consideration of two key factors, i.e. likelihood (e.g. rare, unlikely, possible, etc.) of a given event occurring and the impact (or consequence) that the event may have on the organisation (e.g. financial, reputational, operationally, regulatory, etc.).

The following table provides details of the number of “high” graded risk incidents reported since 2019/20, which have increased substantially. These High / Very High graded incidents were as a result of an increase in Communication/Information Governance Incidents specifically relating to confidential information being sent to the wrong recipent and Staffing Resource Issues where a ward had to implement daytime confinement for patients, modify operations or fully close.. Due to the incidents happening more frequently likelihood was increased and incidents were graded as High or Very High. Both issues are being monitored. To again highlight the significant increase is due to the improved compliance reporting of Staff Resource Incidents on the Datix System, although many other categories did also show an increase.

Year	No. of “High” or “Very High”Graded Risk Incidents
2019/20	1
2020/21	0
2021/22	628
2022/23	684
2023/24	2026

Likelihood	Potential Consequence				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	Very high	Very high
Likely	Medium	Medium	High	High	Very high
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

3.5.4 Duty of Candour

The organisational duty of candour procedure is a legal duty which sets out how organisations should tell those affected that an unintended or unexpected incident appears to have caused harm or death. They are required to apologise and to meaningfully involve them in a review of what happened.

Duty of Candour Incidents	2021/22	2022/23	2023/24
Considered	**103**	**115**	**54**
Confirmed	**1**	**0**	**2**

There was 2 Duty of Candour incident recorded in 2023/24

One incident that was identified is still under review as part of a Category 1 Investigation.

1 incident related to a self-harm incident. The incident was investigated as a Category 2 Report and learning shared within the organisation.

Further information is available in the Duty of Candour Annual Report 2023/24

3.6 Enhanced Adverse Event Reviews

All incidents/near misses assessed as being a Very High (red) risk, will result in a Category 1 Review. Other incidents may be subject to a Level 1 review at the request of CMT/Clinical Team.

Category 1 is the most rigorous type of incident review, using root cause analysis to ensure appropriate organisational learning.

Category 2 Reviews are utilised for less serious incidents, whereby, an in-depth investigation is required to identify any learning points and to minimise the risk of the incident recurring.

One Category 1 Reviews was commissioned during 2023/24

- Cat 1 23/01 Medication Error (Duty of Candour incident mentioned in the previous section, in progress but delayed)

Four Category 2 Review were commissioned during 2022/23:

- Cat 2 23/01 Self Harm
- Cat 2 23/02 Email Incident

- Cat 2 23/03 Incident Command (In progress)
- Cat 2 23/04 Patient Assault (In progress)

3.7 Training Compliance

Training Module	Number of Staff Completed	Percentage of Staff Completed	Increase/Decrease on 2022/23
Health and Safety Awareness	70	98.7%	+0.6%
Manual Handling	238	99.7%	+0.2%
Fire Safety	613	100%	+0.7%
Level 1 PMVA	154	100%	+0.8%
Level 2 PMVA*	385	100%	+26.2%
WRAP	104	79.1%	+7.9%

* Compliance levels for PMVA Level 2 Refresher training were impacted by high levels of staff absence during 2022/23, A compliance improvement plan was put in place in April 2023, with a target to achieve a minimum of 90% which has been successful.

3.8 Freedom of Information (FOI) Responses

During 2023/24 the Risk Management Team received four FOI requests totalling 23 questions. The team provided data for all of them where it was held by our department.

4. Summary

4.1 Areas of Good Practice

In addition to the positive outcomes highlighted throughout the report, there are a number of additional areas of good practice in relation to risk management across the hospital including:

- Effective monitoring of risk information by groups and committees
- Regular monitoring of patient-specific risks by clinical teams
- Strong evidence on learning from incidents, with local action being taken to minimise recurrences

Areas of good practice within the risk management department include:

- Development of the Corporate Risk Register with risk owners has continued into 2023/24.
- Local Risk Register Development
- Department delivered training programmes across the hospital for resilience , H&S and Risk
- Audit from RSM completed in March 23. Reasonable assurance achieved with minor actions.
- Datix Incident Reporting System internal development throughout 2023/24 including updating categories to capture better data for analysis.
- Continued development within the Risk and Resilience Team.
- Positive recruitment within the Risk and Resilience to strengthen team.
- Head of Risk and Resilience was able to build and maintain strong relationships with all external partners, and provide training courses covering different aspects of resilience.

4.2 Identified issues and potential solutions

The Health and Safety Management System review mentioned in the 2022/23 Annual Report, was delayed due to recruitment of H&S Advisor. The post holder in now in place and we will look to review this in 2024/25 alongside the Control Book Training arrangements which are currently paused.

Work is underway to complete the agreed development work on the Corporate and Local Risk Registers as agreed with the board.

4.3 Future areas of work and potential service developments

National Procurment have agreed to purchase an Incident Management System known as InPhase that can replace our current system – Datix. In 2024/25 the team will work with InPhase and explore the system with a view to implementing the system at a suitable time in conjunction with the eHealth Team.

5. Next Review Date

The next annual report will be submitted to the Audit Committee in June 2025.

High Risks

Appendix A

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	07/07/24	Clinical Governance Committee	Monthly	-
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Moderate x Possible	Moderate x Likely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	08/05/24	Clinical Governance Committee	Monthly	-
Corporate FD 90	Financial	Failure to implement a sustainable long term model	Major x Almost Certain	Major x Possible	Moderate x Rare	Finance & Performance Director	Finance & Performance Director	12/06/24	Finance and Performance Group	Monthly	-

Medium Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	12/09/24	Corporate Governance Group	Quarterly	-
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Moderate x Unlikely	Moderate x Rare	Chief Executive	Head of Risk and Resilience	12/09/24	Clinical Governance Committee	Quarterly	-
Corporate CE 12	Strategic	Failure to utilise appropriate systems to learn from prior events internally and externally	Major x Possible	Moderate x Possible	Moderate x Unlikely	Chief Executive	Head of Risk and Resilience	12/09/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate CE15	Reputation	Impact of Covid-19 Inquiry	Extreme x Likely	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	12/09/24	Covid Inquiry SLWG	Quarterly	-
Corporate MD 32	Medical	Absconsion of Patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Associate Medical Director	15/07/24	Clinical Governance Committee	Quarterly	-

Corporate MD 33	Medical	Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Medical Director	Associate Medical Director	15/07/24	Clinical Governance Committee	Quarterly	-
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Unlikely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	15/07/24	Clinical Governance Committee	Quarterly	-
Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Major x Rare	Major x Rare	Security Director	Security Director	12/09/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	12/09/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Unlikely	Moderate x Rare	Security Director	Security Director	12/09/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 53	Service/Business Disruption	Serious security breaches (eg escape, intruder, serious contraband)	Extreme x Unlikely	Extreme x Rare	Extreme x Rare	Security Director	Security Director	12/09/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 54	Service/Business Disruption	Implementing Sustainable Development in Response to the Global Climate Emergency	Major x Likely	Major x Unlikely	Moderate x Rare	Security Director	Head of Estates and Facilities	12/09/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	12/09/24	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate ND 71	Health & Safety	Serious Injury or Death as a Result of Violence and Aggression	Extreme x Almost Certain	Moderate x Possible	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	12/09/24	Clinical Governance Committee	Quarterly	-
Corporate FD 91	Service/Business Disruption	IT system failure	Moderate x Likely	Moderate x Possible	Moderate x Possible	Finance & Performance Director	Head of eHealth	12/09/24	Finance and Performance Group	Quarterly	-
Corporate FD 96	Service/Business Disruption	Cyber Security	Moderate x Likely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth	12/09/24	Information Governance Committee	Quarterly	-
Corporate FD 98	Reputation	Failure to comply with Data Protection Arrangements	Moderate x Likely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth/ Info Gov Officer	12/09/24	Information Governance Committee	Quarterly	-

Corporate FD 99	Reputation	Compliance with NIS Audit	Major x Likely	Moderate x Possible	Moderate x Rare	Finance and Performance Director	Head of eHealth	12/09/24	Information Governance Committee	Quarterly	-
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Unlikely	Minor x Rare	HR Director	HR Director	16/07/24	HR and Wellbeing Group	Quarterly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Moderate x Possible	Moderate x Unlikely	HR Director	HR Director	16/07/24	HR and Wellbeing Group	Quarterly	-
Corporate HRD 113	Service/Business Interruption	Job Evaluation and impact on services in TSH	Major x Possible	Moderate x Possible	Negligible x Unlikely	HR Director	HR Director	16/07/24	HR and Wellbeing Group	Quarterly	-

Low Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate CE 13	Strategic	Inadequate compliance with Chief Executive Letters and other statutory requirements	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Chief Executive	Board Secretary	12/08/24	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	07/12/24	Corporate Governance Group	6 Monthly	-
Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Rare	Moderate x Rare	Director of Nursing & AHP	Director of Nursing & AHP	15/07/24	Clinical Governance Committee	Quarterly	-
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	27/07/24	Security, Risk and Resilience Oversight Group	6 monthly	-
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	06/09/24	Information Governance Committee	6 Monthly	-
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Possible	Moderate x Rare	Moderate x Rare	HR Director	T&D Manager	16/07/24	Clinical Governance Group	6 Monthly	-

Paper No: 24/40

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item No: 9
Sponsoring Director:	Director of Finance & eHealth
Author(s):	Head of eHealth
Title of Report:	Cyber update
Purpose of Report:	To highlight Cyber Security and awareness activities.

1 SITUATION

Cyber-attacks on the NHS have now become a reality as the recent cyber-attacks on NHS Boards have shown. The need for vigilance and defence of our digital infrastructure only grows as does the need to defend against groups who want to infiltrate our networks and systems.

Our largest threat is still from state actors and financially driven cyber criminals who are behind these cyber incursions. Monitoring and maintaining our digital systems has never been more important and this work is carried out each day by the eHealth Infrastructure team.

2 BACKGROUND

The threat of a cyber-attack has never been as high. The recent attack on a Territorial Board has highlighted that our digital estates are vulnerable even with security systems in place. The eHealth Infrastructure team continue to deploy and maintains systems, but all hospital staff have a part to play in protecting the Boards against cyber-attacks.

We continue to have support for the NHS Scotland National Cyber Security Operations Centre (NHSS NCSOC), the National Cyber Resilience Unit Digital Directorate of the Scottish Government and the National Cyber Security Centre (NCSC). These agencies provide alerts and notices regarding emerging cyber threats that are actioned as needed.

3 ASSESSMENT

Since the last update our anti-virus system has reported no high severity incidents or events. There was again a significant number of Low and Medium incidents managed by the system (4959) with 202 of them managed automatically by the system. The other 4757 were false positives caused by Microsoft software updates that had been identified but being false positives have no concerns.

Our Microsoft 365 Defender Advance Threat Protection (ATP) reported 5 high severity events that were managed by the infrastructure team with another 17 alerts managed by the ATP system automatically.

We had 6 interactions with the NHSS CSOC – 5 alerts were false positives due to changes applied to the M365 tenancy and planned security testing with the other related to the deployment of the new wireless network in Harris – no issues are noted from these.

Dumfries & Galloway

As highlighted in the press recently, the provider of our Occupational Health Service – NHS Dumfries & Galloway – was subject to a Cyber breach in early 2024. Information relating to this attack is sparse as it is an ongoing criminal case.

Some records have been affected by this and all relevant staff notified. Support has been offered to them if requested and drop in sessions were put in place to allow staff the opportunity to discuss their concerns. The Information Commissioners Office was contacted and advice was taken from CLO. We continue to monitor this situation with D&G and provide any statutory reporting or compliance as required to meet our data responsibilities.

ICO have now confirmed that they are satisfied with the actions we have taken.

Other

A charity that has been used by NHSScotland was also compromised recently, as was another regular NHSScotland supplier. These attacks had minimal impact to TSH other than their emails being blocked nationally by NHSS CSOC.

An email security matter was noted in early June with regard to the security project contractor. While no issue arose for TSH and the matter was identified and addressed promptly, this continues to be under investigation.

These attacks on the NHS, its partners and suppliers highlight that the threat of a cyber-attack is real. The need for vigilance by all staff continues to be a critical requirement when using digital systems and particularly email.

4 RECOMMENDATION

The Board are asked to note this paper.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Report:	20 June 2024
Agenda Reference:	Item No: 10
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 31 May 2024
Purpose of Report:	For Noting

1 SITUATION

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

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

2 BACKGROUND

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

With regard to the capital spend programme, the Security Project is noted to have a probable end date of August / September 2024, as reported directly to the Board.

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £44.831m is primarily the forecast Scottish Government Revenue Resource Limit core and non-core allocations, and additional allocations as anticipated.

The May accounts show an over spend to date of £0.193m, which is mainly in connection with Ward Nursing pressures, and increased capital charges / depreciation on the capitalised elements, so far, of the perimeter project.

PAIAW ("Payment as if at work") funding continues to be held as a reserve for the current year, and will be released monthly to match actual cost. Some pressure also remains re prior years' PAIAW still outstanding – with claimants now being in the hand of CLO (and some of whom have been paid.) This has been accrued.

3.2 2024/25 Budget

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

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

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

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

Directorates	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 2	Budget WTE	Actual WTE
Nursing And Ahp's	24,152	4,170	4,295	(125)	406.67	432.95
Security And Facilities	7,389	1,238	1,216	22	123.63	118.28
Medical	3,345	656	659	(3)	23.95	20.61
Chief Exec	2,315	410	418	(8)	26.17	25.46
Human Resources Directorate	1,068	178	180	(2)	16.30	17.83
Finance	2,878	480	517	(37)	29.18	32.87
Cap Charges	2,868	478	519	(41)	0.00	
Misc Income	(100)	(17)	(18)	1	0.00	
Central Reserves	916	0	0	(0)	0.00	0.00
	44,831	**7,592**	**7,785**	**(193)**	**625.90**	**648.00**

Nursing & AHPs

Previous analysis of data has identified vacancies, sickness absence and outboarding due to increased clinical acuity as the major factors in increased overtime costs. The directorate continue to actively recruit to all nursing vacancies; following a recent recruitment fayre we have has a considerable response to our current band 5 advert.

Clinical acuity remains high and whilst our outboarding patient has recently returned, the OT costs attributed to this have carried on to this month. We are starting to see a positive impact regarding the recently recruited cohort of nursing staff.

We are currently trying to recruit to the small outboarding team as part of the previously reported test of change, there has been some expressions of interest however, there have been concerns raised regarding loss of earnings, the ADN is liaising with HR to see if this can be addressed.

The series of SCN performance reviews have begun using the dashboard developed by finance Dept. This will enable us to provide education, support and advise to SCNs enabling them to effectively use their allocated funding, through effective use of staffing resource and management of sickness absence, as well as non-pay related spending. These are scheduled on a monthly basis.

Security & Facilities & Utilities

Some accruals brought forward are contributing to funding the electricity and biomass pressures, and a central reserve has been created for the anticipated remaining balance (this will be closely monitored as electricity prices are expected to reduce).

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

It is noted that some directorate savings will not materialise until later in the year.

There are vacancies contributing to the underspend.

Medical

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

Chief Executive

A small variance is noted arising from unachieved savings; it is intended to wait until quarter 1 to agree savings, thereafter will be done monthly.

Human Resources

Erostering pressures, accrued at March 2024, will be released in May – with two project posts ending at the end of June.

Finance

Formal confirmation of eHealth strategic RRL funding is awaited, and will be released as agreed to fund posts.

Rates are noted to have increased significantly this year, once again, after a significant increase last year.

Capital Charges

The draft position is noted awaiting agreement of projections (from SG). – due to increase in asset values from perimeter project capitalisation.

Central reserves

These are phased to Month 12 (March 2025) and released as required, including the Apprenticeship Levy, PAIAW, Provisions, on-call, SLAs, Utilities, and consultants discretionary points.

3.4 Other financial pressures / potential benefits.

Revenue (RRL) Pressures:-

eRostering Project

The project team are expected to cease at end of June 2024, with accruals in place to fund this. The project itself will incur costs but at a significantly lower level than the previous year's set up costs.

M365

Estimated costs, await what charge materialises from NSS.

Energy and inflation increases

Unused prior year's accrual has been carried forward to provide against likely pressure in 2024/25, with a reserve in place as well.

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

AFC Reform (identified and unfunded awaiting SG provision – for which funding is expected)
This comprises three elements –

- 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.
    - The estimated impact of this to date, for April & May, is £76k, which together with future months will be recoverable from SG. We have been informed that this funding has been set aside nationally, and are providing SG with regular returns notifying them of our position.
- Adjustment of a number of posts – yet to be determined – from B5 to B6.
- AFC pay uplift in year.

Sup'ers increase
This is noted and identified – being currently unfunded awaiting confirmation of SG provision.

Benefits:-

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

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

4 ASSESSMENT – SAVINGS

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

Directorate	9051 Pay NR	9052 Pay R	9053 Non Pay NR	9054 Non Pay R	Total £'k
CE	18	4	35.5	16.5	74
Finance	30	10	7	54	101
HR	0	18	0	7	25
Medical	45	0	28	1	74
WN'g	717	90	10	11	828
Security	81	83	45	23.5	232.5
Total Savings Target	**891**	**205**	**125.5**	**113**	**1334.5**

It should be noted that of the Hospital's budget only 15% of costs are non-pay related, certain boards also treat vacancy savings, or a proportion thereof, as recurring savings, we still class as non-recurring.

Savings will be agreed and taken in Quarter 1 and monthly thereafter.

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation is £0.269m, with capital projects planned and agreed through the Capital Group. It is recognised that certain future projects likely to require requests on a project-

by-project basis to SG for additional funding will require to be placed “on hold” until it is known when such national resource may be available.

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

CAPITAL CRL 2024/2025 AS AT MAY 2024	ANNUAL PLAN	YTD SPEND
	£'k	£'k
PERIMETER SECURITY		
STANLEY SECURITY SOLUTIONS LTD		0
THOMSON GRAY LTD		43
TSH STAFFING APR - MAY '24		26
SENSTAR CORP		0
PERIMETER SECURITY TOTAL	436	68
CAPITAL		
IM&T		4
OTHER		-11
CAPITAL	269	-7
Total CRL	705	61

6 RECOMMENDATION

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

Revenue
The year to date position is an over spend of £0.193m.
Of that overspend, we anticipate £76k from SG funding to offset the AfC changes.
Forecast for the year remains for a breakeven position to be achieved, with savings target on track.

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

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item No: 11
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 April 2024 until 31 May 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	46	19	12 + 3 ID surge	100
Admissions	7 (external) 0 (internal)	0 (external) 4 (internal)	0 (external) 0 (internal)	1 (external) 4(internal)	8 (external) (internal)
Discharges/Transfers	1 (external) 3 (internal)	2 (external) 1 (internal)	2 (external) 0 (internal)	0 (external) 4 (internal)	5 (external) (internal)
Bed occupancy as at 31/05/2024	83.3%	95.8%	79.2%	125% (ID beds) 62.5% (all beds)	83.3% (available beds) 71.4% (all beds)

Please note that in total there were 100 patients as of 31st May 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).

There are 13 patients identified for transfer, 7 have been fully accepted, there are none waiting longer than 12 months and there have been 5 excess appeals won. Full details are available but not included for reasons of patient confidentiality.

There are no patients at TSH under the Exceptional Circumstances clause.

b) Bed Occupancy since start of new Clinical Model

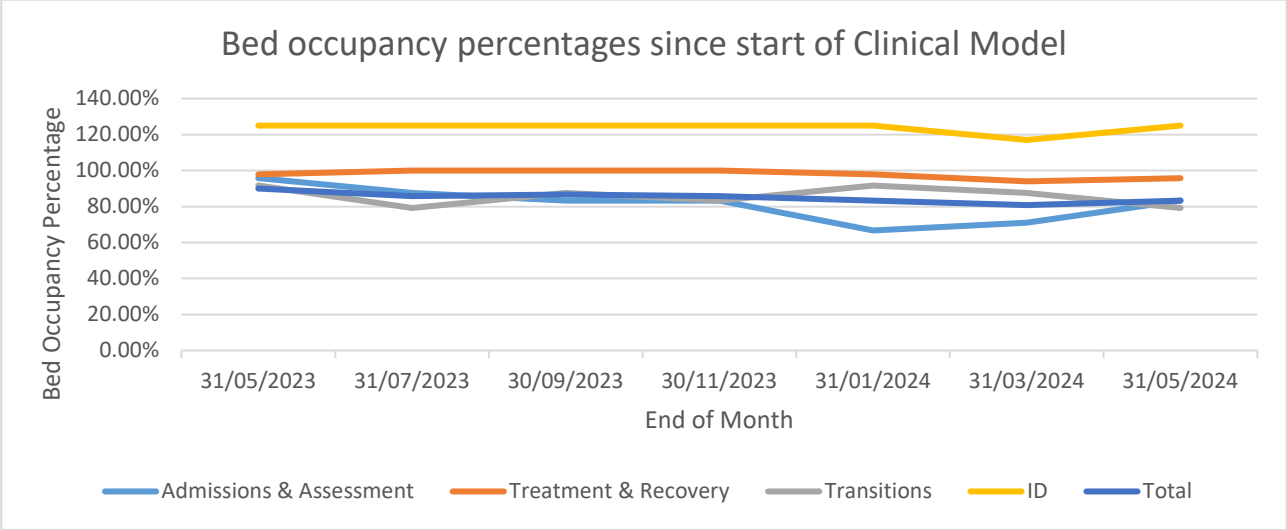


Table 2 Bed Occupancy by Service and in Total

Service	31/05/2023	31/07/2023	30/09/2023	30/11/2023	31/01/2024	31/03/2024	31/05/2024
Admissions & Assessment	95.80%	87.50%	83.30%	83.30%	66.70%	71%	83.3%
Treatment & Recovery	97.90%	100%	100%	100%	97.90%	94%	95.8%
Transitions	91.70%	79.20%	87.50%	83.30%	91.60%	87.50%	79.2%
ID	125%	125%	125%	125%	125%	117%	125%
Total	90%	85.8%	86.7%	85.8%	83.3%	80.8%	83.3%

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

c) TSH Contingency Plan

Following the new Clinical Model being implemented, SOPs for surge bed contingency planning has been agreed through the Clinical Model Oversight Group. There exists 2 agreed SOPs. One allows for use of surge beds within the Intellectual Disability Service solely at night/when patients have defined time in the rooms. The other for patients who would remain in the surge bed within the Intellectual Disability Service day and night. No patients are currently identified given current

bed availability and recent patient flow, it would be possible though to identify patients with clinical teams rapidly should this be required.

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. 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 by 7 beds for urgent repairs. The Forensic Network at the request of Scottish Government has submitted updated capacity reports of the whole forensic estate and for women.

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3 ASSESSMENT

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

The Orchard Clinic's temporary closure of 7 beds for urgent work is causing further pressure across the forensic estate. This work has not yet commenced.

4 RECOMMENDATION

The Board is asked to note the report.

MONITORING FORM

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

Paper No: 24/43

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item No: 12
Sponsoring Director:	Medical Director
Author(s):	Head of Clinical Quality
Title of Report:	Clinical Governance Annual Stock Take
Purpose of Report:	For Decision

1 Situation

The attached Clinical Governance Committee Annual report outlines the wide range of activity overseen by the Committee during 2023/24. The stock take also includes the Committee's Terms of Reference, Reporting Structures and Work Programme.

2 Background

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

- A review of reporting structures within the hospital.
- A review of the committee's work programme for forthcoming years.
- A review of the committee's terms of reference.
- An annual report summarising the work of the groups and departments that report to the Clinical Governance Committee.

3 Assessment

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

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

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

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

4 Recommendation

The Board is asked to note the annual report.

Paper No: 24/43
MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The annual report supports the Quality Strategy within the hospital
Workforce Implications	The various reports throughout the year would include any issues
Financial Implications	The various reports throughout the year would include any issues
Route To Committee/Group Which groups were involved in contributing to the paper and recommendations	Clinical Governance Group for noting
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

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE ANNUAL REPORT

1 April 2023 – 31 March 2024

1. Introduction

The State Hospital, like all NHS organisations, has a statutory responsibility to establish clinical governance arrangements to ensure continuous improvement in the quality of care and treatment provided to patients. The national requirements for clinical quality have been the subject of substantial guidance, from the *Clinical Governance and Risk Management Standards* published by NHS Quality Improvement Scotland (NHS QIS) in 2005, to *Better Health, Better Care*, published by NHS Scotland in 2007, the Scottish Government's publication of the *Healthcare Improvement Strategy for NHS Scotland* in 2010 and subsequently through the NHS Healthcare Improvement Scotland *Making Care Better – Better Quality Health and Social Care for Everyone in Scotland 2017-2022. Further, the Mental Health Strategy 2017-2027 outlines the Scottish Governments vision to meet the challenges in delivering mental health care.*

The 5 main strategic priorities are:

1) Enable people to make informed decisions about their own care and treatment.
2) Help health and social care organisations to redesign and continuously improve services.
3) Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services to improve.
4) Provide and embed quality assurance that gives people confidence in the quality and sustainability of services and supports providers to improve.
5) Make best use of all resources.

The underlying principle of effective clinical governance is that systems and processes provide the framework for patients to receive the best possible care. This report provides an overview of the work of the Clinical Governance Committee during 2023/24 and examples of good practice and matters of concern.

2. Committee Chair, Committee Members and Attendees

Committee Chair
Cathy Fallon, Non-Executive Director

Committee Members
Stuart Currie
David McConnell
Shalinay Raghavan

Attendees
Brian Moore, Chair of The State Hospitals Board for Scotland
Gary Jenkins, Chief Executive
Prof. Lindsay Thomson, Medical Director
Elizabeth Flynn, Head of Psychological Services
Monica Merson, Head of Corporate Planning and Business Support
Karen McCaffrey, Director of Nursing and Operations
Robin McNaught, Director of Finance & eHealth
Dr Khuram Khan, Chair, Medical Advisory Committee
Sheila Smith, Head of Clinical Quality
Margaret Smith, Head of Corporate Governance/Board Secretary

The Committee can decide to invite the Board Chair to sit as a member of the Committee for a meeting, should this be required for quorate decision-making. The Terms of Reference are reviewed annually and are attached.

3. Meetings 1 April 2023 – 31 March 2024

During 2023/24 the Clinical Governance Committee met on four occasions, in line with its terms of reference. Meetings were held on:

- 11 May 2023
- 10 August 2023
- 9 November 2023
- 8 February 2024

	Number of Meetings Present
Cathy Fallon	4
Stuart Currie	4
David McConnell	4
Shalinay Raghavan	2

4. Summary of Reporting

4.1 12 Monthly Internal Governance Reports

Infection Control
The infection Control Committee report was received and noted at the May meeting, covering the period 1 April 2022 - 31 March 2023. The primary focus during the review period had been to reduce the risk of Covid19 within the hospital through various stages of the pandemic and manage Covid19 outbreaks effectively to ensure there was a minimal spread of infection across the site. In addition, HIS Infection Prevention and Control Standards were published in May 2022 and the Infection Control Team had been reviewing current practice with the standards. The Infection Control Team and the Housekeeping and Linen service manager were reviewing the risk assessments, cleaning schedules and recording documentation for the entire site. A quality improvement project had commenced in a non-clinical area (i.e. the Management Centre) with successful outcomes. This was then being trialled in two clinical areas within the Skye Centre. It was anticipated that the project would be completed within the calendar year.

Research Committee/Research Governance and Funding
In May 2023 the Committee received and noted the 2022/23 Research Committee Annual Report. The reporting period covered was 1 April 2022 - 31 March 2023. The main areas of focus within report were the range of research activity and its dissemination undertaken by TSH staff over the period of 2022/23, and the mechanisms and roles in place to support research across the organisation. The report provided details of the annual Forensic Network Research conference, and the wide ranging contribution from State Hospital staff. In addition the report included detailed examples of studies that seek to identify the patient perspective and stakeholder experience of our patient population, and a practical example of the way in which research findings are used to positively influence practice. One specific example of research findings being used to support improvements in practice comes from the study: **"Forensic mental health nurses experience on the use of seclusion; implications for use and elimination in clinical practice.".** The study had recently been completed and the final report provided details of both short and long term implications for practice from the study findings, and a range of solutions to support these changes being made in practice.

Medicines Committee
The Medicines Committee annual report was submitted to the Clinical Governance Committee in May 2023, covering the period 1 April 2022 - 31 March 2023. The Committee received and noted the report and commended the service for being able to work within budget. The key

activities over the 12 months included: the successful implementation on the hospital electronic prescribing and administration system (HEPMA); maintaining and reviewing medicine supply processes; delivering Covid-19, influenza vaccine programmes for staff and patients as per national guidance; proactive work around reducing medicines incidents; ensuring all patients have regular review of all mental and physical health medicines; medicines policy and prescribing guidance updates and a significant range of clinical audit projects.

Patient Learning Annual Report

At the May 2023 meeting, the Patient Learning annual report was presented, covering the period 1 January 2022 - 31 December 2022. The Committee noted the progress that had been made and acknowledged the planned future developments that are detailed within the report. The report noted that learning opportunities for patients had continued to be impacted by Covid and wider resourcing issues. However, positive progress has been made in a number of areas of patient learning within the State Hospital: the curriculum framework continued to provide access to a broad range of nationally recognised qualifications and accredited national units; learning opportunities, although limited during year, ranged from entry level through to further and higher education and included clear progression pathways; a total of 60 patients engaged in formal learning programmes and 53 formal qualifications were attained within 2022. A number of developments were noted for 2023 including the delivery and evaluation of the newly developed 'I Can Lead' Sports Leadership qualification and the completion and evaluation of the Volunteering Skills SQA Award pilot programme (within both the patient library and charity shop)

Duty of Candour

The fifth annual report for Duty of Candour was received and noted at the August 2023 meeting. The report covered information on the policy, training that had been implemented across the site as well as the governance and monitoring arrangements. For the period 1 April 2022 - 31 March 2023 the Risk Management Department forwarded 115 incidents for consideration by the Duty of Candour Group, up from 103 in the previous year. One of the incidents fulfilled the criteria for Duty of Candour, i.e. an unintended or unexpected act or incident that resulted in death or harm, as defined within the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 and did not relate directly to the natural course of a person's illness or underlying condition. At the time of the report being presented at Clinical Governance Committee, the incident was still under investigation. Once the report is published it will be shared with the relevant persons and any required changes implemented.

Patient Safety

In August 2023 the Committee received and noted the Patient Safety Report covering the period 1 July 2022 - 30 June 2023. The four principles remained: Communication; Leadership and Culture; Least Restrictive Practice and Physical Health. The main focus of the national programme included: creating the conditions for improvement within teams; the implementation of the 'From Observation to Intervention' national guidance; reducing the incidence of restraint, whilst improving this experience for staff and patients and reducing episodes of seclusion, whilst improving this experience for staff and patients. All these workstreams had been considered within the report with key priorities for 2023/24 being discussed and agreed at the meeting.

Mental Health Practice Steering Group

At the August 2023 meeting, members received and noted the report from the Mental Health Practice Steering Group. The report covered the period 1 January 2022 – 30 April 2023. Key areas noted within the report included: the standards and guidelines that had been reviewed by the Group; monitoring data for the psychological service; the trial of the Clinical Global Impression scale with the FORUM as outcome measures; the monitoring of grounds access in our patient population; the pre-admission specific needs QI project; review of the CPA process and a trial of carers clinics within Mull and Iona. The Committee also approved the activities and areas of work the Mental Health Practice Steering Group intend to focus on over the next 12 months.

Transfer CPA/MAPPA
At the November 2023 meeting the Committee noted the report covering the period 1 October 2022 - 30 September 2023 and supported the future areas of work. For the fifth consecutive year, 100% of transfers were managed through the CPA process during the reporting period. The report identified a number of key areas in relation to Multi-Disciplinary CPA attendance, Patient and Carer Involvement and Strategic Engagement and Representation. During the review period no patients had been identified as potentially meeting the MAPPA 'risk of serious harm' category, however all patients remain under consideration in this regard and consultation takes place with the relevant MAPPA Co-ordinators as appropriate. Areas of good practice included patient involvement in the process with 92% attending meetings (this was an increase from 77% the previous year) and Advocacy attending 84% (an increase from 81% the previous year). Inter-agency working was also highlighted with receiving services being well represented in transfer/discharge CPAs.

Rehabilitation Therapies Service
In August 2023 the Committee noted the report covering the period 1 October 2022 - 30 June 2023 and endorsed the future areas of work and service developments contained within it. The report provided a summary of the key areas of work that included: updates on the various staff groups that are included in the AHP service; leadership development within the service; staff and team development; the Nu 2 U Charity Project that has allowed a patient run shop to be opened with clothes that patients can purchase for a nominal cost; completion of training staff in Occupational Formulation to allow this to be embedded in clinical practices and a project looking at the potential, scope and limitations of digital inclusion as it relates to the care of our patients and explore what a more digitally inclusive environment would look like.

Child and Adult Protection
The Committee received and noted the report in November 2023 that covered the period 1 October 2022 - 30 September 2023. The report highlighted key areas of work that included key achievements in the areas of keeping children safe and adult support and protection. Other key areas included: ensuring training materials are kept updated and developed to ensure up to date information and practice guidance; liaising with colleagues across the high secure services as they seek to develop their child contact procedures; the State Hospital's successful inclusion in the rollout of the Adult Support and Protection Decision Making Tool and increasing the number of child contact visits. There were 48 child visits to the hospital during the reporting period which represents a significant increase in numbers when compared to the previous year (10). This was a positive development and visitors had commented upon the welcome they receive, the friendliness of supervising staff and the positive atmosphere within the Family Centre. 2024 will see the development and publication of The State Hospital Corporate Parenting Strategy 2024-26.

Physical Health Steering Group
In November 2023 the Committee received and noted the 12 month rolling report from the Physical Health Steering Group covering the period 1 October 2022 - 30 September 2023. The report noted the developments and progress made in the five key strands for which the Physical Health Steering Group had responsibility. These related to Primary Care (including long term conditions); Physical Activity; Nutrition and Weight Management; Food, Fluid and Nutrition and National Guidelines and Standards. Quality improvement activity included the further development of patients undertaking the Level 4 Sports Leadership course allowing them to become Sport Volunteers; the change of the Physical Activity KPI moving from 60% having 150 minutes per week to 70% and the GP continuing to provide venesection on 2 patients which had significantly reduced external clinical outings. 2024 will see the GP also provide minor surgery on the patient group within the hospital, which again will reduce the need for external clinical outings.

Person Centred Improvement Service
The Committee warmly received and noted the Person Centre Improvement Report at its February meeting. The report covered the period 1 November 2022 - 31 October 2023. Key areas of work included: facilitation of the 'What Matters to You' initiative; reviewing the visitor travel support arrangements and developing new Volunteer Driver Scheme; supporting the development and implementation of 'Nu 2 U' Patient Charity Shop; the successful bid for capital funds for renovation of Family Centre garden; continuing to support the Patient Partnership Group (PPG) Chair to ensure that the patient experience influences the Clinical Model implementation plans; developing and implementing the new 'Supporting Patient and Carer Involvement' Policy and the successful completion of 'Talking Mats' Training, which is now in use with the Intellectual Disability PPG.

Clinical Governance Group
At the February 2024 meeting the Committee received and noted the 12 monthly report from the Clinical Governance Group covering the period 1 January 2023 - 31 December 2023. The report provided a summary of the work of the Clinical Governance Group over the past 12 months. As well as overseeing the reports that go to the Clinical Governance Committee other key pieces of work included: monitoring the realistic medicine action plan; receiving updates on the Clinical Care Policy; receiving updates from the Activity Oversight Group; commenting on the digital inclusion updates; receiving updates on the ongoing engagement with Excellence in Care (EiC); receiving updates on daytime confinement and the decrease we have seen with this over recent months and receiving updates on the scoping exercise in relation to the 35 point testing system for oral fluid tests. The areas of future work included: evaluating the Clinical Model; ongoing focus on QI, Realistic Medicine and TSH 3030 initiative; monitoring the use of daytime confinement and monitoring the implementation of the Clinical Care Policy.

Psychological Therapies
A 6 month update was provided at the August 2023 meeting, with the 12 monthly report being noted at the meeting in February 2024. The 12 monthly report highlighted in particular, the improved staffing position and benefits from this although some vacancies remained; the publication of the National Psychology Specification which was launched by Scottish Government in 2023. Along with this, was a document for patients describing what they could expect to receive following referral to psychological therapies. It was also noted that from April 2024, psychological therapies waiting times would be reported on to Scottish Government. Other key pieces of work included: the increase in the number of sessions delivered by 27% compared with the previous year; the increase in variance analysis tool completion rates; the improvement in the target where no patient should wait more than 18 weeks – this has been zero for some time and the attendance data for psychology staff attending the patients' Care Programme Approach (CPA) meetings.

Key pieces of work agreed for 2024 include: recruitment to full department capacity; supporting the implementation of the supporting healthy choices workplan; increasing the number of State Hospital staff trained in trauma-informed care; review of the Relaxation Group and reviewing current risk assessment process and making recommendations for change as appropriate.

4.2 Standing Items Considered by the Clinical Governance Committee during the Year

Clinical Model Progress Updates
The Committee received update reports re the Clinical Model at the February, May and November meetings during 2023. After the hospital moved into the new Clinical Model in July, the Clinical Model Oversight Group reported into the Committee. Some of the key issues noted were: patient flow through each of the services; the requirement for a centralised referral process for movement of patients between clinical services, and the most appropriate forum for

the discussion of those patient referrals; ongoing concerns about the impact of Daytime Confinement (DTC) across each of the services and potential disparity of ward closures across each of the services; the ongoing work to create a more accurate reporting system within RiO for the monitoring of daytime confinement and the increase in clinical demand/requirement for patients to leave the site for physical health investigations and treatment and the impact this is having on patients (i.e. Daytime Confinement). A large scale quality improvement project looking at improving Daytime Confinement was agreed.

Learning from Complaints
The quarterly Learning from Complaints report was considered and noted by the Committee at every meeting. Actions arising from all complaints are included within the report to share the learning which enables the organisation to develop services which take cognisance of complaint outcomes. The report is based on the two stage model that enables complaints to be handled either locally by front line staff, allowing for *Early Resolution* (Stage 1) within 5 working days, or for issues that cannot be resolved quickly or are more complex, by *Investigation* (Stage 2) within 20 working days. The main themes for complaints during the year were staff shortages (as these resulted in patients bring confined within their bedroom for longer periods of time), staff attitude/behaviour/conduct, written/oral communication and clinical treatment (this covers a wide range of subjects including involvement in care plans and time taken to go through the grounds access process). An annual report demonstrating themes and outcomes
will be prepared and published once available.

Learning from Feedback
The quarterly Learning from Feedback report was considered and noted at every Clinical Governance Committee meeting. These reports highlight the feedback received, encompassing concerns, comments and suggestions, (including evaluation forms) and any compliments/positive feedback received. The report noted the outcome from all feedback and any lessons that have been learned by the hospital. The Committee members were happy to see the positive feedback from patients around reverting back to face to face tribunals within the hospital and what the new Webex option provided that the old system did not.

Patient Movement Statistical Information
The Committee received and noted two reports during the year at its May 2023 and November 2023 meetings. The May 2023 report covered the reporting period 1 October 2022 - 31 March 2023 and the November 2023 report covered 1 April 2023 - 30 September 2023. These reports provided an overview of bed occupancy, area and source of admission, delay if any between referral and admission, admissions of young people (under 18), 'exceptional circumstances' admissions, appeals against excessive security, discharges and transfers and number of patients on the transfer list.

Incident Reporting and Patient Restrictions Report
The quarterly Incident Reporting and Patient Restrictions report was considered at every Clinical Governance Committee meeting. The report showed the type and number of incidents received through the incident reporting system DATIX, as well as all the restrictions applied to patients during the periods under review. The report provided more information on the various incidents that had occurred in relation to PAA activations; the use of handcuffs; patient seclusions; withheld mail; urinalysis results; security incidents; communication/information incidents and incidents relating to equipment, facilities and property. At the November meeting, it was agreed that this report, going forward, would only focus on clinical rather than all incidents, in other words those relevant to the Clinical Governance Committee. The first reviewed report was welcomed at the February 2024 meeting. The Committee continue to welcome the trend graphs that are included within the report that allows them to see incidents over time.

Safe Staffing Report – Clinically Focussed

The staffing and care report was presented at all the meetings during 2023/24. The reports included any challenges with staffing; including the number of times a ward had to close due to staff shortages (this would mean patients being cared for in their rooms for the duration of the shift – Day Time Confinement) and the challenges the hospital has recruiting an acceptable gender mix due to the small numbers of males going into mental health nursing. The report evolved into a Nurse Resource Report during the year.

Corporate Risk Register – Clinical Update

The Clinical Corporate Risk register was received and noted at every Committee meeting. The most recent paper at the February 2024 meeting showed that all clinical risk assessments were within their review date; ND71 Failure to assess and manage the risk of aggression and violence effectively – this risk had been updated to better reflect the risk of violence and aggression within the hospital. All current control measures and Datix data were considered with the risk assessment now focusing on serious injury from violence and aggression incidents, a change from the previous focus of all violent incidents. The assessment highlighted that the majority of incidents are managed without issue or injury and therefore the risk to staff and other patients should reflect this. After analysing the data the risk had been reduced from High to Medium (Moderate x Possible) and will be monitored regularly; MD30 Failure to prevent/mitigate obesity – it was noted that there are multiple approaches in place across the organisation to address this issue and ND70 Failure to utilise our resources to optimise excellent patient care and experience - implementation of E-Rostering continued across the hospital; Full time project manager has been appointed to complete the rollout of the project.

4.3 Other Items discussed During the Year

Overview of the Trauma Champion Role

The Committee received and noted a report at the February 2024 meeting which gave an overview of the role of the Trauma Champion. Key contributions of the Trauma Champion to date included: supporting capacity building with 54 staff attended level 1 training and 45 staff attending level 2 training and supporting staff wellbeing through providing strategic leadership for the development and implementation of the Board's 'Staff and Volunteer Wellbeing Strategy'. The Committee were also asked to note additional guidance that had been published to help services and organisations reflect on progress and identify strengths and opportunities for embedding a trauma-informed and responsive approach across policy and practice. Included within the guidance is a self-assessment checklist and a roadmap of activities that, based on growing evidence, are most effective in supporting organisations in their journey towards becoming trauma-informed and responsive. Going forward, the guidance will enable the Trauma Champion to support the Transforming Psychological Trauma Implementation Coordinator (TPTIC), senior leaders and other key stakeholders, to review and assess progress and identify further actions required to ensure that trauma-informed and responsive practice is effectively embedded and sustained across the State Hospital.

Update to Telephone System

In response to a recommendation from a CAT 2 review where a patient misused the patients' telephone system within the ward, the Committee received a report at its November 2023 meeting. The report confirmed the available options and decision-making processes by the Corporate Management Team (CMT). Option 3: to replace the current recording hardware and software, using the Mitel Interaction Call Recording Solution was approved at CMT and noted by the Committee. This will give increased functionality, at a lesser cost than a completely new system. It was also noted that the costs involved for this would be within the remit of the Capital Group, and would not need formal Board approval. It will be included in routine reporting to the Board in respect of capital spend.

4.4 Presentation Items During the Year

Clinical Model
The May 2023 meeting saw a presentation that provided an overview of the preparation that had gone into the successful implementation of the new Clinical Model. The presentation gave key updates on:

- Details of the four sub specialties and benefits and intentions aimed to be achieved through the new model, such as increased patient physical activity for the betterment of their physical health, feeling of progression for patients, effective use and deployment of available resources, enhanced treatment environment with a more tailored and individualised approach.
- Progress against the Project Plan such as individual contingency, workforce, service and communication plans, as well as the leadership approach and the movement of patients to the appropriate service.
- Clinical guidance updates which consisted of a section that described the configuration and working of the model, followed by specific guidance for each service. It was noted that the overarching document was being finalised by a Task and Finish Group. The next step would be for the final draft to be approved by the Project Oversight Board, with ownership sitting with the Clinical Model Oversight Group.
- Other key current work strands involved were contingency planning and arrangements, service leadership, movement of patients, patient engagement and communication, staff engagement and communication, next steps and learning.

Members thanked those involved in this area of extensive work and for the very interesting and reassuring presentation.

Daytime Confinement
Daytime confinement (DTC) was the subject of the presentation item at the August and November meeting. The Committee were advised that 4 workstreams were included within the project. These were to:

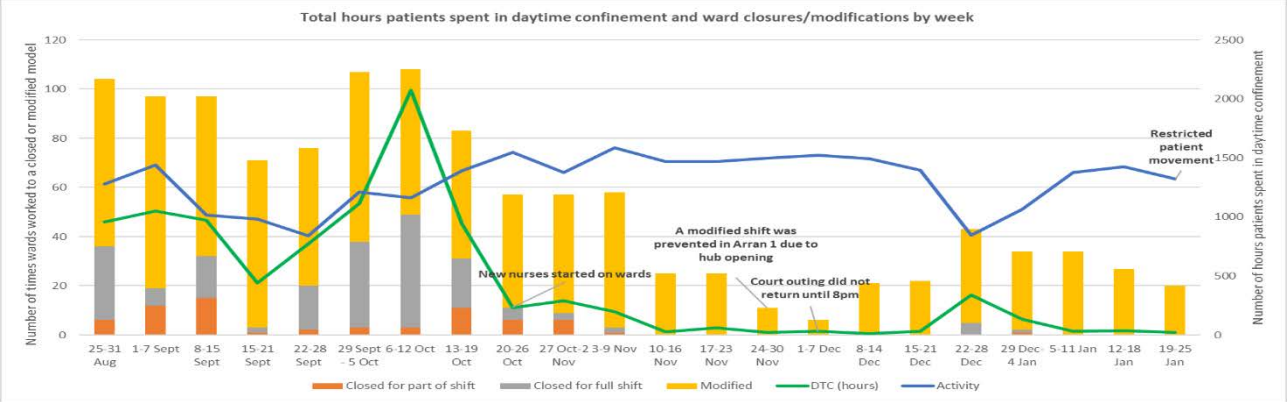
1. Maximise efficiency and effectiveness of patients boarding out.
2. Fully understanding the extent of the use of daytime confinement.
3. Implement tailored approaches to risk assessment and management.
4. Develop a culture based upon trust, connectivity and ‘one team’ that motivates and engages all staff.

Each workstream provided a report to the Daytime Confinement Short Life Working Group at its monthly meeting.

Recruitment was noted as the core solution along with reducing sickness absence. The Committee were pleased to note that the hospital had implemented a system that allowed the recording of daytime confinement so this could be measured during, and after, the project. The data can be looked at across the full site, over services and over individual wards and patients. Posters are sent out every week to the wards to allow them to see longitudinal data of their daytime confinement over time. The 0830 huddle ensures that a multidisciplinary approach is taken to try and minimise the use of daytime confinement.

The Chair of the Committee emphasised that the successful outcome would be where daytime confinement was a never event.

At the meeting in February 2024, an update paper was presented. The paper showed positive steps in reducing the amount of daytime confinement experienced by patients at The State Hospital. It was noted that the project had been extended until March 2024 to ensure thorough escalation processes are in place. It is planned that a project closure report will be presented at the May meeting of the Committee. DTC will be monitored through the Clinical Governance Group.



Patient Activity
The February 2024 meeting saw the Committee receiving and noting a paper on activity from the Activity Oversight Group covering the period 14 September 2022 to 30 September 2023. This paper formed the basis of the presentation item at the meeting. Key achievements from this Group in its first year included: an agreed definition and classification of activity; an agreed single unit of measurement; improving consistent delivery of activity within the Skye Centre; a reduction in manual and duplicate processes and the inclusion of activity as part of site safety meetings.

Key future areas of work agreed during the discussion were: developing measure definitions for KPIs and testing these; engagement with Service Leadership Teams to build the will for the KPI and agreed standards for each service; each service to look at timetable data and identify where they would like to see improvements and to take forward the use of the interest checklist in partnership with security.

The Committee also noted during the discussion item, the collaborative efforts among the Physical Health Steering Group, Patient Partnership Group and the Clinical Model Oversight Group.

4.5 Special Topics

Clinical Governance Annual Stock Take
At its May 2023 meeting, the Committee received and noted: the Clinical Governance Reporting Structures 2023/24; the Programme of Work for 2023/24 subsequent to any changes that may arise at future meetings; the Clinical Governance Committee Terms of Reference; and the Clinical Governance Annual Report 2022-23. The Annual Report summarised the work of the Committee during the financial year 1 April 2022 - 31 March 2023.

Category 1 Review Reports
No Category 1 reviews were presented to the Clinical Governance Committee during the reporting period.

5. Areas of Good Practice/Concern identified by the Committee

Good Practice:

- Positive feedback from SQA under the Patient Learning Annual Report
- All About Me passports
- Positive atmosphere within the Family Centre for visiting
- Transfer CPA report being at 100% complete as was detailed in the CPA Annual Report.
- Increased visibility of the Complaints Officer and access to telephone line.

- The extensive work and efforts by the Catering Service as was detailed within the Learning from Feedback Report.
- Corporate Services Complaints Team and the Patient Partnership Group around positive working practices and confidence built between the two links and the complaints process itself.
- The extensive work by the Quality Department and eHealth Department around their efforts in pulling together information and the extensive background work involved with producing Flash Reports and Tableau Dashboards.

Matters of Concern:

Matters of concern	Update
Recurrence of issues with clinical waste	Infection Control is undertaking a quality improvement project that will look to reduce the number of clinical waste issues.
Staff incidents at security due to prohibited items	Assurance was received that these were everyday items such as personal mobiles and umbrellas

6. Conclusion

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

Appendix 1

The State Hospitals Board for Scotland

CLINICAL GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

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

2 COMPOSITION

2.1 Membership

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

Members:

- Stuart Currie
- David McConnell
- Shalinay Raghavan
- C Fallon (Chair of the Clinical Governance Committee)

In Attendance

- Brian Moore, Chair of The State Hospitals Board for Scotland
- Gary Jenkins, Chief Executive
- Prof. Lindsay Thomson, Medical Director
- John Marshall, Head of Psychological Services
- Monica Merson, Head of Planning, Performance and Quality
- Karen McCaffrey, Director of Nursing and Operations
- Robin McNaught, Finance & eHealth Director
- Dr Khuram Khan, Chair, Medical Advisory Committee
- Sheila Smith, Head of Clinical Quality
- Margaret Smith, Head of Corporate Governance/Board Secretary

2.2 Appointment of Chair

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

2.3 Attendance

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

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

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

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

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

3 MEETINGS

3.1 Frequency

The Clinical Governance Committee will meet quarterly to fulfil its remit and shall report to the Board following each meeting. The Chair of the Committee may convene additional meetings as necessary.

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

3.2 Agenda and Papers

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

The lead Executive for co-ordinating agendas and papers is the Medical Director.

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

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

3.3 Quorum

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

3.4 Minutes

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

Following approval, minutes will be submitted to the Board and then published on the hospital's website.

4 REMIT

4.1 Objectives

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

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

4.2 Systems and Accountability

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

4.3 Safe and Effective Care

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

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

4.4 Health, Wellbeing and Care Experience

- To ensure that the environment supports delivery of high-quality care with a culture and appropriate mechanism to allow staff and others to raise concerns on the standard of care provided, including the performance of clinical colleagues, in the knowledge they will be addressed without detriment to themselves or prejudice to the principles of confidentiality.
- To ensure systems are in place to monitor and measure the mental health and physical health requirements of our patient population, including medicine management, psychological therapies, and rehabilitation services.
- To ensure that arrangements are in place to embed Person Centred Improvement activities, including equality and diversity issues pertinent to clinical governance.
- To ensure that care is provided by appropriately trained and skilled professionals with the competencies required to deliver the required care.
- To ensure that clinical policies and procedures are developed, implemented, and reviewed.
- To ensure that poor performance of clinical care will be identified, and remedial action taken.

4.5 Control Assurance

- To ensure that quality of clinical care drives decision making and that clinicians are involved in planning, organising, and managing services.
- To ensure that the planning and delivery of services has taken full account of the perspective of patients and the general public.
- To ensure that systems are in place to measure and monitor performance to foster a culture of quality and continuous improvement.
- To ensure that research and development programmes are initiated, monitored, and reviewed.
- To ensure a comprehensive information governance framework is in place which ensures the Codes of Practice on Openness and on Confidentiality of Personal Health Information are fully applied.

The Committee will manage its business through a workplan, agreed by the Chair of the Committee. This will ensure that the full remit is covered on a rolling basis.

5 AUTHORITY

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

6 PERFORMANCE OF THE COMMITTEE

The Committee shall annually review and report on:

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

7 REPORTING FORMAT AND FREQUENCY

The Chair of the Committee will report to the Board following each meeting of the Clinical Governance Committee.

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

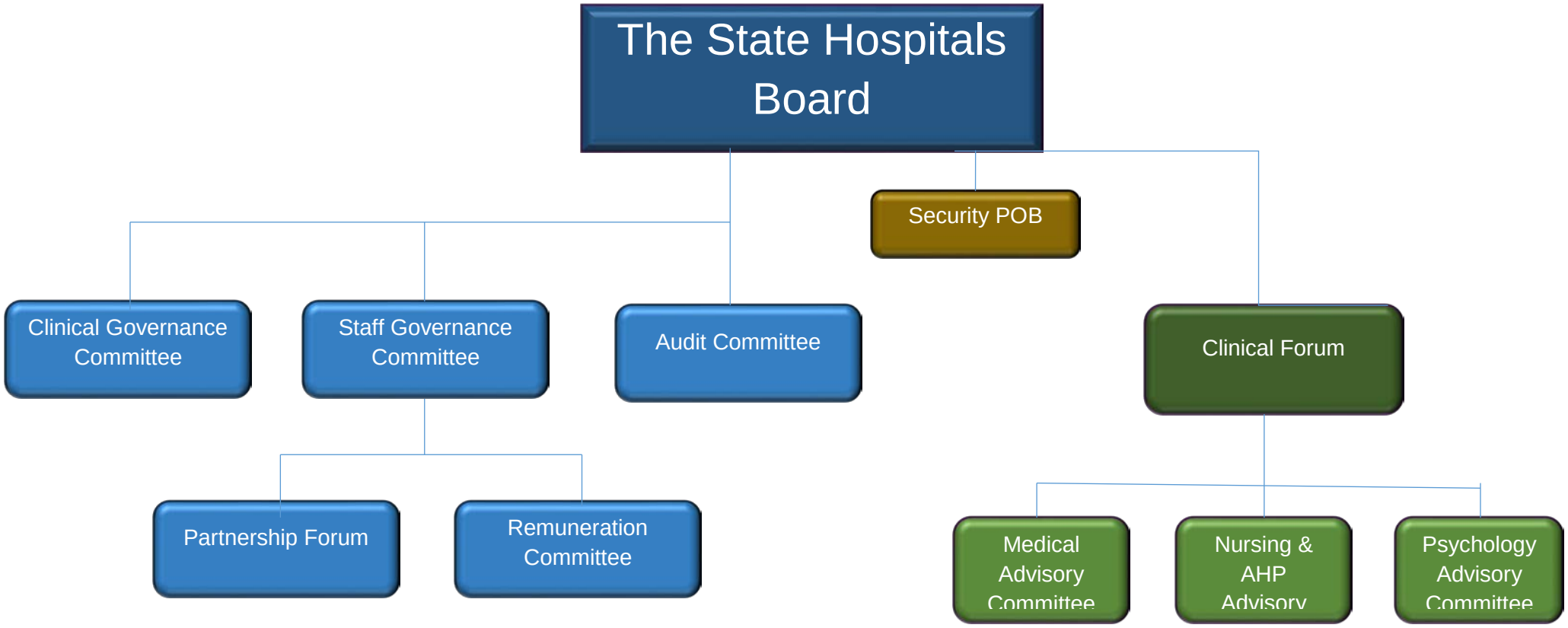
8 COMMUNICATION AND LINKS

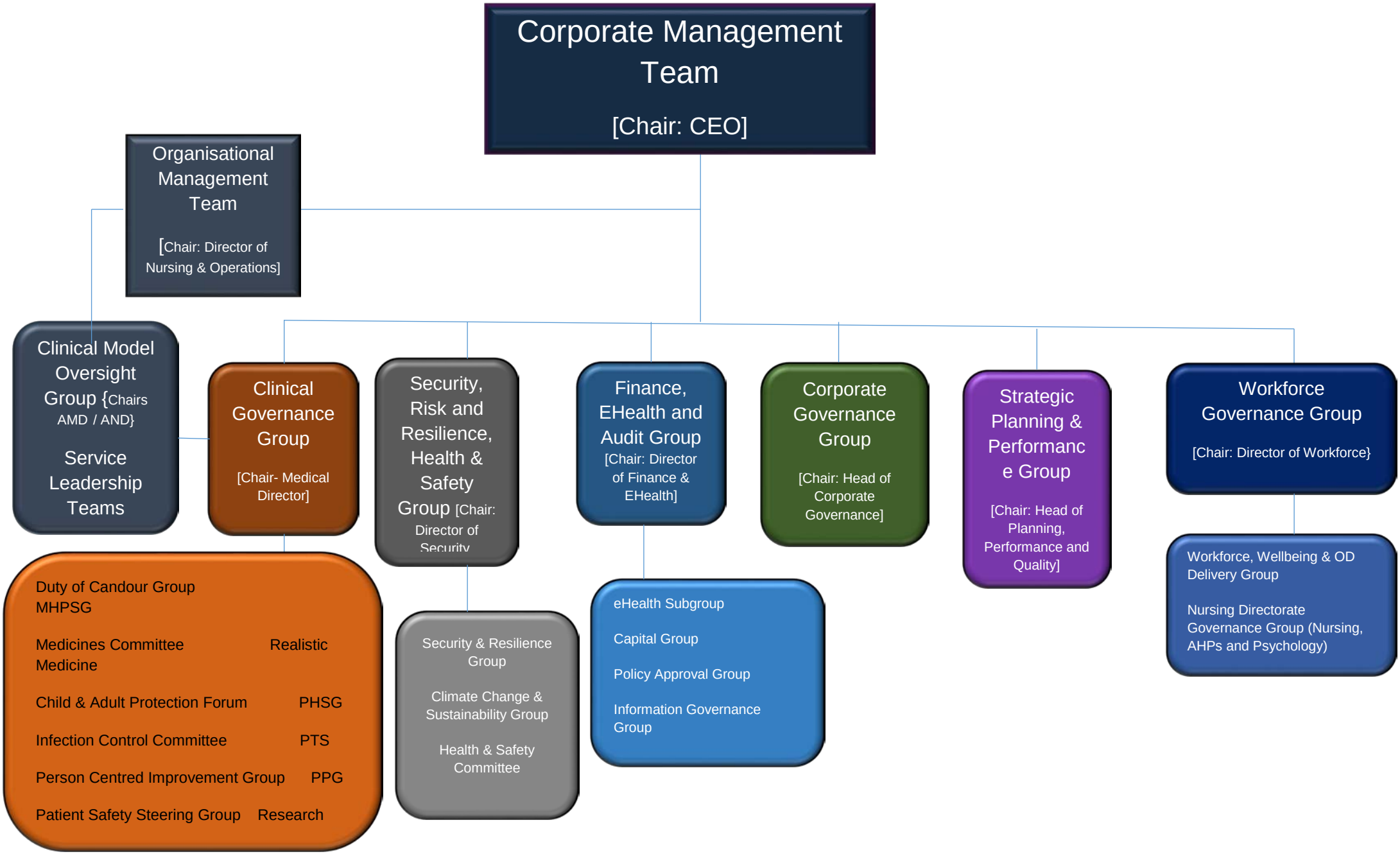
The Chair of the Committee will ensure that relevant issues are shared with the Staff Governance Committee.

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

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

Subject to annual review.
Next revision: May 2024.


The State Hospitals Board
Security POB
Clinical Governance Committee
Staff Governance Committee
Audit Committee
Clinical Forum
Partnership Forum
Remuneration Committee
Medical Advisory Committee
Nursing & AHP Advisory
Psychology Advisory Committee


Corporate Management Team
[Chair: CEO]
Organisational Management Team
[Chair: Director of Nursing & Operations]
Clinical Model Oversight Group {Chairs AMD / AND}
Service Leadership Teams
Clinical Governance Group
[Chair- Medical Director]
Security, Risk and Resilience, Health & Safety Group [Chair: Director of Security
Finance, EHealth and Audit Group
[Chair: Director of Finance & EHealth]
Corporate Governance Group
[Chair: Head of Corporate Governance]
Strategic Planning & Performanc e Group
[Chair: Head of Planning, Performance and Quality]
Workforce Governance Group
[Chair: Director of Workforce}
Duty of Candour Group
MHPSG
Medicines Committee
Realistic Medicine
Child & Adult Protection Forum
PHSG
Infection Control Committee
PTS
Person Centred Improvement Group
PPG
Patient Safety Steering Group
Research
Security & Resilience Group
Climate Change & Sustainability Group
Health & Safety Committee
eHealth Subgroup
Capital Group
Policy Approval Group
Information Governance Group
Workforce, Wellbeing & OD Delivery Group
Nursing Directorate Governance Group (Nursing, AHPs and Psychology)

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item No: 13
Sponsoring Director:	Medical Director
Author(s):	PA to Medical & Associate Medical Directors
Title of Report:	Board approval for Approved Medical Practitioner status
Purpose of Report	For Decision

1 SITUATION

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

2 BACKGROUND

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

3 ASSESSMENT

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

4 RECOMMENDATION

The Board is invited to agree the following recommendation:

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

SoFMH
School of
Forensic
Mental Health

NHS
Education
for
Scotland

Certificate of Attendance

This is to certify that

James Morphett

Attended a one day online

AMP Initial Training Course

On 1st May 2024

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

and was successful in the following modules:

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

Course ID
109491

GMC
7560136

MONITORING FORM

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

Paper No: 24/45

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item No: 14
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning, Performance and Quality Corporate Planning Support Manager Clinical Quality Facilitators
Title of Report:	Quality Assurance and Quality Improvement
Purpose of Report:	For Noting

1. SITUATION

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

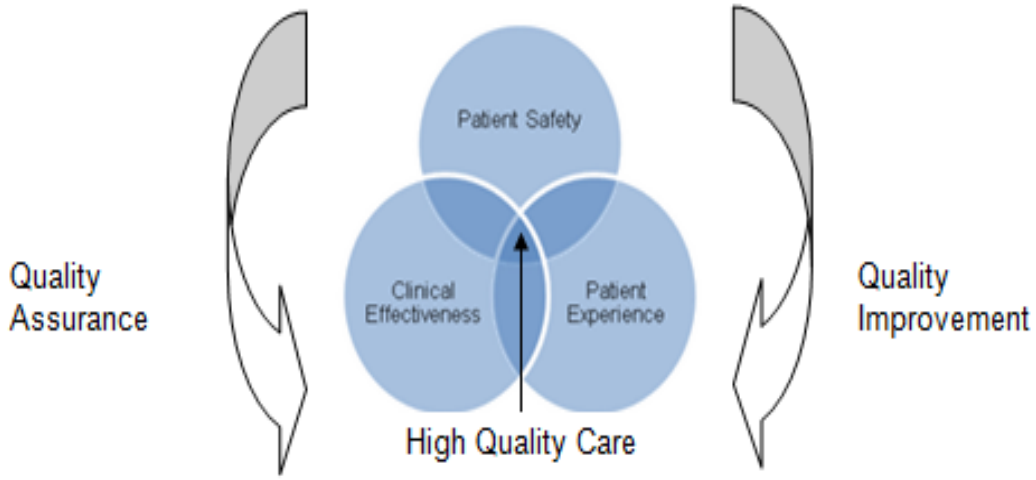
2. BACKGROUND

Quality assurance and improvement in TSH links to the Clinical Quality Strategy 2017 – 2020. The Clinical Quality Strategy is currently being updated and revised. A Board development session was delivered in May 2024 to provide an opportunity for the Board to engage with the strategy. It will return to the Board in August 2024. The current Clinical Quality Strategy sets out the direction, aims and ambitions for the continuous improvement of clinical care. It outlines the following seven goals to ensure the organisation remains focussed on delivering our quality vision:

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

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

3.



ASSESSMENT

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

- The monthly report from the analysis of variance analysis tools and completion of two clinical audits:
  - PRN Psychotropic Medication Audit
  - RMO Record Keeping
- An update on the work of the QI Forum including current training in progress for QI.
- An update on the actions associated with the Realistic Medicine portfolio.
- An overview of the evidence for quality including analysis of the national and local guidance and standards recently released and pertinent to TSH

4. RECOMMENDATION

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

MONITORING FORM

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

QUALITY ASSURANCE AND IMPROVEMENT IN TSH APRIL/MAY 2024

ASSURANCE OF QUALITY

Clinical Audit

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

There have been 2 audits completed and actioned during this reporting period.

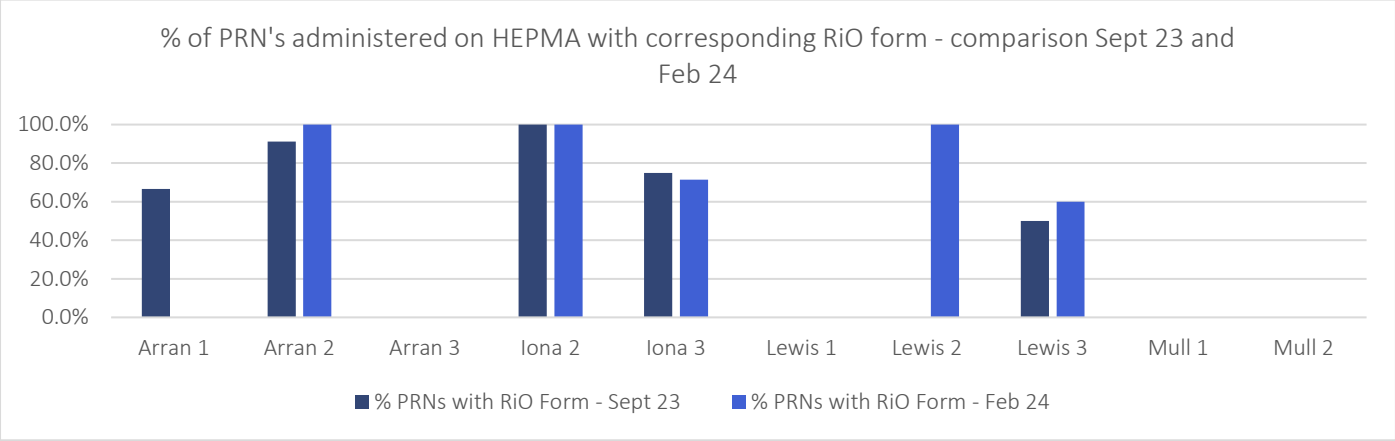
- PRN Psychotropic Medication Audit
- RMO Record Keeping

PRN Psychotropic Medication Audit

This audit was two-fold. It checked whether all psychotropic PRN administrations on HEPMA had a corresponding PRN Psychotropic Medication form on RiO and whether the RiO forms complied with the patient safety 8 rights:

- Right patient
- Right medication
- Right dose
- Right route
- Right time
- Right documentation
- Right reason
- Right response

59 PRNs were administered over the audit period (over 5 wards – the other 5 wards had no PRN psychotropic medication administered during the audit period) with 53 having a corresponding PRN Psychotropic Medication form. As can be seen from the graph below, excellent compliance was found in 3 of 5 wards with improvements from the last audit in the 4th ward. Only one ward's results was lower than the previous audit.



For the 53 occasions where the RiO PRN Psychotropic Medication form was completed, all 8 rights were well recorded fully or correctly on 42 (79%) occasions. This means on 11 occasions (21%), the 8 rights had not been recorded fully or correctly. The most common error was the wrong time being put on the form (this can be cross referenced with HEPMA). Actions from the audit included designing a poster for all wards to remind them of the 8 rights and to feed back the results from the audit.

RMO Record Keeping
96 patient records were checked from the month of April. Of the 96, there were 5 patients that had not been seen by an RMO in April. All 5 had been seen in March (1 on 13th March, 2 on 20th March and 2 on 27th March). This gave a compliance rate of 95%. There was an issue highlighted in this audit with an RMO not validating their 4 entries (this means they are not a legal entry). This has been highlighted to the Associate Medical Director along with the results of the audit for them to action.

During this reporting period The State Hospital have also taken part in a Prescribing Observatory for Mental Health (POMH) national benchmarking audit looking at rapid tranquillisation. The report will be due out later this year and will be presented to the Medicines Committee for discussion and actions agreed as required.

Clinical Quality have also been supporting the successful implementation of the Clinical Care Policy that went live on 1st May. Discussions re an audit into this policy will take place during the next reporting period with audit tools agreed.

Variance Analysis Tool (VAT) – Flash Reports

The most recent flash report was circulated in May 2024 and covers the month of April:

HOSPITAL WIDE VARIANCE ANALYSIS FLASH REPORT

Date: April 2024

Overview and areas of good practice

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

The monthly VAT report is split as follows:

March 24	Annual	Intermediate	Total	VAT completion	MDT attendance
Admission	1	0	1	100%	71% decreased from 75% in Mar 24
Arran T & R	2	0	2	99%	63% increased from 50% in Mar 24
Lewis T & R	3	3	6	94%	79% Increased from 75% in Mar 24
ID	0	2	2	99%	71% increased from 69% in Mar 24
Transition	0	0	0	-	No reviews held-

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

- VAT completion decreased slightly from 98% to 96%
- Medians have now been able to be added to the graphs and show random variation over time for all interventions
- Patient attendance increased from 81% to 100%
- Security attendance increased from 44% to 100%

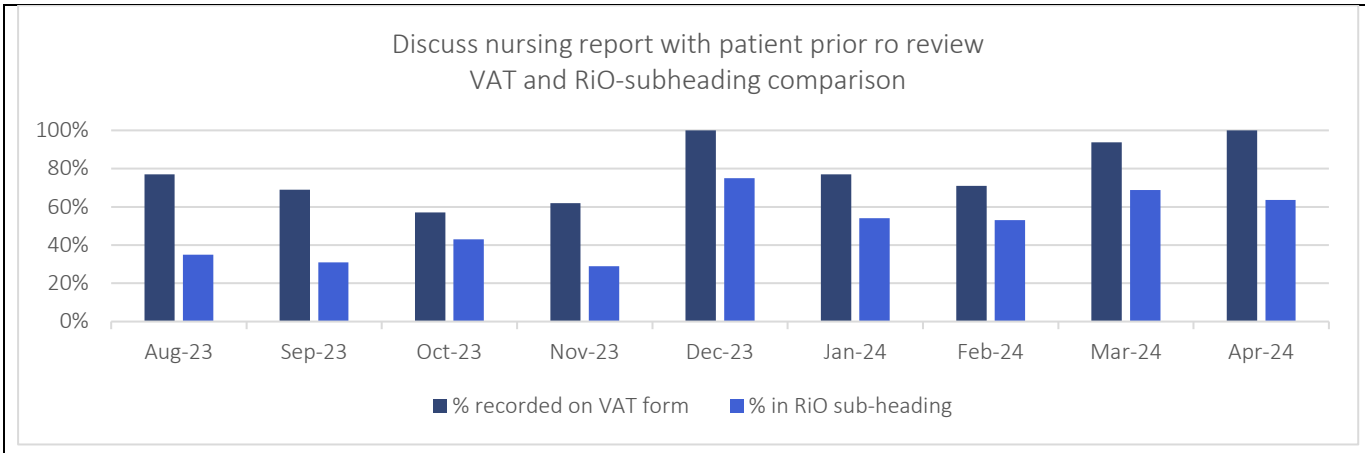
Areas of concern

- Medical completion in Lewis T & R service was 50% in April – short of the 90% required for robust data
- Occupational Therapy – Decrease in Occupational Therapy interventions linked to staff vacancy

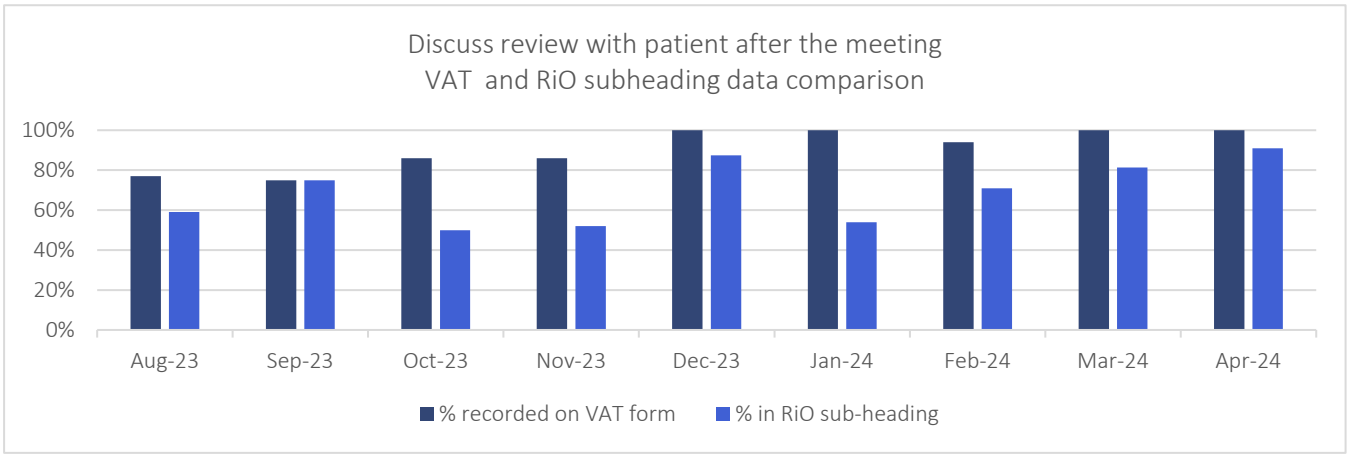
Any challenges with the systems that are being addressed

Going forward the VAT data will be collected from RiO due to the risks to the organisation in using the current system. As can be seen in the graphs below the current project testing the new process is still showing descrepanices. Discussion with nursing to identify alternative solution.

According to the VAT data, discussing the nursing report with the patient prior to the review was 100% in April but running the data from RiO showed a result of 64%. The Clinical Quality Facilitator continues to work closely with Senior Charge Nutses on this QI project.



Discussing the review with the patient post review was 100% according to VAT data but showed a result of 91% on RiO.



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

QUALITY IMPROVEMENT

QI Forum

The QI Forum's purpose is to champion, support and lead quality improvement initiatives across the hospital and raise awareness and understanding of quality improvement (QI) approaches. The QI Forum meets on a six weekly basis and has a focus to raise awareness and build capacity to support and embed QI. Over this quarter there are currently a total of 14 QI projects being undertaken throughout the organisation.

QI Capacity Building

Qi Essential Training Cohort 2; Over this quarter, two members of staff have fully completed the QI Essentials two day training, one day feedback session and have developed posters on the outcomes from their QI Projects. These two projects' overviews were: a) Evaluation of the effectiveness of a 12 week football fan in training course on the aerobic fitness of patients within a high secure forensic in-patients setting. b) Information was obtained via Rio timetables to identify the number of errors occurring in the entry of activity our patients attended. The aim of this project was to focus on duplication of activity entries which effected the Skye Centre activity departments (Appendix 1). These posters are displayed within the the notice board within the reception area and Staff Wellbeing Centre.

Scottish Improvement Leaders (ScIL) Programme: Two members of TSH staff are continuing to work through the modules in cohort 46-47 ScIL Programme.

The Scottish Coaching and Leading for Improvement Programme (SCLIP): One member of TSH staff was successful in obtaining a place on the next funded SCLIP course which should start nearer the end of 2024.

Managing Quality in Complex Systems Programme: Two members are currently each on Cohort 1 & 2 of the Managing Quality in Complex Systems.

Realistic Medicine

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

The six key themes of RM are:

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

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

1) Re launch of Learning into Practice sessions and supporting the establishment of Team Based Quality Reviews whereby local teams will identify and review areas of good practice and areas of concerns to ascertain opportunities for learning.

2) Embed the use of BRAN (Benefits, Risks, Alternatives and Nothing) questions as part of the Nutrition & Physical Health Pathway project. The Nurse Practice Development and Realistic Medicine Teams are supporting keyworkers and patients to have more meaningful conversations and provide patients with informed choices around their nutritional and physical health needs.

Evidence for Quality

National and local evidence based guidelines and standards

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

Over a 12-month period, an average of 200 evidenced based guidance documents issued from a variety of recognised bodies and reviewed for relevancy by the Clinical Quality Facilitator. During the period 1 May to 31 May 2024, 24 guidance documents have been reviewed. There were 22 documents which were considered to be either not relevant to TSH or were overridden by Scottish guidance and 2 documents which were recorded for information and awareness purposes.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
Mental Welfare Commission (MWC)	2	2	0
SIGN	1	0	0
National Institute for Health & Care Excellence (NICE)	21	0	0

There are currently 5 additional evaluation matrices, which have been outstanding for a prolonged period and await review by their allocated Steering Group. The progress of the first two evaluations (1 from HIS re Observation to Intervention and 1 from the MWC re seclusion) were temporarily paused due to TSH adapting to the COVID-19 pandemic, action on matrix completion began again at the start of July 2020. The responsibility to review these matrices changed ownership from the PMVA Review Group to the Patient Safety Group, which recommenced meetings in September 2020. Both policies were launched on 1st May 2024 and work to finalise compliance within the policies against the evaluation matrix is nearing completion.

The third evaluation matrix guidance review regarding MS has temporarily been paused as further consideration being given as to whether this is relevant or not.

The fourth evaluation matrix for SIGN national guideline for stroke was delayed due to prioritizing of numerous guideline reviews by the practice nurse and GP. An adapted evaluation matrix (for pre-referral and post discharge) has been compiled and is undergoing the review process involving a multidisciplinary review group.

The final evaluation matrix from SIGN in relation to Dementia is in the middle of the review process with meetings having already taken place. It is anticipated that this process will be concluded once the next review session take place at the end of June 2024.

Table 3: Evaluation Matrix Summary

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
HIS	From Observation to Intervention: A proactive, responsive & personalised care & treatment framework for acutely unwell people in mental health care	Patient Safety	The outstanding 28 recommendations will be reviewed now that the Policy has been implemented and it is expected that we will now meet many of the outstanding recommendations.	Jan 2019	June 2024
MWC	The use of seclusion	Patient Safety	This has been reviewed now that the seclusion policy has been implemented. There were 3 outstanding recommendations, one in relation to the CCTV that will be picked up via the CCTV policy, one in relation to the physical build of the MSRs that will be an accepted variance and the third in relation to the bedroom next to the seclusion room which needs more discussion.	Oct 2019	June 2024

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
NICE	Multiple sclerosis in adults: Management UPDATED	PHSG	Temporarily paused as further consideration being given for relevancy.	June 2022	July 2024
SIGN	National Clinical Guideline for Stroke	PHSG	Document collated and the first review meetings have taken place. A further 1/2 meetings will be required due to the extent of the guidelines. It is the pre-admission and post-discharge that will be the focus.	April 2023	July 2024
SIGN	Assessment, diagnosis, care and support for people with dementia and their carers	MHPSG	Document is going through review process with 2 meetings already having taken place. What is expected to be the final review meeting before submission to MHPSG is scheduled for 27 June.	Nov 2023	July 2024

Paper No: 24/45

Appendix 1

Rio Timetable Recording

Susan Tweedlie, Skye Centre Secretary

Project Overview

Information was obtain via Rio timetable's to identify the number of errors occurring in the entry of activity our patients attended. The aim of this project was to focus on Duplication of activity entries which effected the Skye Centre activity departments.

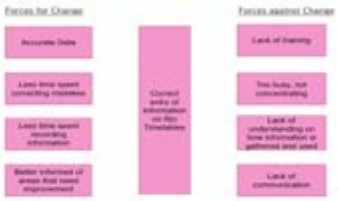
Project Aim

"By March 2024 all clinical staff will reduce errors on Rio timetables by 50%"

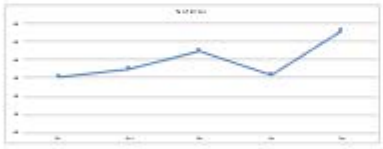
Method

Weekly patient activity data is already obtained via Rio timetables and it was evident that a number of entries were inaccurate. However, the exact number of entries had not been tracked or recorded nor had the reasons for the inaccuracies been explored.

A Force Field analysis was one of the methods used to explore the possible barriers and reasons for the inaccuracies

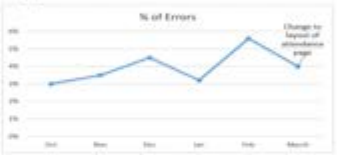


The amount of errors that occurred over a 5 month time period was also recorded.



Results

There are still some measures to be put in place before we can safely assess the effectiveness of all changes put in place however, the information has shown that there has been a slight decrease in the percentage of errors made



Whilst this decrease has still not met the project aim this is a work in progress and other measures are lined up to help reduce this figure further.

Conclusions

- Training and guidance document were helpful in gaining staff understanding of issues caused
- Procedural changes being implemented is not enough for changes to be sustained, monitoring and training will need to continue
- Changes to how activity date was displayed have shown a reduction in the amount of duplication almost immediately

Process Changes

In order to see an improvement –

- From 1st March a change was implemented within the timetables to display the date of activity in a more prominent place to reduce duplication errors. This change saw a decrease of duplication of planned activity from 2.5% in February to 1.8% in the 1st month.
- Set up a 'How to Guide' to show staff the correct procedure when entering activity
- This guide was sense checked by various members of staff to receive their feedback and advice, making alterations where necessary
- A flow chart was developed as a visual guide on entering activity

Learning points

- Ongoing work in progress
- Measures put in place wont create an instant fix, a period of monitoring will need to be sustained

Achievements

- Measures put in place have shown signs of improvement
- Positive response to changes made
- Changes made will reduce amount of time spend in identifying and correcting errors

Next Steps

- Work in conjunction with Corporate Planning and Performance to monitor, review and improve further
- Continue to monitor progress and to deliver training and guidance when needed

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Scottish Improvement Foundation Skills Programme (SIFS)

THE STATE HOSPITALS BOARD FOR SCOTLAND

Clinical Governance Committee **CGC(M) 24/01**

Minutes of the meeting of the Clinical Governance Committee held on Thursday 8 February 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
Non-Executive Director	Shalinay Raghavan
In attendance:	
Head of Psychology	Dr Liz Flynn [Item 9]
Skye Centre Manager	Jacqueline Garrity [Items 11 & 12]
Head of Organisational Development and Learning	Sandra Dunlop [Item 14]
Chief Executive	Gary Jenkins
Board Chair	Brian Moore
Medical Director	Professor Lindsay Thomson
Director of Nursing and Operations	Karen McCaffrey
Director of Security, Estates and Resilience	David Walker
Consultant Forensic Psychiatrist	Dr Khuram Khan
Head of Corporate Planning, Performance & Quality	Monica Merson
Head of Corporate Governance & Board Secretary	Margaret Smith
Head of Clinical Quality	Sheila Smith
Personal Assistant to Employee Director	Julie Burt [Minutes]

1 APOLOGIES AND INTRODUCTORY REMARKS

Ms Fallon welcomed everyone to the meeting, and apologies were noted from Robin McNaught, Director of Finance and eHealth.

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 HELD ON 9 NOVEMBER 2023

The Committee approved the Minutes of the previous meeting held on 9 November 2023 subject to the following amendment:

On page two, under item 6 Corporate Risk Register – Clinical Risks, with reference to Risk ND71, should be recorded that grading was reduced to “medium”, not low.

The Committee:

1. Approved the minute of the meeting held on 9 November 2023 following the amendment noted above.

4 MATTERS ARISING

a) Update on virtual consultations and external hospital admissions

Professor Thomson advised that the virtual consultations equipment within the Health Centre was up and running, and fully functional, with a process now in place. Only one consultation had been thought suitable but the clinic consultant requested attendance for imaging. She further advised that an excellent piece of work had been carried out in relation to Boarding Out at general hospitals, by two current Psychiatric Trainees, and work was presented to the Corporate Management Team in January 2024. In terms of Accident and Emergency Admissions, findings were that these had been consistent over the last five year period with 2-4 A&E attendances per month, and all A&E outings in 2023 had been independently reviewed by both doctors and none were considered unnecessary with 36% of cases being admitted and all others requiring imaging and / or active treatment. Professor Thomson commended the work done to date and highlighted that recommendations would be taken forward by the Physical Health Steering Group. Mr Jenkins advised that from a Corporate Management Team perspective, the recommendation and ask was (1) if the State Hospital could provide services in-house, should they be required, and (2) if boarding out at a general medical facility was required. He advised that based on the evidence presented the decision made was that there was no requirement for additional in-house services or extra resources, given the sufficient infrastructure in place.

There were no other additional urgent matters which arose for discussion.

5 PROGRESS ON ACTION NOTES

The Committee received the action list and noted progress on the action points from the last meeting.

Members were content to regard all actions as complete and closed.

The Committee:

1. Noted the updated action list.

6 CORPORTE RISK REGISTER – CLINICAL RISKS

Members received and noted the Corporate Risk Register in relation to current updates. Professor Thomson provided an overview of the report and advised that there were no out of date risks. She highlighted Risk ND71 i.e. Serious Injury or Death as a Result of Violence and Aggression, and advised this had been downgraded to medium risk, as per the explanation set out in appendix two.

In relation to Risk MD30 i.e. Failure to prevent / mitigate obesity, she advised that this was in relation to a total of 103 patients who were overweight / obese. In January 2024 the figure was 85.4%, showing a slight decrease from 86.1% in December 2023.

The Committee noted there were multiple approaches in place across the organisation to address the issue as set out in the report. Of particular note, the Supporting Healthy Choices initiative was gaining pace and a piece of work was recently completed which took one document, specific to secure settings and weight management, developed by Public Health England, and used this to develop a full guidance document for the State Hospital. The updated document was sent to Public Health Scotland to seek comment and approval to ensure the hospital had captured external views on this specific piece of work. This work would then feed in to development of a new plan, specific to Supporting Healthy Choices and new initiatives for patients. She further advised that the other aspect of this work was that using the new clinical model and the four services now in existence, we were now able to tailor the interventions in line with these services. The obvious area to prioritise was admissions and assessment and to create a prevention model. Dr Khan reiterated this and advised the focus would be on admission wards, then to convert the

guidance document in to an actionable plan, with the work on this having started. An update on this work would be provided at the next meeting.

Action: Lindsay Thomson / Khuram Khan

In relation to Risk ND70 i.e. Failure to utilise our resources to optimise excellent patient care and experience, it was noted that the implementation of E-Rostering continued across the hospital. A full time Project Manager had been appointed to complete the rollout of the project. Of particular note, daytime confinement and full time ward closures had fallen markedly.

Mr Currie made reference to Risk ND71, and the work involved in terms of interventions and training put in place, as well as learning from events and resources deployed to ensure the risk was mitigated, and the workings behind the risk rating was helpful to see as recorded in the monitoring form.

Mr Jenkins mirrored Mr Currie's comments and was reassured that the environment of the hospital was controlled, and that the matrix and risk assessment process was comprehensive. Credit was given to the extensive work carried out by the specific departments across the hospital.

Ms Fallon queried the narrative and grading around risk ND71 and that grading had been reduced to medium. There was conflicting narrative within the draft minutes of the previous meeting in November 2023 where it was noted to have been reduced to low rating. Professor Thomson advised that following clarification with the Risk Department, this had been a typing error within the minutes which would be rectified.

Action: Secretariat *(completed)*

The Chair thanked individuals for the work which went in to preparing the comprehensive report, which detailed a lot of positives in relation to offering activity and the appointment of the full time Project Manager, which gave assurance from a governance point of view. Ms Fallon advised that full and partial ward closures would be kept under review, with updates in reports later on today's agenda.

The Committee:

1. Approved the Corporate Risk Register as an accurate statement of risk.

7 INCIDENT REPORTING AND PATIENT RESTRICTIONS REPORT

Members received and noted the report on Incidents and Patient Restrictions which provided the Committee with an overview of activity within the third quarter of 2023/24. The report showed the type and number of incidents received through the incident reporting system (Datix). Further, it updated all the restrictions applied to patients during the period.

Professor Thomson provided an overview of the content and advised that during this quarter following meetings between the Risk Management Department, Mr Walker and herself, a number of changes were made to the report. These changes referred to a more focused and detailed recording of clinical incidents only. Non clinical incident items would be re-routed to the appropriate Committee. She further gave an overview of the report and advised that Members would see a recurring theme throughout today's Committee around the Intellectual Disabilities Service experiencing more incidents across the board in relation to a number of patients. Detailed updates were provided in the following areas:

- Restrictions
- Health and Safety
- Clinical Security

- Infection Control
- Direct Patient Care
- Communication / Information Governance

Mr McConnell sought clarification that security incidents and risks would be re-routed and reported to the Audit and Risk Committee, then the Board Meeting. Mr Walker confirmed that security incidents would be reviewed by the Security, Risk and Resilience Oversight Group then reported to the Audit and Risk Committee going forward. Mr McConnell also made reference to the clinical waste section on pages 10 and 11, where it referred to the number of incidents as eight, though stated that incidents had decreased. Professor Thomson advised this was a typing error within the report and the narrative would be updated to state 'decreased'. Ms Fallon also highlighted the similar typing error on page three of the SBAR paper.

Mr Moore welcomed the new format of the report and the focus on clinical issues at this Committee. He questioned if the Category One medication administration incident mentioned in the report, was the same incident as was mentioned in the previous minute, or whether there was now two Category One incidents. Professor Thomson confirmed this was the same investigation.

Mr Jenkins commented on the observation on patterns and reference points in relation to challenges within the Intellectual Disability Service and complexities around this cohort of patients in terms of data on assaults and attempted assaults, and highlighted an awareness of this going forward. He reassured Members advising that actions were ongoing in this problematic area.

Members acknowledged the extensive in-depth narrative contained within the report and took assurance from the reduction in staff resourcing incidents. Professor Thomson confirmed that the outcome of the Category One Investigation would be presented at the next Committee given that the due date was 24 February 2024.

Action: Risk Management Department

The Committee:

1. Noted and approved the content of the Incidents and Patient Restrictions Report, pertaining to Quarter 3 2023/24.

8 CLINICAL GOVERNANCE GROUP 12 MONTHLY REPORT

Members received and noted the Clinical Governance Group 12 Monthly Report, which covered the period January to December 2023 and detailed the overall delivery of the two strategic aims i.e. (1) to deliver safe, effective and person-centred care based on available evidence and best practice, and (2) to achieve demonstrable improvements in outcomes including the patient experience.

Professor Thomson highlighted a typing error on page 13, section 3, whereby the Senior Management Team' was referred to. This should be rectified to Corporate Management Team.

Ms Sheila Smith provided an overview of the report and highlighted the main key areas and progress made in each respect. The main areas covered a summary of core activities including the reports tabled at the Clinical Governance Group, a comparison with last year's planned quality assurance and quality improvement activity, quality assurance and improvement activity during 2023, and planned quality assurance and improvement activity for 2024. Members agreed with all aspects and areas of planned work for 2024.

In order to gain a better understanding, Mr Moore questioned how the Excellence in Care (EIC) overall framework operated, and whether the Board would receive feedback evaluation on the information submitted on the range of areas. Ms McCaffrey advised that a report was submitted to

the EIC Team at Public Health Scotland and feedback received following this. In addition, the Associate Nurse Director is the lead for EIC for the Board and has routinely met with the national EIC Team to gain additional feedback. There were no issues raised around feedback, or the information the State Hospital submitted. Mr Moore questioned if there were concerns or positive feedback, how these would be or were captured within this area of framework. Ms McCaffrey commented that the report submitted to the Clinical Governance Group would be refreshed as required.

Professor Thomson provided additional detail around the Scottish Patient Safety Programme (SPSP) framework and advised that this was innovative when it commenced, and a substantial amount of work was carried out in areas such as nursing and pharmacy. Professor Thomson highlighted that the work was set aside during Covid-19 and wondered if there was a national perspective on the longer term plan for this piece of work. Ms McCaffrey commented that both the EIC and the SPSP lost impetus during Covid-19. Though there had been attempts to reinvigorate the programmes, she was conscious of the operating landscape, in particular the territorial Boards. From a mental health perspective, she was satisfied the hospital was achieving more than the actual set standard, and received excellent feedback on the standards consistently reported on.

The Chair thanked the Clinical Quality Team for the extensive detailed report which was of great benefit to the Committee in terms of reassurance on the delivery of strategic quality aims, as well as governance of person centred care and experience.

The Committee:

1. Noted the Clinical Governance Group Annual Report.

9 PSYCHOLOGICAL THERAPIES 12 MONTHLY REPORT

Dr Liz Flynn joined the meeting to present the Psychological Therapy Service Annual Report from the period January until December 2023. This report highlighted data regarding the core activities of the Psychology Department, key performance indicators, quality assurance and improvement activity, as well as performance objectives for the following year.

Dr Flynn provided an overview of the report and highlighted, in particular, the improved staffing position and benefits from this although vacancies remained; and the National Psychology Specification which was launched by Scottish Government in 2023 and was a document for patients describing what they could expect to receive following referral to psychological therapies. Lastly, she highlighted that from April 2024, psychological therapies waiting times would be reported on to Scottish Government.

Mr McConnell thanked Dr Flynn for the very useful report and referred to page three, Table 3 Clinical Sessions delivered. The table detailed the number of sessions delivered by psychological therapies staff with years 2018-2022 for comparison. There was a 27% increase in clinical sessions delivered in the past year compared with 2022. This was noted to be a positive step particularly given that the pressures experienced in staff resourcing during this period. A similar increase next year would see the clinical contacts return to pre-pandemic levels. In response to a question from Mr McConnell on the increased positivity, Dr Flynn advised that following recruitment, the department had significantly more staff than the previous year.

Mr McConnell also commented on page eight, Section 5, Performance against Key Performance Indicators, where it was reported that over the review period the service had difficulty achieving the set target due to vacancies and absences within the team. This resulted in one of the planned groups being delayed. However, having reviewed the data, only three patients did not receive any psychological therapy in the reporting year. One of these patients was unable to participate in any structured therapeutic work and the two others, who were admitted during the last quarter, had since commenced psychological work. Dr Flynn advised the dip in figures in the last quarter of the year was due to the vacancies and depleted capacity. Two new members of staff were noted to be

in post from November 2023 and January 2024. During the reduction in staffing levels, focus remained on completion of Risk Assessments and attendance at Care Programme Approach meetings.

Mr Moore welcomed the report and was pleased to see that three members of staff returned to work within the organisation albeit in different roles, this was positive for the organisation as a whole when staff return. He also commented on the reference to the clinical model and anxieties around disruption to therapeutic relationships and queried if this remained a persisting concern or whether it had been resolved. Dr Flynn advised that anxieties were managed given the long transition period, and that therapeutic relationships were ongoing. It was recognised that there was disruption to therapeutic relationships at a time of significant change i.e. the new clinical model, which was felt to be important to stabilise. The department had also supported an away day for staff, which had been very positive.

In terms of the governance of treatment programmes, Professor Thomson advised there was a large piece of work on the forensic psychological matrix on the horizon. This matrix consists of the programmes that were adopted across Scotland, and NHS Education Scotland (NES) is currently carrying out a literature review on the overall psychological matrix.

Dr Flynn advised that the matrix was now an online resource, which NES developed, and provided the evidence base for the psychological therapies which the State Hospital delivers. She emphasized the importance of ensuring that the psychological therapies provided to patients actually achieved what was aimed at and expected, and that the matrix website provided all evidence, which was then evaluated against the programmes and different types of specialties. She highlighted that one of the issues for forensic psychiatry was that there was not a huge evidence base for the therapies which the hospital delivered, therefore the intention was to draw evidence from other areas such as the Adult Mental Health literature, then create adaptations as required. It was expected that following review, the evidence for forensic tables would look different in future. Lastly, Dr Flynn advised that one member of staff was currently on secondment to NES as the Forensic Principal Educator, which helped build links with NES.

Mr Currie commented on the current level of work provided which was similar to the level provided pre pandemic and questioned how this related to the current staffing levels given they were under establishment, and whether these levels were sustainable. He also made reference to the Supplementary Staffing Register monitored by the working group, whereby staff were listed, should they wish to return and work within the organisation. Dr Flynn recognised the possibility that staff may wish to leave working within the healthcare setting and move to a private setting, which was a concern for moving forward, though was heartened to see staff return, who were previously in employment at the State Hospital. In terms of the work carried out with the current workforce establishment, she advised that the focus on external work had decreased due to this, though it was hoped to increase with additional capacity going forward.

Following these comments, Ms McCaffrey made recognition, and gave credit to Dr Flynn, for her exceptional impact to the organisation in terms of impact on service delivery, leadership and direction. In terms of the review process, she advised she was keen to reinforce and highlight that processes across all departments under the Nursing and Operations Directorate would be continually and routinely monitored for improvement.

Professor Thomson took the opportunity to emphasize the extremely positive work of the department, as was detailed in the report.

Ms Fallon thanked Dr Flynn for the thorough report and acknowledged the extensive services offered throughout the year.

<u>The Committee:</u>

1. Noted the Psychological Therapies Annual Report.
2. Recorded their thanks to Dr Flynn and her team.

10a NURSE RESOURCING REPORT QUARTER THREE 2023-24

Members received and noted the Nurse Resource Report for Quarter 3 of 2023/24. The report provided an update to the Committee on the impact of nursing staffing levels on the provision of clinical care and any actions taken during this period. Members acknowledged that wider aspects of workforce governance were now monitored and reported through the Workforce Governance Group and the Staff Governance Committee. Ms McCaffrey provided a brief summary of the report and acknowledged the risk associated with safe staffing i.e. ND70 – Failure to utilise our staffing resources to optimise excellent patient care and experience. She further gave updates in areas such as Day Time Confinement, Resource Management, Clinical Resourcing, Resource Incidents, Activity, Nursing Recruitment and Health Care Staffing Act.

In terms of context, Mr McConnell queried the resource incidents on page two, detailed as 561, and what the highest related reason for this was. Ms McCaffrey advised that whilst there had been a number of measures undertaken which had successfully reduced incidents, the benefit of other factors such as the recruitment of staff who were not yet in post, had not filtered through. In addition to this, there had also been periods of increased activity. Ms McCaffrey emphasized the decrease in number of incidents (869) from the previous quarter.

Looking forward, Mr Moore referred to the Terms and Conditions changes linked to the pay settlement, 36-hour week, Band 5 posts and protected learning, and questioned if there was any update in these areas given this would affect resources going forward. Ms McCaffrey advised that scoping work was carried out with the Employee Director and Executive Directors, to understand potential impacts within each directorate. Mr Jenkins further advised that all Boards had carried out scoping work in this area and a series of meetings had been held to discuss any potential impacts. He acknowledged this area of work was live and active and expected to hear further information over the next two-month period. Lastly, he advised that discussion also took place at the Corporate Management Team where it was agreed that an indicative report would be presented and reviewed over the next month.

The Committee:

1. Noted the Nurse Resourcing Report for Quarter 3 of 2023 – 2024.

10b DAY TIME CONFINEMENT REPORT

Members received and noted the report, which outlined the current Daytime Confinement (DTC) position within the State Hospital and the work underway to discontinue its use by January 2024. Ms McCaffrey provided an overview of the report; particularly the four key work stream aspects identified i.e. Boarding Out, Understanding Fully the Extent of the Use of DTC, Implement Tailored Approaches to Risk Assessment and Management, and Culture. She highlighted progress made to date and that the hospital was sitting within a positive position around DTC. She advised that the working group had been extended until March 2024. Ms McCaffrey commented that given the group would be disbanded in the near future, a paper would be presented to the Committee in May 2024 in terms of closure.

Action: Karen McCaffrey

Ms Fallon commented on the extensive work carried out in this area and thanked Ms McCaffrey for her report.

The Committee:

1. Noted the Daytime Confinement Report.

11 PERSON CENTRED IMPROVEMENT SERVICE 12 MONTHLY REPORT

Members received and noted the Person Centred Improvement Team Annual Report for the period November 2022 to October 2023. Ms Jacqueline Garrity joined the meeting and provided a summary of the content detailed within the report.

Mr Moore requested additional information around recruitment of frontline staff through Patient Partnership Group engagement. Ms Garrity advised that this cohort of patients provided feedback and questions to the recruitment process around core values and patient activity. She added that patients had also recently been involved in recruitment within the Patients Advocacy Service.

Ms Fallon commented on the extensive list of activity progressed with over the previous 12 month period. She added that the Committee looked forward to receiving updates on the Carers Strategy in August 2024, which was a change in reporting from May as per the workplan. Secretariat agreed to update the workplan in this respect.

Action: Secretariat *(completed)*

The Committee:

1. Noted the Person Centred Improvement Service Annual Report.

12 LEARNING FROM FEEDBACK REPORT

Members received and noted the Learning from Feedback Quarterly Report, which provided the Committee with an overview of activity related to feedback for the third quarter of the financial year i.e. 1 October to 31 December 2023). Ms Garrity provided members with a brief summary of the report and highlighted the following areas in terms of feedback shared relating to concerns and a number of themes identified:

- Compliments regarding Theme Nights, being able to bring in lunch for visits, the value of having extended visits and being able to engage in meaningful activity during visits
- Confusion regarding Room 4 U (R4U) and DTC
- Inconsistencies with hot drinks served on ward
- Patient views that they were not adequately informed or prepared for the introduction of hub activity
- Visiting arrangements - time allocated and not being able to hand over gifts during the festive period

Mr Currie emphasised the importance of feedback received, whether it be good, bad or indifferent, and the overall appreciation from the Patient Partnership Group on staff attempts to try and resolve any concerns or feedback raised, as he felt this helped with building confidence, credibility and meeting patient needs, or at least detailed the efforts made to attempt to resolve matters.

The Chair welcomed the overall update on effective feedback in terms of ensuring that patient and/ or carer experience informed service delivery and took assurance in this regard.

The Committee:

1. Noted the Learning from Feedback Report, pertaining to Quarter 3, and its relevance, in terms of ensuring that patient and/or carer experience informed service delivery.

13 LEARNING FROM COMPLAINTS REPORT

Members received and noted the Learning from Complaints report presented by Ms Smith. The report provided an overview of activity of complaints, concerns and enquiries for the third quarter of the financial year 2023/24. The report also detailed the complaints received, the stages at which they were handled, as well as complaints closed within this period.

Ms Smith provided an overall summary of the report and Members acknowledged that from Quarter 2 a change to the clinical model required the reporting to change from Hubs to Services. Most complaints were received within the Intellectual Disability Service, and it should be noted that multiple complaints were received from the same complainants. Further, consideration of the outcomes was provided in detail within section 5 of the report.

Mr Currie welcomed the report and reiterated his point as mentioned above in respect of credibility of feedback and the aspects of reasons why people make complaints. He also referred to the linkage to and from the Patient Partnership Group and flow of information, with patient confidence in the complaints process route as a whole. He questioned in line with the nursing recruitment process and inductions, how the issue around complaints was introduced and built in to this induction process in terms of learning from complaints, how the hospital positively handle complaints and how the Board discussed these in detail.

Ms Smith advised that raising awareness of types of complaints and the Complaints process itself was always part of the induction process though this was a generalised approach. She advised that going forward the intention would be to hold staff engagement sessions with small individual groups of nursing staff to work on understanding the process. In addition, Ms McCaffrey advised she routinely met with all new members of nursing staff who were inducted in the organisation where part of the conversation included linking the values of the organisation and the importance of the complaints process.

The Chair commended Ms Smith and the Complaints and Legal Claims Officer on their very comprehensive report and thanked them for the extensive work carried out by the department.

<u>The Committee:</u>

1. Noted the Learning from Complaints Report, pertaining to Quarter 3 and its relevance, in terms of ensuring areas of improvement and learning taken.

14 TRAUMA CHAMPION REPORT

Members received and noted the update report on overview of the Trauma Champion role within the State Hospital. Ms Dunlop joined the meeting and provided an overall summary of the report and advised that the key purpose of the role was to support the local Trauma Implementation Coordinator, with helping to develop a Trauma Informed Response Service within the State Hospital.

Mr McConnell thanked Ms Dunlop for the report and noted the interesting initiatives going forward. He commented on the numbers within Section 3 ‘supporting capacity building’ whereby it reported that 54 staff had attended ‘Trauma Informed Practice’ Level 1 training, and 45 staff had attended ‘Trauma Skilled Practice’ Level 2 training. He queried if the 45 was a subset of the 54, or was the total 99. Ms Dunlop advised the numbers were separate given the two levels of training within the framework and there was national guidance on which training staff should attend. She further advised that level one training was for non-clinical staff and level two training was for frontline facing clinical staff.

Ms Fallon thanked Ms Dunlop for her report and advised she would share discussions with the Chair of Staff Governance Committee given the relevance across both Committees.

The Committee:

1. Noted the Trauma Champion Report.

15 DISCUSSION ITEM – PATIENT ACTIVITY

a) Activity Oversight Group 12 Monthly Report

Members received and noted the Activity Oversight Annual Report which provided an overview of the work of the Activity Oversight Group (AOG) for the period from 14 September 2022 until 30 September 2023. Ms McCaffrey provided an overview of the report and of the opportunities for improvement identified through quality improvement methodology. Members noted the extensive planned quality assurance / quality improvement for the coming year as noted within the report and supported the future areas of work identified.

Professor Thomson highlighted that the AOG was clear in its role, measurements and link to the four service leadership teams and the Skye Centre. Focus for the upcoming year would be to review meaningful activities for patients and to raise the level of activity.

Ms Fallon thanked Ms McCaffrey for the comprehensive report and the collaborative efforts between the Physical Health Steering Group, Patient Partnership Group and Clinical Model Oversight Group.

The Committee:

1. Noted the Activity Oversight Group Annual Report.

16 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

The Committee discussed areas of good practice and areas of concern from today's meeting and suggested the following:

Areas of good practice;

- Chair advised she would write to the Catering Team on behalf of the Committee to thank them for their extensive work and efforts as was detailed within the Learning from Feedback Report.
- Mr Currie suggested that feedback be provided to the Corporate Services Complaints Team and the Patient Partnership Group around positive working practices and confidence built between the two links and the complaints process itself.
- Ms McCaffrey suggested recognition be made of the Clinical Quality Department and eHealth Department around the efforts in pulling together information and the extensive background work involved with producing Flash Reports and Tableau Dashboards.

Ms Fallon commented on previous discussion around including the agreed areas of good practice within a Staff Bulletin. Professor Thomson suggested that if an item was felt relevant to be included within the bulletin then this would be taken forward and reflected at that time.

Mr Moore suggested and advised that discussions recently took place around how Non-Executive Directors would attempt to explain their roles within the organisation and the roles of Chair. He suggested this be taken forward in terms of profiling the role of the Board and its standing Committees.

The Committee:

1. Noted the update on Areas of Good Practice / Areas of Concern.

17 COMMITTEE WORKPLAN

Members received and noted the Committee Work plan for 2024/25.

The following suggestions were made and agreed:

- Clinical Model to be removed from standing item section given that it was due to be reported to the Board in April and October 2024;
- Carers Strategy item deferred to August given that it would be reported to the Board meeting in October 2024;
- Update on Daytime Confinement would be presented at the May 2024 meeting;
- Brief Physical Health Update on important areas would be presented in November 2024;
- Change of narrative from Health and Care Staffing Report to Nursing Resource Report;
- Change of title from Person Centred Improvement Service update to Person Centred Improvement Group update;
- Addition of Activity Oversight Group Annual Report in February 2025;
- Removal of the Clinical Quality Audits Report from May 2024 given that it would be reported to the Clinical Governance Group (GCG) and update was provided within the CGG Annual Report.

Action: Secretariat (completed)

The Committee:

1. Noted and approved the Clinical Governance Committee Workplan following the updates required as detailed above.

18 ANY ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTIEES

Ms Fallon agreed to appraise the Chair of the Staff Governance Committee around today's discussions on the 36-hour working week, Trauma Champion role, update on Complaints Report and of the positive steps made in relation to patient care given daytime confinement work.

19 AGREEMENT OF ITEM FOR DISCUSSION AT NEXT MEETING

Professor Thomson suggested that an update on the Clinical Model evaluation be presented in August 2024. Other suggestions for May discussion items made were:

- Clinical Care Policy
- Seclusion Observations update
- Realistic Medicines update
- Financial budget in relation to changes to Clinical Care Practice and risk resourcing staffing consequences
- Barron Review update

The position of the above listed items would be reviewed nearer the May meeting to confirm which was best progressed, to ensure a meaningful discussion. Secretariat agreed to update the rolling action list to ensure this was addressed in March and take an active decision then.

Action: Secretariat

20 ANY OTHER BUSINESS

Members raised no other items of other business.

21 DATE OF NEXT MEETING

The next meeting would be held on Thursday 23 May 2024 at 0930 hours via Microsoft Teams.

The meeting concluded at 1230 hours

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item No: 15
Title of Report:	Clinical Governance Committee – Highlight Report
Purpose of Report:	For Noting

This report provides the Board with an update on the key points arising from the Clinical Governance Committee meeting that took place on 23 May 2024.

1	Corporate Risk Register / Risk Reporting	The Committee reviewed the clinical risks within the Corporate Risk Register, and confirmed these to be an accurate statement of risk. The Committee also received an update on progress of a Serious Adverse Event Review related to a medication incident, which was delayed because of the difficulty of concluding witness evidence due to staff absence.
2	Supporting Healthy Choices	The Committee received an update on this programme, particularly on a pilot for patients on admission to the State Hospital (TSH) aiming to prevent weight gain.
3	Medicines Committee/ Pharmacy Service	The Committee received reporting on the activity of the Medicines Committee as well as delivery of pharmacy services. This was a very positive report with all targets being met, save for full benefits realisation of HEPMA i.e. electronic prescribing. This was being progressed for improvement through NHS Lothian, given the Service Level Agreement in place.
4	Clinical Governance Annual Report	The Committee reviewed its own activity throughout 2023/24, with reporting demonstrating the range of work and assurances provided throughout this period. Members were content to approve this report, that it could be submitted to the Audit and Risk Committee, and to the Board as part of end of year reporting.
5	Patient Learning Annual Report	This report provided assurance to the Committee, showing an increase in patient learning activity during this time, as well as describing the achievements that patients had made. It was noted that the aim was to return to pre-covid levels of activity, and that there was dedicated focus on ensuring that patients were supported to attend sessions within the Skye Centre, even during periods of pressure on staffing resourcing.

6	Infection Prevention and Control Annual Report	Reporting provided an overview of all activity throughout the year, and a year on moving to business as usual practice following the covid pandemic. The hospital was in a positive place in relation to reported standards, and it was also noted that efforts are made to encourage uptake of vaccinations offered within patient and staff groups. The Committee noted that the IPC Lead was moving to a promoted post and thanked her for her service. Recruitment was underway for this position within TSH.
7	Incident Reporting and Patient restrictions	The Committee received quarterly reporting on the types and numbers of incidents, including RIDDOR reporting and serious adverse events, and patient restrictions during this period. This report also included data for the full year 2023/24. There was an increase in incidents/ activation of personal attack alarms (PAA) related to clinical acuity.
8	Patient Movements	Reporting provided an overview of patient movements, on a statistical basis. It was noted that TSH remained closed to exceptional circumstance admissions. As reporting on bed capacity is received at both the Board and the Committee, it would be reviewed to ensure the right assurances were being provided as well as constancy of reporting.
9	Nurse Resourcing	The Committee noted the position on nurse staffing with an improvement overall. There was active recruitment ongoing for both registered and non-registered staff, and a continued focus on improving sickness absence rates. Further that an increased use of the supplementary staffing register was helping to resource delivery of services. TSH was also in a positive place with the Health and Care Staffing Act coming into effect as of 1 April 2024. The Committee commended the work progressed in this area.
10	Daytime Confinement Update	The Committee received an update which confirmed that this workstream was in the stage of being finalised, with a planned move to business as usual. There was a link to the Activity Oversight Group, and that the improved position on staff resourcing should support the delivery of patient activity. It was noted that CMT would take oversight of bringing this workstream back into business as usual, and that the Clinical Governance Group would retain focus on this area going forward, and would horizon scan for any area of risk.
11	Learning from feedback	Reporting highlighted positive patient feedback relating to festive events, food and sporting activities. There had been concern about the wander paths in the hospital, and when these would be fixed so that they could be used. There was also discussion on the way in which patients interact with the Patient Partnership Group and take responsibility to feedback to their own ward areas. The Committee noted the improvements in patient engagement in the past 12 months. It was also noted that improvement in staff resourcing should help support family visits.

12	Learning from complaints	The Committee received reporting on the complaints received and closed within the last quarter of 2023/24. This showed an increase in complaints activity, as well as in wider enquiries. The Committee discussed the background to this relating, and the steps put in place to take learning. It was also noted that a recent audit focused on quality improvement actions, had resulted in a rating of substantial assurance. The Committee received assurance that the way that complaints training was delivered as part of staff inductions had been reviewed so that it was linked to promoting NHS Values and Behaviours. The Committee thanked the complaints team for their diligent work.
13	New Clinical Care Policy	The Associate Nurse Director delivered a presentation on the new Clinical Care Policy which went live on 1 May 2024. This included how the policy would be delivered within, and links to the Mental Welfare Commission for patients who required enhanced care. The Committee took assurance on this new way of working, and that it represented an individualised approach to patient care. The update was received very positively, as a good step forward.
14	Areas of good practice/concerns	The Committee noted good practice in three areas: safe use of medicines, continued support for patient learning once patient moved on from TSH, and linkage of complaints to NHS Values and Behaviours within staff induction days.

RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP / Corporate Objectives	As part of corporate governance arrangements, to ensure committee business is reported timeously to the Board.
Workforce Implications	None
Financial Implications	None
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board requested, pending approval of formal minutes
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
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 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:	20 June 2024
Agenda Reference:	Item No: 16
Sponsoring Director:	Staff Governance Chair
Author:	Director of Workforce
Title of Report:	Staff Governance Annual Report – 2023/24
Purpose of Report:	For Decision

1 SITUATION

The attached Staff Governance Annual Report outlines the workplan overseen by the committee during 2023/24.

2 BACKGROUND

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

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

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

3 ASSESSMENT

In the performance year 2023/24, The State Hospitals Board for Scotland's Staff Governance Committee continued to focus its monitoring activities in respect of the above. The Committee members recognised their obligations to support a culture within The State Hospitals Board for Scotland where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the organisation and is built upon the principles of partnership.

The Staff Governance Committee reviewed and approved this report at its meeting on 16 May 2024.

4 RECOMMENDATION

Board Members are asked to approve the Staff Governance Committee Annual Report, as demonstrating that the committee has met its remit and terms of reference during 2023/24.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Reporting to demonstrate that committee has met its remit
Workforce Implications	No specific proposal to consider
Financial Implications	None Identified
Route To Board Which groups were involved in contributing to the paper and recommendations.	Staff Governance Committee Audit Committee
Risk Assessment (Outline any significant risks and associated mitigation)	Not required for reporting
Assessment of Impact on Stakeholder Experience	Not required for reporting
Equality Impact Assessment	Not required for reporting
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No impact 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

STAFF GOVERNANCE ANNUAL REPORT

1 April 2023 – 31 March 2024

1. Introduction

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

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

In the performance year 2023/24, The State Hospitals Board for Scotland's Staff Governance Committee continued to focus its monitoring activities in respect of the above. The Committee members recognised their obligations to support a culture within The State Hospitals Board for Scotland where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the organisation and is built upon the principles of partnership. Members of the Staff Governance Committee are appointed annually by the NHS Board. Membership details of the Committee during 2023/24 are detailed below.

2. Committee Chair, Committee Members and Attendees

Committee Chair:
Pam Radage (Chair of Committee, Non Executive Director)

Committee Members:
Allan Connor (Employee Director)
Stuart Currie (Non-Executive Director)
Cathy Fallon (Non-Executive Director)
Shalinay Raghavan (Non-Executive Director)

In attendance:
Alan Blackwood (lay member, Prison Office Association)
Chelsea Burnside (lay member, BAOT)
Josephine Clark (Associate Director of Nursing)
Gary Jenkins (Chief Executive)
Anthony McFarlane (lay member, UNISON)
Garry McKendrick (lay member, Prison Office Association)
Michelle McKinlay (lay member, UNISON)
Monica Merson (Head of Planning and Performance)
Brian Moore (Board Chair)
Laura Nisbet (Head of HR)
Margaret Smith (Head of Corporate Governance/Board Secretary)
Stephen Wallace (Director of Workforce)

Where required by the Chair or by other members of the Committee, appropriate members of staff were invited to be in attendance for the purposes of verbal updates, information sharing and presentations.

3. Meetings 1 April 2023 – 31 March 2024

During 2023/24 the Staff Governance Committee met on four occasions, in line with its terms of reference (Appendix 1). Meetings were held on:

18 May 2023
17 August 2023
16 November 2023
15 February 2024

Attendance of Committee members were as follows:

	Number of Meetings Present
Pam Radage	4
Allan Connor	2
Stuart Currie	4
Cathy Fallon	4
Shalinay Raghavan	3

4. Summary of Reporting

The Committee received reports and monitored areas as follows:

- Monitoring of Personal Development Planning & Review (PDPR) performance
- Monitoring of Attendance Management performance
- Attendance Management Task and Finish Group
- Monitoring HR Performance – Employee Relations Activity
- iMatter
- Healthy Working Lives (HWL)
- Workforce Planning
- Whistleblowing
- Statutory and Mandatory Training Compliance
- Corporate Training Plan
- Fitness to Practice
- Recruitment
- NHSScotland Staff Governance Standard Monitoring Framework
- OD, Learning and Wellbeing
- Occupational Health
- Safe staffing Implementation
- eRostering Implementation
- Corporate Risk Register – Staff Governance Risks
- Internal Audit Payroll
- On Boarding survey results
- NHS Education for Scotland Deanery Quality Management Visit
- Formal Dismissal Appeal Hearing Guidance

4.1 ANNUAL REPORTS

Staff Governance Monitoring 2022/23

Staff Governance Monitoring return for 2022/2023 was sent to the Scottish Government by the deadline date of 4 December 2023. This was approved by Staff Governance at their meeting on 16 November 2023.

iMatter

Members of the committee received an update on 16 November 2023 meeting and received the iMatter 2023 National Report at the February 2024 meeting.

Occupational Health Service Annual Report

The annual report was presented to the 17 August 2023 meeting by the Specialist Practitioner in Occupational Health from NHS Dumfries and Galloway. In April 2023 the Board awarded the new SLA for Occupational Health to NHS D&G. The report presented reflected critical findings, objectives, performance and challenges to date. Due to the SLA being in place for 5 months at time of reporting, the report included their SWOT analysis, initial focus, the current priorities and the future opportunities. A 6-month update was presented in February 2024, to give the committee further assurance regarding the implementation of the new contract. This included a review of the early intervention service.

4.2 PROGRESS UPDATES

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

- **Personal Development Planning & Review (PDPR)**

Quarterly updates on Personal Development Planning & Review (PDPR) completion rates were reported to the Staff Governance Committee to provide assure that all staff have an annual review in accordance with the standards set out in the PDPR national PIN policy. The average monthly compliance rate for 2023/24 was 85.9% - an increase of 2.4% when compared to the previous year. Compliance trends highlighted incremental improvements throughout the year and the compliance level at 31 March 2023 was 91.5%.

- **Attendance Management/Task and Finish Group**

Due to consistently high sickness absence rates, the Staff Governance Committee requested that a Task & Finish Group be established to develop an action plan to reduce the absence rate to 5% organisationally.

The group was initially chaired by the Workforce Director, terms of reference were agreed and the group was structured in such a way that departments with the highest absence rates were required to attend. A driver diagram was developed to aid action planning and the department representatives were asked to update from their sub groups in each meeting.

From August 2023 there was a continued reduction in sickness absence Board wide, until the winter months when short term absence increased due to seasonal flu and cough colds, flu reasons. However, the committee were satisfied that there continued to be an overall downward trajectory of reduction in long term absence. The committee received regular reports to explain, in detail, the absence pattern and impact of the range of actions being taken within the context of the Task & Finish approach.

- **HR Performance – Employee Relations Activity**

A presentation outlining the organisational learning from employment relations cases was presented to the committee in February 2024. This outlined activity, which showed high compliance with Early Resolution and no identified patterns of specific departments for consideration. The presentation also provided data in relation to timescales and the committee encouraged a KPI of 18 weeks being established for formal cases.

The presentation identified key learning with associated action points which have been identified through formal cases as well as broader themes across the range of cases for consideration.

The committee also endorsed guidance documentation which was produced to support non-executive directors fulfil their responsibilities in accordance with Once for Scotland policy arrangements for appeals against dismissals.

- **Healthy Working Lives / Wellbeing / OD Learning**

The Committee received quarterly reports highlighting the key OD, learning and wellbeing initiatives and interventions being delivered to help maintain a positive, supportive and enabling working environment in line with the Staff Governance Standards and TSH Staff Wellbeing Strategy.

Key achievements in 2023/34 included refresh of the corporate induction, introduction of a new Peer Support etwork, and delivery of a broad range of wellbeing programmes and activities for staff.

- **Occupational Health Contract**

In April 2023, the Board awarded a new SLA for Occupational Health Services (OHS) to NHS Dumfries & Galloway. By agreed reporting arrangements, Dumfries & Galloway Occupational Health and Safety Services (DGOHSS) provided an annual report to the Staff Governance Committee in the summer of 2023 and then a six-monthly update noting areas of progress and continued improvement.

DGOHSS carried out a SWOT Analysis during the transition of OHS from the previous Occupational Health (OH) provider, which outlined areas for attention during the first months of implementation and in February 2024 were able to updated that:

- In the six months since the initial report to the Staff Governance Committee, DGOHSS had increased case management clinics, to meet demand as described above, to accommodate appointment availability for new referrals, subsequent reviews and case reviews.
- The primary focus for DGOHSS remains to encourage staff engagement whilst striving for a positive and professional experience for employees and managers who utilise OH. This emphasis interlinks to TSH's objective to maximise healthy attendance at work in support of the Task & Finish Group. DGOHSS are encouraged by the improvements in scheduled clinic attendance and overall engagement with services.
- Ongoing assessment continues of need and opportunities for staff to attend OH for health assessment, health surveillance and immunisation evaluation and advice. Resulting data on OPAS G2 can now provide individual immunisation reports for employees, and if required, DGOHSS can report on immunisation compliance for key risk areas or groups of staff.
- Health surveillance programmes are in place for workers identified as coming into contact with hazards such as hand-arm vibration, noise or respiratory irritants in their roles to support TSH with legislative compliance.
- An agreed exclusion procedure is now in place, which is aligned with NHS Dumfries & Galloway, giving seamless clarity to OH nurses in the Triage clinic.
- Regardless of the poor engagement by TSH staff with the sickness absence early notification and intervention process, the remaining triage service continues to facilitate weekday open access to OH for staff and managers

- DGOHSS will persist in encouraging feedback to enhance resources to benefit TSH through a continuous improvement approach. Moreover, we will continue to build relationships and working partnerships with TSH stakeholders by sharing professional, impartial advice with employees, managers and HR to ensure robust, evidence-based OH service provision.

4.3 STANDING ITEMS CONSIDERED BY THE COMMITTEE DURING THE YEAR

Fitness to Practise

A report was provided in May 2023 to assure the Staff Governance Committee that all professional staff were registered and fit to practise.

Whistleblowing Quarterly updates

The Committee received quarterly reports on the following dates:

19 May 2023	-	Quarter 4 Update for 2022/23 and Annual Report for 2022-23
17 August 2023	-	Quarter 1 update for 2023
16 November 2023	-	Quarter 2 update for 2023
15 February 2024	-	Quarter 3 report

Statutory and Mandatory Training

The Committee reviewed the arrangements for completing Statutory and Mandatory training in order to ensure that these were robust, compliant with legislative requirements, and supported the Staff Governance Strand of the workforce being “Appropriately trained and developed”.

Notes of Minutes and updates from other meetings

The Committee received and noted minutes/reports from the following:

- Partnership Forum
- Human Resources and Wellbeing Group
- Clinical Governance papers (as appropriate and where related to a Staff Governance issue)
- Workforce Governance Group

5. Areas of Best Practice

Improvement

· Improved reporting giving better evidence for decision-making
· Streamlined reporting highlighting key areas
· Stronger links to Clinical Governance Committee in areas of shared interest
· Improvement in sickness absence especially long term absence
· Improved compliance in PDPR compliance
· New focus and strengthening of Organisational Development

Concern

· Attendance management:
· PDPR compliance across whole organisation

6. Conclusion

The performance year 2023/24 has underlined the continuing need to focus our attention on key Staff Governance issues.

The main priority area in terms of Staff Governance performance management continues to be the pursuit of the Attendance Management target of 5% absence, effective and efficient use of resources in light of financial challenges and issues around Recruitment & Retention. Other key priorities include delivery and evaluation of the Wellbeing Strategy and the development of our Board Wide OD Strategy.

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

I offer my thanks for the continuing support and encouragement of Committee members and also to those members of staff who have worked on the Committee's behalf during 2023/24**.**

Pam Radage
STAFF GOVERNANCE COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Staff Governance Committee

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item No: 17
Sponsoring Director:	Remuneration Committee Chair
Author:	Director of Workforce
Title of Report:	Remuneration Committee Annual Report – 2023/24
Purpose of Report:	For Decision

1 SITUATION

The attached Remuneration Committee Annual Report outlines the workplan overseen by the committee during 2023/24.

2 BACKGROUND

Staff Governance is defined as 'a system of corporate accountability for the fair and effective management of all staff. The State Hospitals Board for Scotland's Remuneration Committee fulfils this remit with particular regard to the performance, pay and terms and conditions of Executive and Senior Managers.

3 ASSESSMENT

In the performance year 2023/24, the Remuneration Committee continued to focus its monitoring activities in respect of the above responsibilities and provided reporting to the National Performance Monitoring Committee in this regard. The committee also considered the award of Consultant Discretionary Points.

The Remuneration Committee reviewed and approved this report at its meeting on 13 June 2024.

4 RECOMMENDATION

The Board is asked asked to approve the Remuneration Committee Annual Report, as demonstrating that the committee has met its remit and terms of reference during 2023/24.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Reporting to demonstrate that committee has met its remit
Workforce Implications	No specific proposal to consider
Financial Implications	None Identified
Route To Board Which groups were involved in contributing to the paper and recommendations.	Remuneration Committee Audit Committee
Risk Assessment (Outline any significant risks and associated mitigation)	Not required for reporting
Assessment of Impact on Stakeholder Experience	Not required for reporting
Equality Impact Assessment	Not required for reporting
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No impact 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

REMUNERATION COMMITTEE ANNUAL REPORT

1 April 2023 – 31 March 2024

1. Introduction

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

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

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

In the performance year 2022/23, The State Hospitals Board for Scotland's Remuneration Committee continued to focus its monitoring activities in respect of the above, with particular regard to the performance, pay and terms and conditions of Executive and Senior Managers.

The NHS Board Vice-Chair remains Chair of the Committee which aligns with practice throughout NHS Scotland. This ensures that the committee chair does not play a role in the Executive and Senior Manager Appraisals process, avoiding potential conflict of interest

2. Committee Chair, Committee Members and Attendees

Committee Chair:
David McConnell (Chair of Committee, Non-Executive Director)

Committee Members:
Allan Connor (Employee Director)
Cathy Fallon (Non-Executive Director)
Brian Moore (Board Chair)
Pam Radage (Non-Executive Director)

In attendance:
Gary Jenkins (Chief Executive)
Linda McGovern (Director of Workforce)
Margaret Smith (Head of Corporate Governance)

3. Meetings 1 April 2023 – 31 March 2024

During 2023/24 the Remuneration Committee met on three occasions, in line with its terms of reference (Appendix 1).

Meetings were held on:

- 8 June 2023
- 17 October 2023
- 14 February 2024

Attendance of Committee members were as follows:

	Number of Meetings Present
David McConnell	3
Allan Connor	2
Cathy Fallon	2
Brian Moore	3
Pam Radage	2

4. Summary of Reporting

The Committee received reports and monitored areas as follows:

- Approval of the Performance Management arrangements and Performance Appraisals for Executive Directors for the performance year 2022-23.
- Agreement that the Appraisal outcomes for Executive Directors be submitted to the National Performance Management Committee.
- Agreement of the Executive Directors Performance Planning and Review (Objectives) for the year 2023/24.
- Agreement of the Executive Directors Mid-Year Reviews for 2023/24
- Consultants discretionary points were reported on and approved.

The Remuneration Committee also reviewed other issues related to its remit. During this year the committee considered recruitment to Executive and Senior Management positions in the organisation to ensure resilience in the Executive Team.

5. Areas of Best Practice

Improvement:

Greater Clarity and consistency of objectives set across the full Board.
Working towards greater clarity on the basis of committee decisions

Concern:

Greater control on the management of the Appraisal process to ensure all relevant paperwork is completed timeously.

6. Conclusion

The Remuneration Committee discharged its responsibilities with regard to the oversight of Executive and Senior Managers' performance management and remuneration.

I offer my thanks for the continuing support and encouragement of Committee members and also to those members of staff who have worked on the Committee's behalf during 2023/24**.**

David McConnell
REMUNERATION COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Audit and Risk Governance Committee

Paper No: 24/49

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item No: 18
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Workforce Plan 2022-25 (Annual Review)
Purpose of Report:	For Decision

1 SITUATION

This paper provides an update on the National Workforce Planning expectations for The State Hospital described in DL(2022)09. The Workforce Plan 2022-25 was developed in line with this guidance.

A letter followed from this dated 5 May 2023, emailed to Boards on 31 May 2023, which detailed that the Workforce Plan update should be provided as part of the Board's Annual Delivery Plan.

2 BACKGROUND

On 1st April 2022, Health Boards and HSCPs were issued with guidance from Scottish Government relating to the development of Three-Year Workforce Plans which reflect the National Health and Social Care Workforce Strategy. The guidance constituted the first iteration of new medium term workforce planning guidance for health and social care, with the express intention of improving the strategic alignment between workforce, financial and service planning. It further requested that the Plan be reviewed and updated by 31 October 2023.

Thereafter, information was received by Board Planning Leads which indicated that the update from the Workforce Plan 2022-25 should form part of the ADP. The letter was later received by HR / Workforce Directors on 31 May 2023.

3 ASSESSMENT

The Workforce Plan details the five pillars of workforce planning outlined in the National Workforce Strategy. TSH strives to be an exemplar employer; therefore, the development of a supportive culture that puts staff needs and wellbeing central to delivery is essential. This is currently reflected in the Staff & Volunteer Wellbeing Strategy and Action Plan and will be developed further in the Organisational Development Strategy. The Workforce Plan will remain under review and updated in line with nationally led changes to terms and conditions such as the implementation of the 36 hour working week, protected learning time, and the review of Band 5 nursing profiles.

An update of the Workforce Plan has been included in the ADP 2024/25. The update is as follows:

As detailed previously, TSH Workforce TSH Workforce Plan for the period 2022 – 2025 details the Five Pillars of Workforce Planning outlined within the National Workforce Strategy, these are:

1) Plan
2) Attract
3) Train
4) Employ
5) Nurture

The National Strategy details that these should be the basis for action to secure sufficient workforce to meet both short term recovery and medium term growth and transformation in our services and workforce. Therefore, detailed below is progress towards actions achieved in year 2 of the 2023/24 plan within each of the areas.

1) Plan

TSH was an Early Implementer for elements of the Health and Care Staffing Bill and have completed all necessary actions in relation to this and E:Rostering by 31 March 2024 deadline.

The forthcoming year will see the implementation, and embedding of the modules as business as usual, along with the introduction of final modules and the realisation of benefits.

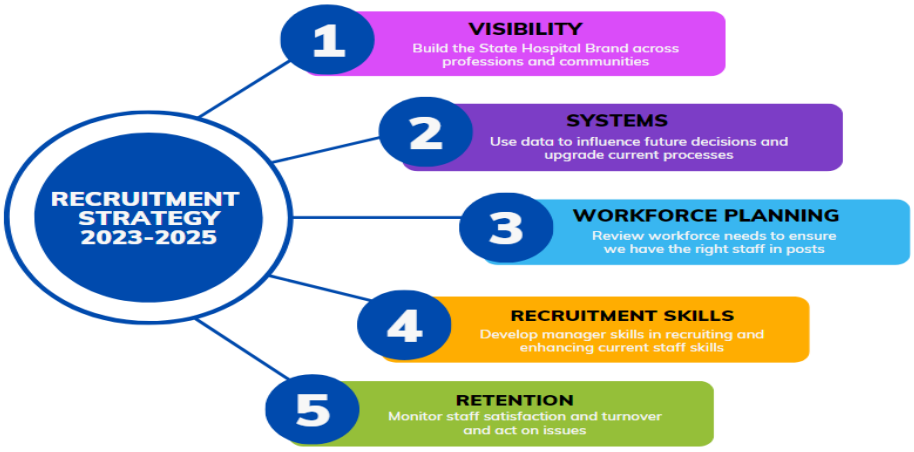
Further refinement to daily operational planning has seen the introduction of a daily resource meeting, along with the development of our Supplementary Staffing Resource, which creates greater opportunity to flex to meet patient needs.

Ongoing review of service needs and requirements across the Board which has seen service structural changes, with a view to reaching an optimum level in provision and resilience.

We have also introduced improved information describing employee demographics, particularly in relation to gender, which have been updated on the organisation's reporting platform Tableau where managers can access reports for their teams to support decisions regarding gender skill mix, evolving trends and future requirements in the workforce.

2) Attract

TSH continue to implement our Recruitment Strategy to meet the organisational objectives of recruiting and retaining an effective and modern workforce. The purpose is to ensure that we recruit the right people, in the right place at the right time. A Short Life Working Group was established to update this Strategy in 2023, with an additional emphasis on retention and marketing TSH as a great place to work. This was approved in June 2023.



In order to develop the organisation's profile, actions to widen the reach for potential new employees have been a significant focus for TSH over 2023-24. TSH has been successful in attracting new staff members through the use of social media and will continue with this approach, together with raising the profile of the work carried out through development of the Board website, attendance. This will continue to be developed and TSH will explore opportunities to widen employment to underrepresented groups. This work links to actions within the TSH Anchors Strategy.

Actions include:

- Attendance at local careers, employability events and national job fayres
- Increased use of social media including twitter and Facebook
- Development of manager's guidance regarding safe and appropriate use of apprenticeships (including the appointment of a Medical Secretary Modern Apprenticeship).

Progress was made in 2023/24 with the development of an on boarding survey, seeking feedback and learning from new staff at 3,6,12 months from commencement of employment.

A review and refresh of the corporate induction programme has been undertaken to ensure that all new employees complete a robust induction process, and are provided with relevant training, information and support when they commence in post. Non-executive Directors also now attend the staff induction sessions to support connection of new staff to TSH Board.

As part of the induction refresh project, a new Welcome Handbook was produced and is now issued alongside the employment contract to all new staff. A new 'Core Induction' online learning module was also introduced in July 2023 and, to-date, feedback from new staff completing the module has been very positive.

Inductions have been held face to face from September 2023 with positive feedback of this return to original practice post Covid. This will continue in 2024/25 and any trends in data from the on boarding survey can be fed into management groups for actions.

Proactive and regular recruitment has taken place in roles where there is a known turn over. Challenges continue to exist in filling Nursing Band 5 vacancies, which reflects the national picture and TSH have reviewed skill mix of teams to balance potential shortfalls. Projections of known leavers and retirements are considered when recruiting, to ensure that recruitment is efficient and there is minimal impact to patient care.

3) Train

TSH has a strong focus on staff wellbeing, career development, and adhering to staff governance standards to maintain a skilled and motivated workforce that feels valued and is equipped to deliver high quality services and care.

TSH is committed to supporting the training and ongoing development of all staff, and a key component of this plan is the provision of education and learning to help train and develop staff at all stages of their employment.

TSH has maintained high levels of compliance in mandatory and statutory training over 2023/24 and this has been a focus across all Directorates. An annual training plan is developed which supports development across TSH staff.

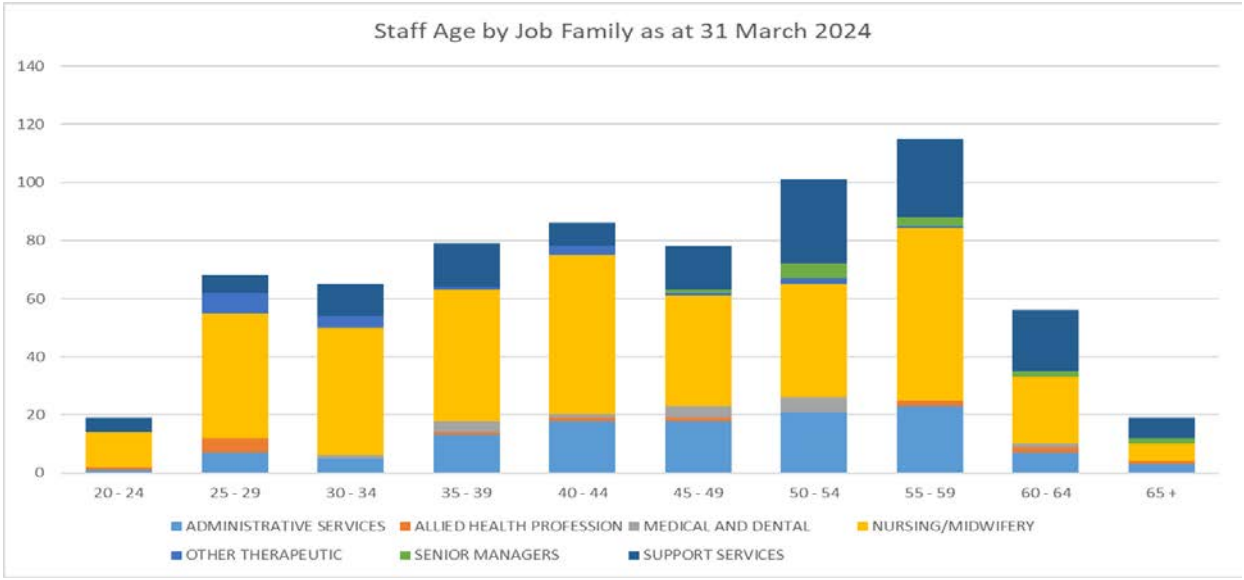
Once for Scotland, phase 2-policy roll out was carried out in 2023 with focused training being available for managers and staff side on consistent use of all policies. Consultation of phase 3 policies will be taken forward in 2024/25.

Plans for staff development 2024/25 include a refresh of our leadership and management development programmes and associated coaching framework to enhance leadership and people management skills and capabilities across all levels of staff. Work is also being progressed to ensure compliance with the requirements set out within PCS(AFC)2024/1 (Protected Learning Time for Agenda for Change Staff in NHS Scotland).

4) Employ

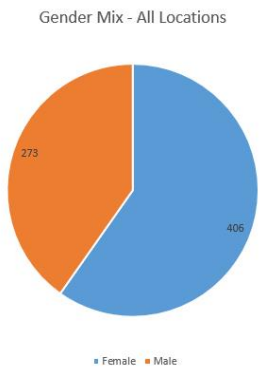
Delivery of high quality care is dependent on recruiting a workforce who are skilled and retaining their skills to ensure we meet patient care needs.

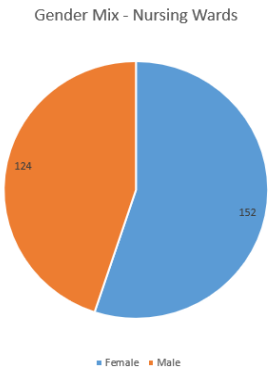
The chart below demonstrates the age range of TSH employees and associated job families.



The age profile remains relatively static from previous years, there has been a slight decrease in the 30-34 range and slight increase in the 55-59 age range.

Gender Mix





In response to the shift in gender balance within the nursing workforce, male targeting recruitment was undertaken in 2023 as part of the regular recruitment to registered positions. This shift in the workforce is represented across all Boards and reflects the national positon of genders entering the profession.

Turnover

Turnover was 10.32% in 22/23 and this has reduced to 7.53% on 23/24 (55 leavers compared to 73 the previous year).

Exit interviews continue to be offered using the QR code facility which encourages uptake (end of 2023 this was 40% which is favourable in comparison to other Boards.

On-boarding surveys were offered to all new employees in 23/24 at 3,6,12 month intervals to understand more about the employee experience in the early stages of employment. The feedback was presented to the Workforce Governance Group and remitted to Organisational Management Team to action plan within Directorates.

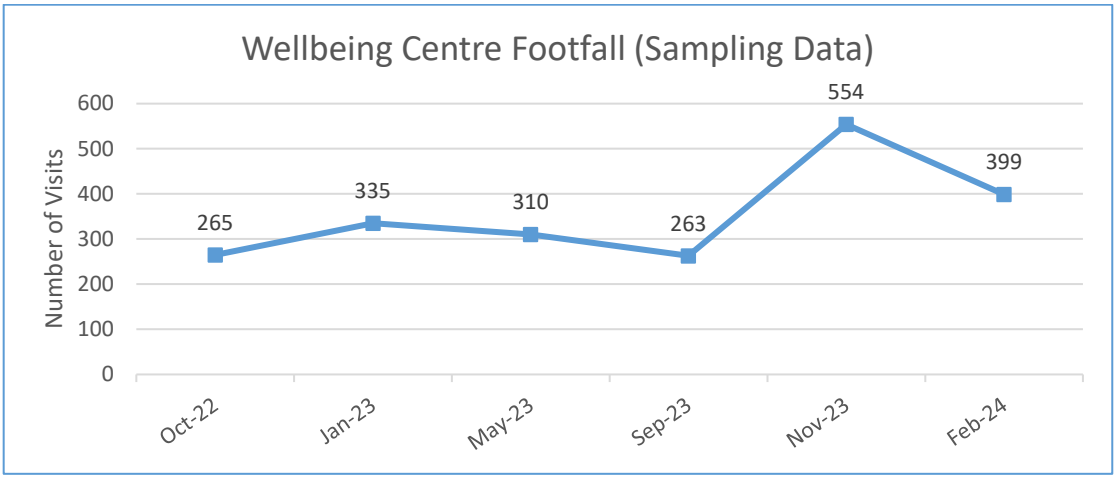
The option remains for Nurses and HCSWs retiring from the service to join the SSR and 29 have taken this opportunity.

5) Nurture

TSH is committed to providing a healthy working environment which promotes and protects the physical and mental wellbeing of its employees. A tiered support model has been adopted based on the principles of Psychological First Aid (i.e. Care, Protect, Comfort, Support, Provide, Connect, and Educate).

Our workforce is the most valuable asset and we aim to ensure that individuals are fully supported in the pivotal roles of maintaining safety and security whilst delivering front line care to patients in sometimes challenging and complex circumstances. A permanent Wellbeing Centre has been in place since October 2020, and a Staff and Volunteer Wellbeing Strategy was approved by the Board in April 2022.

The Wellbeing Centre can be accessed by staff 24/7 and provides a space for staff and volunteers to relax and recuperate, in addition to housing the Staff Care Specialist service (which provides pastoral support to staff) and hosting staff wellbeing activities and events. Data on use of the Wellbeing Centre is obtained through sampling, with footfall monitored and recorded (during standard office hours) for one month within each quarter, and sampling data obtained during 2023/34 indicates that high levels of Centre utilisation by staff are being maintained.



In line with the Wellbeing Strategy, a broad range of wellbeing activities and interventions were delivered during 2023/24. This encompassed the work of the Healthy Working Lives group and included activities to support the eight wellbeing domains highlighted within the Strategy (i.e. mental health, financial, personal growth and development, physical health, environmental, social, spiritual and occupational).

Examples of support offered during 2023/24 include:

- Launch of a Peer Support Network in September 2023 with 26 staff trained to provide direct peer support. Staff are engaging with Peer Supports for support on a broad range of issues and from September 2023 to March 2024 over 80 staff sought support through the Peer Support Network.

- Provision of 'Coffee, Cake & Conversation' outreach sessions across hubs and departments (including evening and weekend sessions) which engaged 347 staff over 27 events.

- Delivery of women and men's health check events, which were attended by 85 staff, plus a range of fitness activity challenges which engaged 47 staff.

- Targeted information sessions and wellbeing events e.g. relaxation and mindfulness sessions, yoga, 'weigh to go' weight management programme, reading and creative writing groups, massage therapy (which engaged 188 staff over 5 events), pre-retirement workshops, credit union information sessions, etc.

- Introduction of the Cycle to Work scheme in May 2023, with 14 staff signing up to the scheme.

- Provision of pastoral support via the Staff Care Specialist service, including information events, signposting, listening spaces, counselling and coaching. During 2023/24 the Staff Care Specialists provided support for 14 referrals.

- Provision of targeted training interventions linked to existing priority work streams. This included trauma informed care (with 21 staff attending Level 1 Trauma Informed Practice training, and 56 staff attending Level 2 Trauma Skilled Practice training) and training specifically aimed at enhancing line manager capability in relation to staff wellbeing and support (with 22 managers attending Coaching Skills for Managers training, and 24 supervisors/managers having attended training on Supporting a Mentally Healthy Workplace)

An evaluation of the Staff and Volunteer Wellbeing Strategy is being undertaken to assess the outputs and impact of the strategy to-date. A mixed-methods approach has been adopted that includes an online survey (which achieved a response rate of 40%), one-to-one interviews to obtain qualitative feedback from stakeholders on the impact of the strategy and associated wellbeing activities, and review of local data and KPIs. The

evaluation data is currently being analysed and will be used to support development of an updated three-year Wellbeing Strategy and Action Plan and to inform priorities for future staff wellbeing interventions.

TSH continues to encourage staff feedback through the annual iMatter survey and to support improvements in staff experience through completion of Action Plans by individual teams. The State Hospital survey response rate in 2023 was 72%, the 5th highest response rate across all NHS Boards. "What Matters to You" was carried out in 2023/24 and will continue to be asked on an annual basis to ascertain what additional supports can be put in place for staff and volunteers.

Work to develop an Organisational Development (OD) Strategy for the State Hospital is also being progressed. Discussions regarding the purpose and aims of OD have taken place with a broad range of stakeholders at all levels of the organisation, and feedback has been sought on what the focus/priorities should be in relation to 'organisational health'. This data will be used alongside other metrics to clarify OD priorities and objectives, and ensure we make the right strategic choices to support staff wellbeing through interventions linked to broader aspects of organisational health.

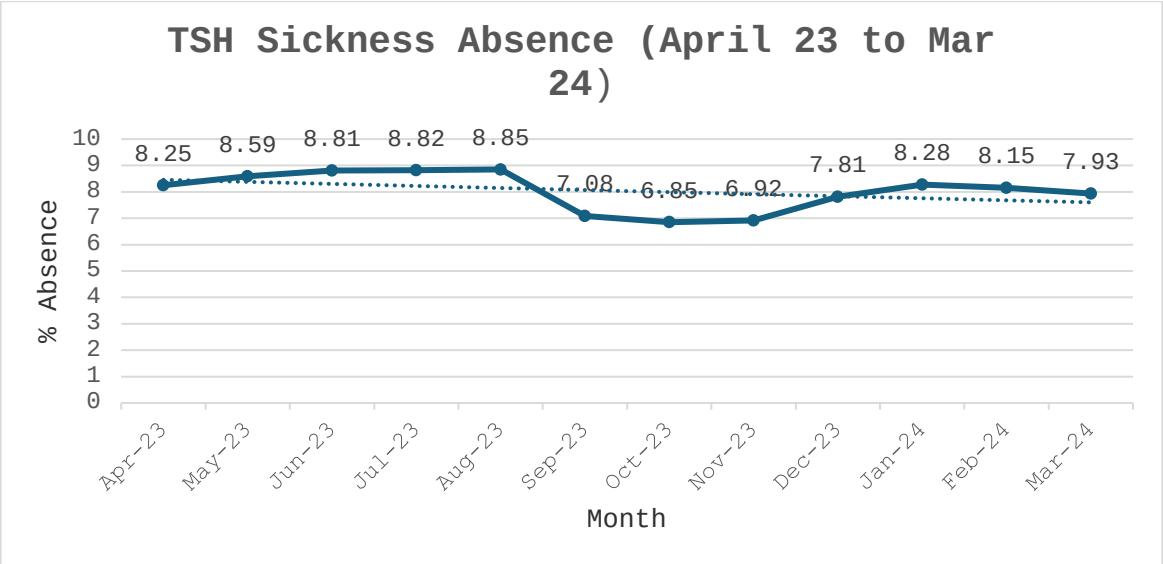
The SPSO (Scottish Public Services Ombudsman) developed a model procedure for handling whistleblowing concerns raised by staff and others delivering NHS services and this was formally published on 1 April 2021. The Independent National Whistleblowing Office (INWO) provides a mechanism for external review of how a Health Board, primary care or independent provider has handled a whistleblowing case. For NHS Scotland staff, these form a 'Once for Scotland' approach to Whistleblowing. As part of the Whistleblowing Standard, a quarterly update is provided to the Board on the current situation with any outstanding Whistleblowing Investigations. An Annual Report is also produced and a copy is also sent to the INWO for their information.

Attendance Management

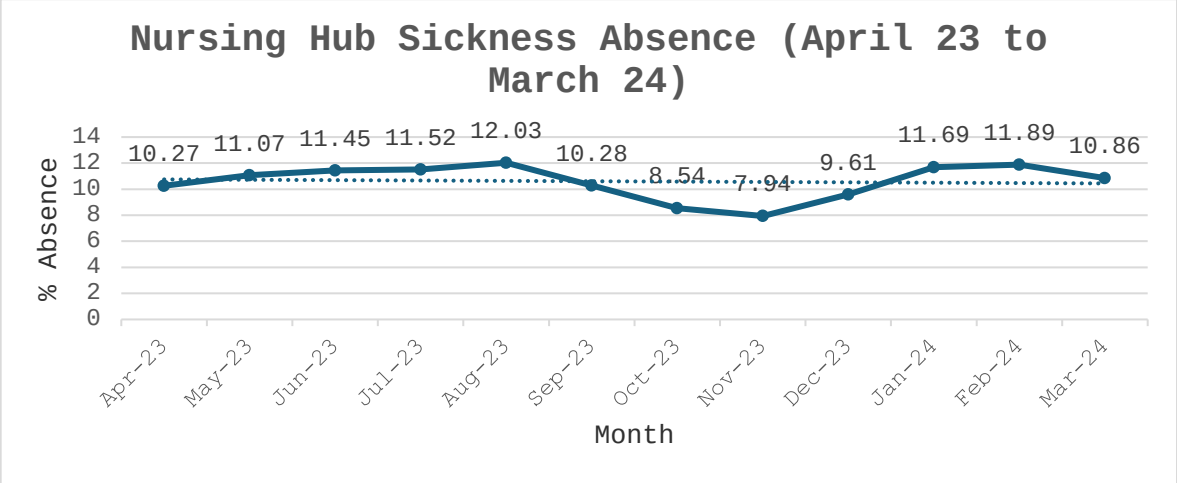
Attendance management continues to be a challenge within TSH in line with NHS Scotland as a whole. The figures below demonstrate a downward trend in the final quarter of 23/24,

Stress, Anxiety and Depression continues to be the most common reason for sickness absence which is reflected in the orgnisation's wellbeing provisions.

Sickness Absence



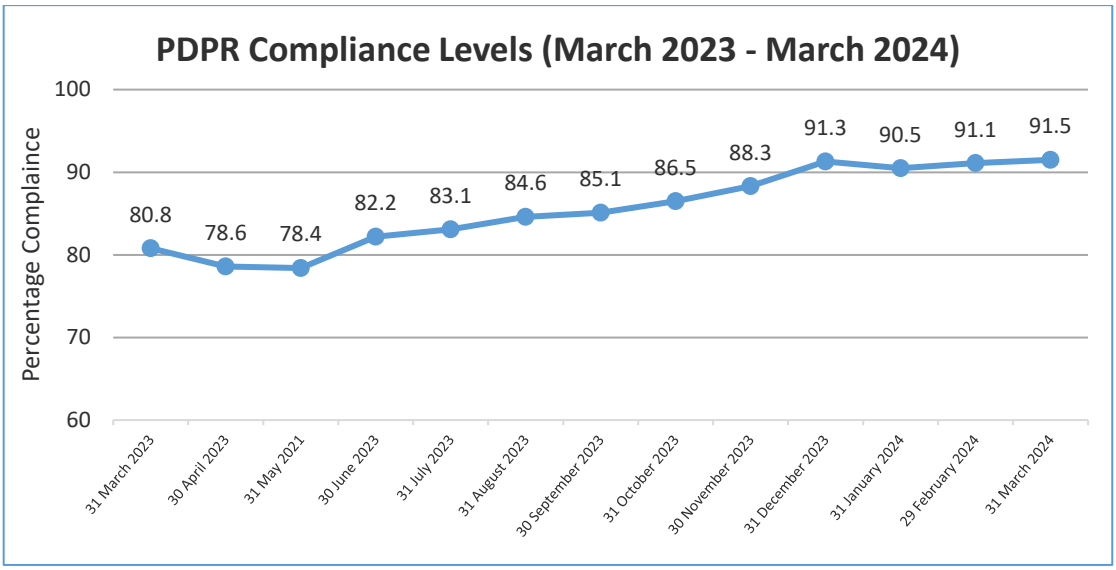
Nursing Staff



Significant work has been undertaken through the absence task and finish group throughout 2023/24 and this will provide the bedrock for the continuation of our business as usual approach, 'Maximising Attendance' moving forward.

PDPR

PDPR has seen significant improvement over the course of 2023/24, increasing to 91.5% at the end of March 2024. This is managed and monitored through the Organisational Management Team and data is provided through the monthly Workforce Report highlighting areas for redress.



4 RECOMMENDATION

The Board are invited to note the information and update.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Workforce Plan links into Financial and Clinical Governance Plans and processes.
Workforce Implications	The Workforce Plan includes implications for workforce in relation to • Demographics - age profiling and potential impact of pension changes on workforce • Recruitment and retention of appropriately skilled workforce and sustainable workforce • Staff support, health and wellbeing
Financial Implications	The Workforce Plan financial impact is consistent with the level of funding contained within the TSH's Financial Plan.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Staff Governance Committee Partnership Forum
Risk Assessment (Outline any significant risks and associated mitigation)	Workforce Planning is included within the Corporate Risk Register and reported on through the Staff Governance Committee and NHS Board on a regular basis.
Assessment of Impact on Stakeholder Experience	Failure to adopt would undermine the principles of Partnership Model and Employee Engagement.
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	**X There are no privacy implications.** □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

Paper No: 24/50

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item No: 19
Sponsoring Director:	Director of Workforce
Author(s):	HR Advisor / Training & Professional Development Manager / Head of HR
Title of Report:	Staff Governance Report
Purpose of Report:	For Noting

1 SITUATION

This report provides a summary of ongoing activity in relation to key staff governance factors, with particular reference to changes since the last Staff Governance Committee on 16th May 2024.

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

2 BACKGROUND

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

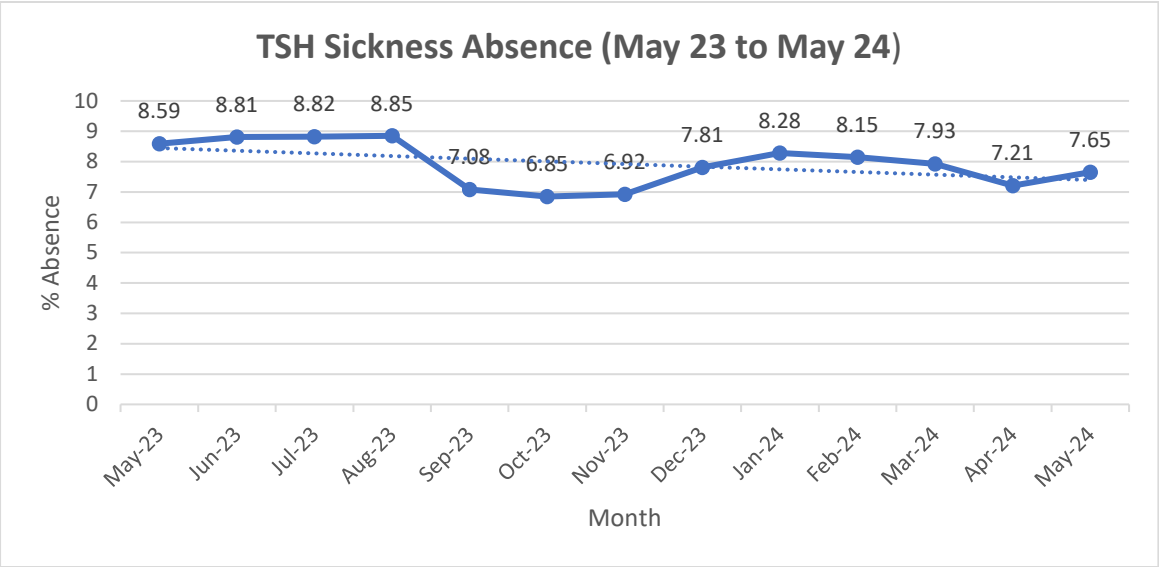
The Teams work closely together to support Managers and Staff within TSH on a number of key areas and this report details the background and update for each Department.

It was agreed by the Board that the reports should be amalgamated into one regular update.

3 ASSESSMENT

a) HR UPDATE

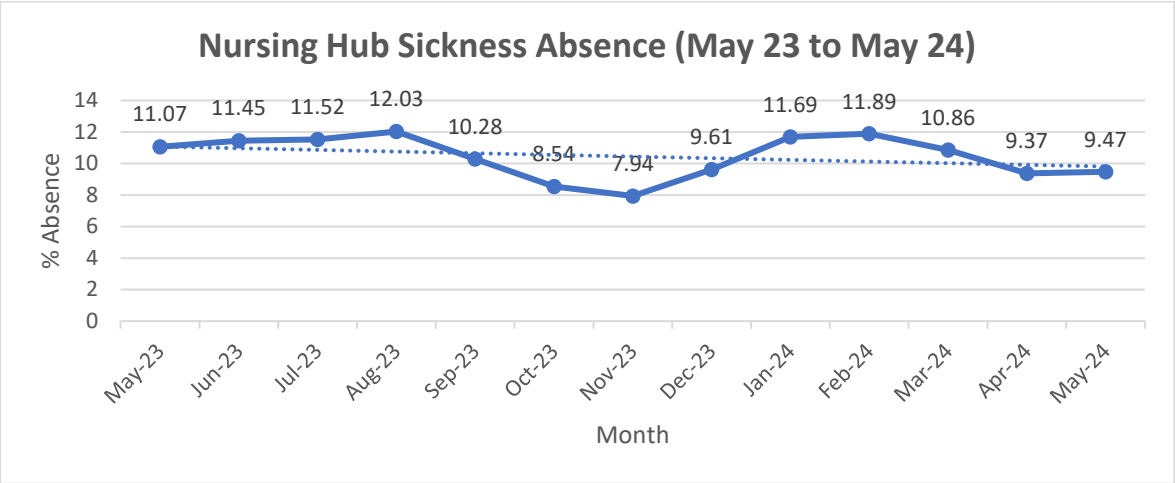
i) Absence



Our position of 7.65% sickness absence in May 2024, comprised of 4.69% long term and 2.97% short term, highlights: -

- A halt in the recent downward trend in sickness absence: however. Our long term absence continues to reduce.
- The increase in short term absence in the month of May is common with public holidays, improved weather and football cup finals etc.
- Our monthly position is approximately 0.43% higher than our 12 month rolling average.

- **Nursing focus**



The Nursing Hub remains a key area of concern in terms of overall absence, however, absence for May 2024, whilst showing a small increase, highlights a much improved position compared to early 24 and was comprised of 6.58% long term and 2.89% Short Term.

- **Absence Reasons**

- Key reasons for short-term absence were Gastro-intestinal problems, Cold/Cough/Flu and Anxiety/stress/depression/other psychiatric illnesses. ·
- Key reasons for long-term absence, were anxiety/stress/depression, injury / fracture and Gastro-intestinal problems.**Key Actions**

- **Attendance Management Activity (June 23 to May 24)**

Staff actively monitored from effective date of monitoring

Active Monitoring	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	April 24	May 24	Total
2023													
Stage One	14	14	25	32	19	17	13	11	19	17	24	16	221
Stage Two	2	4	3	2	4	1	1	1	1	2	5	4	30
Stage Three	0	0	0	0	0	0	0	1	0	0	1		2
Grand Total	16	18	28	34	23	18	14	13	20	19	29	20	252

- 88 staff currently have an active monitoring period in place.
- Active Stage 1 monitoring – 72
- Active Stage 2 monitoring – 15
- Active Stage 3 monitoring - 1

- **Attendance Management *Training / Support***
- The HR team continue to support line managers and offer guidance around policy compliance and best practice.
- Attendance Policy training is continuing to take place for all managers and staff side representatives within the hospital. 38 managers have attended to date and the topics covered in the training include application of the Attendance Policy, absence reporting, holding meaningful absence meetings, return to work discussions, occupational health referrals and employee assistance. Proposed to train further 70 managers/supervisors over the next 12 months.

- **Maximising Attendance – Future Actions**

As we look to build on the success of the Task and Finish Group looking at Absence, we will now shift to a everyday approach to maximising attendance, with focus on: (a) examining our processes to reduce or remove waste and repetition, (b) the quality of our interactions throughout the process, ensuring that these are supportive, person centred but equally reiterate the responsibility of the employee to attend work, (c) define clear and

distinct pathways for specific absence type, (d) how we use our data better and (e) ensure that absence is managed through our existing performance frameworks.

An action plan will be drawn up in partnership with staff side and monitored through the Workforce Governance Group in the first instance.

ii) Recruitment & Retention

- 4 separate posts were advertised in May totalling 16 vacancies. ·
- There are 5 individuals with confirmed starts dates and a further 3 with conditional offers pending pre-employment checks.
- Time to Hire for May was 72 days. The KPI is 75.
- Nursing Establishment · Page 14 of the report reflects 11.99 WTE variance for Band 5 RNs and +1.82 WTE for Band 3.
- Alongside planned retirements, in June the projected variance will be 12.99 WTE Band 5 Registered Nurses and no Band 3 deficits. · Recruitment to registered nurses is underway.

- **Employability**

Nursing Practice Development and Workforce collaborated to arrange an in person event for prospective nurses and nursing students to come along and find out more information about working for the State Hospital. This day was very successful with 27 prospective applicants attending. Feedback received to date has been positive and the teams will be looking at future dates. 86 applications have been received for the current registered nurse advert making it one of the most applied for adverts in recent years. Further analysis will be undertaken to understand whether the event led to successful appointments. ·

South Lanarkshire Council employability department are continuing to liaise with the State Hospital about opportunities for Work Placements. A proposal will be put to WGG in July to consider adopting a formal process for Work Placements which will support the wider Workforce and Anchor strategies. Manager's guidance has been written in partnership and will accompany the SBAR proposal.

iii) Other Key Indicators

- WTE Supplementary Staff: 63.58 wte for May, increasing trend in line with sickness increase.
- WTE Nursing Supplementary Staff: 40.89 WTE for May, also an increasing trend.
- Supplementary Staff Register: 11.87 wte for May

Increased clinical activity on site, coupled with increase in absence in May has seen an increase in supplementary staff usage.

- Leavers: 1 in month of May, 4 for Year to date (in comparison to 9 Year to date last year)
- Exit Interviews: 1 of 4 completed (25%)

iv) Employee Relations

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

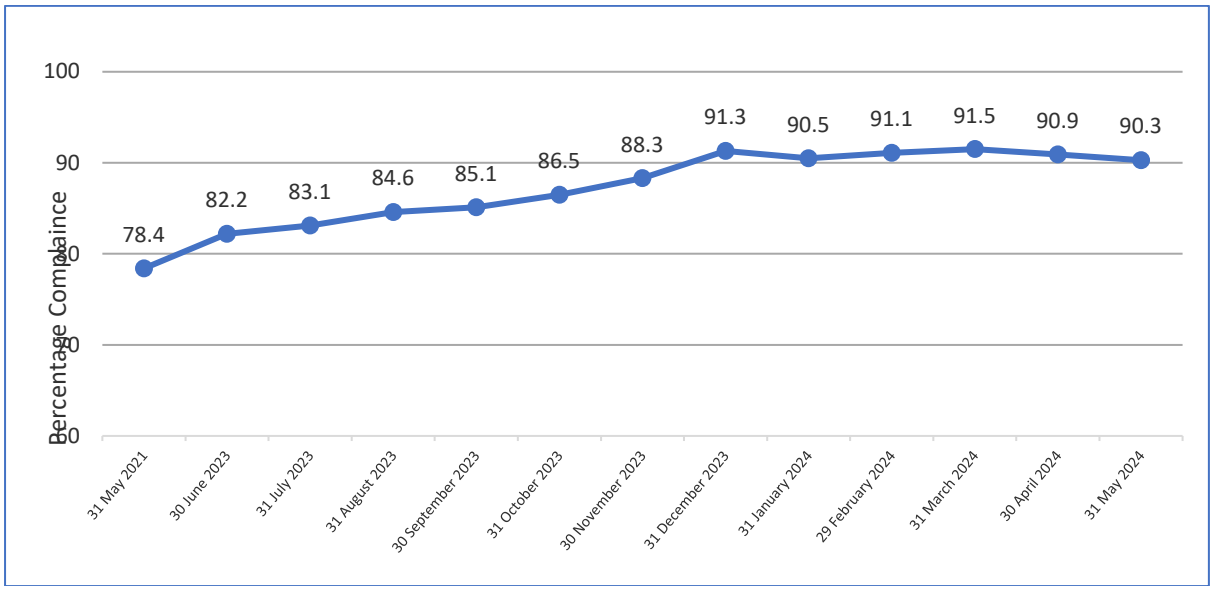
ER Cases – commenced	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	March 24	April 24	May 2024
Capability- informal	0	0	0	0	2	0	1	1	0	0	0	0	1
Capability - formal	0	1	0	0	0	0	0	0	0	0	0	0	0
Conduct - informal	0	0	0	0	1	0	2	1	1	1	2	0	0
Conduct - formal	3	0	0	1	1	2	1	0	0	2	0	2	0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

b) Learning, Training & Organisational Development

i) PDPR Compliance

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

As at 31 May 2024:



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

4 RECOMMENDATION

Board Members are invited to note this report.

MONITORING FORM

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

Paper No 24/51

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item No: 20
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Quarter 4 Update– 2023/24
Purpose of Report:	For Decision

1 SITUATION

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

As part of the Standard, each Health Board is required to produce an Annual Report which should detail the work undertaken in the implementation of the Standard.

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 4 update is from 1 January 2024 to 31 March 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 2023/24, the State Hospitals Board for Scotland had no cases raised under Whistleblowing.

This Annual Report details the work undertaken to develop the established processes within the Board, and supportive speak up culture, within our Action Plan will be shared at the next Staff Governance Committee.

4 RECOMMENDATION

Members of the Board are asked to note the nil return for Quarter 4 of 2023/24.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

DRAFT

WHISTLEBLOWING ANNUAL REPORT

1 April 2023 to 31 March 2024

1. INTRODUCTION

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 form a 'Once for Scotland' approach to Whistleblowing.

The SPSO worked with NHS National Education Scotland (NES) on the development of training materials, and these are now available to all staff through the TURAS Learn Website. There are two training modules: one for raising general staff awareness of whistleblowing, and a more detailed programme for managers or others who may receive concerns. This provides additional support and guidance on best practice, should a concern be raised through the policy.

In addition to this, the Scottish Government revised and promoted the role of the Whistleblowing Champion as a formal Non-Executive member of each NHS Board, with our appointment finalised in December 2022. Their role is to ensure that the systems are in place to enable staff to raise concerns, and that the culture of the organisation supports the full application of these systems, by valuing staff concerns.

The State Hospital supports and encourages an environment where employees, both current and former, contractors, trainees and students, volunteers, non-executive directors and anyone working within the Board can raise concerns.

The aim of this Annual Report is to be transparent about how Whistleblowing concerns are handled, highlight actions taken and any improvements.

This is the third Annual Report and is for the reporting activity from 1 April 2023 until 31 March 2024.

The Executive Lead remains the Director of Workforce. However, discussions will take place with the new Non-Executive Whistleblowing Champion and will be reviewed in line with the Standards recommendations.

2. BACKGROUND

Whistleblowing is an important process to enable an individual to speak up about any Whistleblowing concerns they may have in the organisation with respect to quality and safety in patient care and service delivery. The way we respond to Whistleblowing concerns raised is important, so that individuals feel that their concerns will be valued and handled appropriately, and that the organisation will take on board what they have to say.

In line with the organisation's values, The State Hospital encourages Whistleblowing concerns to be dealt with at the earliest opportunity and where possible in real time within the management structures that our staff work in within the organisation. Alternate routes for raising Whistleblowing concerns include with the Whistleblowing Champion Non-Executive Director, Senior Managers, trade unions and other staff.

The delivery, adherence, monitoring and review of our implementation of the National Standards is fully supported by all members of the Board who play a role in ensuring communication and development of our approach in line with those standards.

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The quarterly and annual reports are scrutinised by the Staff Governance Committee and Board, including performance against the relevant Action Plan.

A collective and proactive approach has been taken in engaging with the organisation and raising awareness of the Standards whilst the Whistleblowing Champion is in post to provide critical oversight of governance mechanisms for reporting on and dealing with Whistleblowing concerns, to complement the oversight provided by the Board.

3. CONCERNS RAISED

Since 1 April 2023 to 31 March 2024 there was no Whistleblowing concerns raised direct to the Board.

No cases have been raised by any other contractors or anyone linked to the Standard during this time.

4. ACTIONS

Over the last year, it would be noted that the majority of actions in relation to whistleblowing focused on the communication and raising awareness. For example, the State Hospital participated in the "Speak up Week" which took place on 2-6 October 2023. Staff Bulletins were circulated to the service with updates from a number of contributors including the Chair, Chief Executive and Employee Director. Noticeboards provided information to staff on the Standard and the main one was placed in the front reception area.

Furthermore, from a training perspective, work continues in highlighting the requirement for Staff and Managers to complete the on-line module on the Whistleblowing Standards and update to date is:

Introduction for all Staff – 518 (96% of target group)
Managers Training – 88 (85% of target group)

The State Hospital also recently met with INWO in March 24 and received feedback on our current position and also areas in which we could target improvement. This feedback will support our review with a clear focus on how we can continue to develop and improve our overall approach to whistleblowing and promote a 'Speak Up' Culture.

5. FUTURE ACTIONS

A refresh of our full approach to (a) implementing the standards, (b) developing our 'speak up culture' and (c) actively promoting this change will be our aim for 24/25. This will include:-

- Ensuring that Whistleblowing is seen as independent and objective in terms of how the service is delivered. (how we provide the service, the executive Director responsible)
- Clarity and continued development of how staff access whistleblowing and the process they will follow.
- Refresh of approach to Confidential Contacts, which includes discussions with other National Boards to support this agenda, ensuring complete confidentiality and independence at all stages.
- Alignment of whistleblowing and Speak Up culture with our programmed OD activity during 2024/25.
- Development of a Communication Calender to focus on whistleblowing and speak up.

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6. REPORTING

Reporting of any concerns raised through Whistleblowing is reported through Partnership, Workforce, Wellbeing and OD Delivery Group, Corporate Management Team, Staff Governance and the Board. Ongoing work will continue to improve communication with a dedicated plan to ensure that information is regularly sent to all Staff regarding their access to this Policy and Standard.

All Whistleblowing Complaints are recorded locally via the DATIX system and then updated as and when the case is investigated and concluded.

All the relevant Committees received quarterly updates on any concerns raised which was finally discussed at Board on the following dates:

27 April 2023	-	Quarter 4 update for 1 January to 31 March 2023 and Whistleblowing Standard Annual Report-2022/23
24 August 2023	-	Quarter 1 update, 1 April to 30 June 2023
21 December 2023	-	Quarter 2 update, 1 July to 30 September 2023
22 February 2024	-	Quarter 3 update, 1 October to 31 December 2023
25 April 2024	-	Quarter 4 Update, 1 January to 31 March 2024

7. QUALITY AND PATIENT CARE

Whistleblowing remains an important Policy and process for staff, students and volunteers to enable them to speak up about any concerns they may have in the organisation with respect to quality and safety in patient care. The information in this report has no direct impact on patient care, except in those circumstances when the whistleblowing process is used to highlight patient safety concerns or other quality matters in the organisation. Any recommendations or actions that come out of future whistleblowing cases will help to improve quality of The State Hospital services and patient care.

8. CONCLUSION

Although there were no formal cases raised via Whistleblowing, there is clear focus on the areas in which we can improve and develop on the provision of Standards which in turn will encourage staff to raise their concerns in a safe and secure environment.

The State Hospitals Board for Scotland
12 June 2024

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THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE COMMITTEE **SGC(M) 24/01**

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

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

Chair:	
Non-Executive Director	Pam Radage
Present:	
Non-Executive Director	Cathy Fallon
Non-Executive Director	Stuart Currie
Non-Executive Director	Shalinay Raghavan
In attendance:	
Chief Executive	Gary Jenkins
Board Chair / Non-Executive Director	Brian Moore
Head of HR, Facilities & Estates, NHSGGC	Stephen Wallace
Associate Director of Nursing	Josie Clark (Items 10 &14)
Head of Corporate Governance and Board Secretary	Margaret Smith
Acting Director of Workforce	Laura Nisbet
Head of Organisational Development & Learning	Sandra Dunlop
Organisational Development Manager	Graeme Anderson
Specialist Practitioner in Occupational Health	Leanne Keenan
POA Representative	Alan Blackwood
Personal Assistant	Julie Burt (Minutes)

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Ms Radage welcomed everyone to the meeting, and in particular, Stephen Wallace and Graeme Anderson as this was their first meeting.

Apologies were noted from Monica Merson, Head of Corporate Planning, Performance & Quality and Allan Connor, Employee Director.

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 HELD ON 16 NOVEMBER 2023

The Committee approved the Minutes of the previous meeting held on 16 November 2023 subject to the following amendments:

- Page one, insert ‘Sandra Dunlop, Head of Organisational Development & Learning’, as in attendance at the meeting.
- Page four, third paragraph, last sentence should read “Ms Nisbet confirmed was hours”, not instances.

The Committee:

1. Approved the minute of the meeting held on 16 November 2023 following amendments noted above.

4 MATTERS ARISING AND ROLLING ACTIONS LIST UPDATE

There were no matters arising. The Committee received the action list and noted progress on the action points from the last meeting. Members were content to regard all other actions as complete and closed, or with a date to return to the committee.

The Committee:

1. Noted the updated action list.

5 REVIEW OF HR AND WELLBEING GROUP

The Committee received and noted the update regarding the HR and Wellbeing Meeting and Workforce Meeting structure which detailed the recommendation to establish a 'Workforce, Wellbeing and Organisational Development Delivery Group', following the stand down of the HR and Wellbeing Group. Ms Nisbet provided an overview setting out the background to the recommendation and advised that the Corporate Management Team (CMT) had approved this in February 2024.

Ms Fallon commented on the operational content of the paper and queried the requirement of it being presented to the Committee given that it was approved by CMT. Ms Nisbet advised she was keen to assure Members of the organisational focus on wellbeing and acknowledge this would remain a focus within the new group. Mr Jenkins commented that streamlining workflow was recently discussed at the Clinical Governance Committee (CGC) as well, and this new group would help achieve this within the context of staff governance issues. The report was for noting and to detail the working structures and linear decision-making.

Ms Radage commented on the clear line of sight as was detailed in the paper and which was helpful for the Committee to note.

The Committee:

1. Noted the update from the HR and Wellbeing Group.

6 CORPORATE RISK REGISTER – STAFF GOVERNANCE RISKS

The Committee received and noted the Corporate Risk Register - Staff Governance quarterly update, which detailed the current positon on risks that sit under the Workforce Directorate.

Ms Nisbet provided an overview of the four risks: HRD111 – Deliberate Leak of Information, HRD122 – Compliance with Mandatory Level 2 PMVA Training, HRD110 - Failure to Implement & Develop the Workforce Plan and HRD113 - Job Evaluation and impact on services. Overall, there was no change to the risks and it was highlighted that the new 'Workforce, Wellbeing and Organisational Development Delivery Group' governance structure would aid HRD110. It was hoped HRD113 would be reduced within the next few months.

Ms Fallon commented that the impact HRD113 had had on clinical care had been discussed at Clinical Governance Committee and it was good to see the reduction in Job Evaluations outstanding and that this workstream was being delivered going forward. Ms Radage echoed this and commented that it was a helpful improvement in a short space of time. She added that it was good to see that with the correct resources in place, a difference had been made, and was

testament to the responsible working group. The Committee noted the stable position in terms of risks.

The Committee:

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

7 OCCUPATIONAL HEALTH – SIX-MONTH REVIEW INCLUDING REVIEW OF EARLY INTERVENTION SERVICE

Members received and noted the six monthly update on Occupational Health Services (OHS), including a review of the Early Intervention Service (EIS). Ms Keenan provided an overview of the paper for the benefit of the Committee and highlighted that case management clinics had been increased and the format of these had been changed to include an additional day for when staff would be able to attend. She emphasised OHS involvement in focused sickness absence groups with Lead Nurses, Senior Charge Nurses and HR where individual and or specific cases could be discussed and supported. The reduction of 'did not attend' appointments was also worthy of note.

Members noted the update on the Triage Service and summary provided by both Ms Keenan and Ms Nisbet. Ms Nisbet advised that in February 2024, the Workforce Governance Group considered that the EIS should cease in relation to the notification of every absence that occurred, though would remain available to Line Managers where they determined a concern that require immediate attention. Going forward, communications would be developed to explain that resources were focused on appropriate cases and the best use of the OHS was provided in managing sickness absence.

Mr Currie commented on the positives of staff engaging with the OHS and on clear joint beneficial communications issued to staff to perhaps change perspectives that the service is there to support rather than hinder. Ms Keenan acknowledge this impression however advised that staff who had engaged voiced a positive and supportive experience.

Ms Fallon echoed the helpful information and overall positive report. She questioned given that there were 18 self-referrals, whether there was a way to capture the positives to communicate the helpfulness of the service. She also commented on the gap in referrals from the date the staff member actually made first contact with the OHS, for example three to four weeks, and wondered if this could be explained in more detail. Ms Keenan advised that the key performance indicator from referral to first contact was the offer of an appointment within 15 days, however generally this was much quicker by making use of telephone consultations. Where staff cancelled their first appointment, this pushed appointments back and extended timescales, which remained problematic.

Ms Fallon also recognised the important requirement for a homogeneous approach to hand cleansing and moisturising products used by staff. Ms Keenan explained that OHS met with the Senior Nurse for Infection Control in January 2024 to determine standards and alternate products used to deliver consistent, research-based, and practical advice to employees and managers. A report was sent to the Senior Nurse for Infection Control for consideration regarding the need for OHS to have clear direction on products used by to ensure best practice and continuity in providing advice to employees.

Mr Jenkins commented on the promoting of the OHS and whether an introduction and understanding of the function and service was provided at staff inductions. Ms Nisbet advised this was included in the focused in-person introduction package. Mr Jenkins advised this was supportive of newly appointed staff and going forward, as Mr Currie had alluded to, would change staff perceptions.

Mr Moore commented that he was surprised on the data around the EIS given that the previous provider EASY was a key important early intervention service which made a difference, however accepted the reasoning around what the difference is now made and to make best use of

resources. He requested assurance that discussions with Line Managers were taking place in a supportive and purposeful manner, otherwise there was a gap in communication. Ms Keenan advised that the Triage Service remains open five days a week and was available for staff and Line Managers for guidance or general conversation. She explained the research based on early intervention was supportive of an informal approach, which was fed back from staff.

Mr Moore acknowledged the service remained open however, felt there was a contrast between the previous service and emphasis on easy intervention and perhaps over time there was a requirement to engage the impact of what the different interventions were. Ms Nisbet advised there was evidence initially that the EIS had a significant impact. However, over time the impact diminished, which was seen within the organisation. In terms of ability to maintain in the long term, it was not sustainable and compliance levels had dropped. She explained the importance of empowering Line Managers to have quality conversations early on, whilst seeking advice from the OHS where appropriate. As a Line Manager and Union Representative, Mr Blackwood supported this approach, and commented that future data would prove this change was a successful approach. He also provided feedback from a Line Manager and from a Staff Side Representative viewpoint, the positives from the new OHS provided by NHS Dumfries and Galloway.

Ms Radage added that Mr Blackwood's comments on staff feedback were refreshing and hugely important as were the positive achievements and relationships with staff noted within the report. In terms of the electronic feedback surveys the OHS issued to staff, she asked for additional information on when this was issued and outcomes. Ms Keenan advised there was good relevance to some of the feedback, which had been issued on a blanket approach via a Staff Bulletin followed by an All Users email however, a poor response has been received. Several approaches to how the service captures feedback are being explored such as a paper based feedback form being issued following an appointment or the OH administrator following up with individuals via email to ask for feedback.

Ms Radage thanked Ms Keenan for her extensive report and helpful discussion. She felt the report was reassuring in terms of the transition to the new service provider.

The Committee:

1. Noted the Occupational Health Service Six monthly update including review of the EIS.

8 WORKFORCE REPORT INCLUDING SICKNESS ABSENCE – TASK AND FINISH GROUP

Members received and noted the Workforce Report, which provided a high-level overview of Workforce Performance and an update in relation to the organisational Sickness Absence - Task and Finish Group. Ms Nisbet highlighted key areas and summarised the information under subjects such as attendance management, nursing recruitment and job evaluation.

Mr Jenkins commented that work was commissioned around gender mix balance and would be submitted to Joint Staff Side in collaboration with Head of Risk and Resilience. This was to revisit the discussion around gender mix, refresh, relook at the data, and bring a recommendation back in relation to the functions of the hospital, whilst conscious of the fact that it is a male only facility. He also highlighted that members should not be despondent about absence given the prediction mapping data from Public Health Scotland due to the seasonal variation. Ms Radage welcomed the useful context.

Mr Currie noted the positives within the report, recognised that long-term absence had been a previous issue, and remained problematic. In terms of resources and results, he questioned if there was a handle on why long term absences on a downward trend, as welcomed as they are, was simply good fortune, or could be correlated to resources and the impact on staff wellbeing and other areas a result of that investment. Mr Jenkins referred to the next paper on the agenda and advised that there were generic themes where long term absence may be linked to and cause and effect, but there were more bespoke cases where specific support would be offered. He also linked in the iMatter, OD and Wellbeing Report on the agenda and how this correlated to a feeling

of staff satisfaction about coming to work, which he felt was an interrelation and part of the gradual reduction in long-term sickness absence.

Ms Radage highlighted the wealth in the data provided and queried when the triangulation of information would be available around the effectiveness of the systems in place. Ms Nisbet reflected that the evaluation and review of the Wellbeing Strategy and OD Strategy were underway which would cover this area of work in order to make meaningful and sustained change.

Members welcomed the positive report and the helpful discussion.

The Committee:

1. Noted the Workforce Report.

9 EMPLOYEE RELATIONS CASES - REVIEW

The Committee received and noted the presentation on Employee Relations cases review update. Ms Nisbet provided a summary and advised the main points of note were that the hospital had a well-established use of the early resolution process, which was well managed at Line Manager level. In terms of the timescale to close cases, this was considered lengthy at 26 weeks. There was one particularly lengthy case included, though this did not reduce the average timescale significantly, and a target of 18 weeks should be reasonable to set for cases from start to finish. She advised that the Human Resources department would review key performance indicators and recording mechanisms to ensure timescales were reduced going forward. Regarding outcomes, a quarter of cases resulted in learning outcomes. In terms of themes from formal and informal cases, and from investigations, these were felt to be unique to the organisation given the size and nature of hospital though common with other organisations. Lastly of note, was the work taken forward and changes made as a result of areas of learning identified during the process.

Mr Currie commented on a trend within the report around long-term positive improvement. Themes around people being reluctant to act as witness and of the organisational learning of the 'Speak Up' culture was important. He agreed with the target aim of 18 weeks from the start to the closure of cases, which would support the staff involved. Ms Nisbet also took the opportunity to emphasise the support given by staff side on cases and throughout the process. Ms Radage acknowledged the benefit of keeping on top of such cases and the aim to move to an 18-week timescale was a positive recommendation.

The Committee:

1. Noted the update on Employee Relations Cases review.

10 HEALTH AND CARE STAFFING ACT / EROSTERING UPDATE

Members received and noted the Implementation for Health and Care Staffing Act and eRostering update, which detailed the role of the Board and identified specific actions that required to be progressed to ensure readiness for enactment of the legislation, meanwhile ensuring the Committee remained sighted on the requirements of the legislation.

Ms Clark provided an overview the ongoing work and progress towards the enactment of the Act in April 2024. In terms of eRostering, Ms Clark advised there were 42 rostered locations, 41 of which were live. All ward-based rosters were now live which staff were utilising for annual leave and training. Updates were also provided on Safecare 1, Employee Online and eJob Plan. These areas were noted to be on track, with positive feedback received from reports submitted and no real concerns identified at this time.

Mr Blackwood commented that the support of the eRostering training and rollout and funding was due to come to an end. He enquired if the organisation was confident that training had been carried out within all areas of the hospital, and resources were in place to support the

implementation of the Act given that the eRostering Team had now dissolved. Ms Clark advised that there was a meeting planned in the near future with herself, the Director of Nursing and Operations, the Head of Human Resources and Project Team Lead to discuss the next steps and the preliminary plans in place on how this would become business as usual.

Mr Currie commented on the increasing efficiency of the system in comparison to the previous structure and making sure that at the end of the process, the attainment was the same as what was hoped for at the beginning, given the extensive resources in support. Ms Clark advised that the efficiency of the new system would be monitored as it was utilised more. Ms Nisbet advised that from a staffing attraction and employment point of view, particularly around the online packages, this should, if embraced, allow staff more flexibility and oversight of their shifts where they request leave or swap shifts through the system rather than it being paper based. She advised that assurance about the new system would be through various testing in terms of experience and security. Mr Jenkins highlighted the marginal benefits in terms of the system itself and of the legislation in place, which required the hospital to report on staffing. Fundamentally, this would enable us to comply with the legislation. Mr Moore requested that these marginal gains be detailed more specifically within future reports.

Action: Josie Clark / Karen McCaffrey

In terms of eJob Plan, Ms Radage noted that medics were in the process of implementing this and wondered what the timing was in terms of a system that would be used more widely. Ms Nisbet advised that the package was solely available for medical staff due as their contracts were underpinned by an agreed Job Plan. In terms of timescale, she advised they were seeking to understand the impact by the Project Team to spread over a longer period into business as usual, given the size of the medical team and what the rota looked like. Mr Jenkins advised it would be interesting to see what the modelling work looked like in this respect given that Consultants had prescribed job plans in place with hours per session and considered this a worthwhile desktop exercise to understand any potential implications.

Ms Radage thanked Ms Clark for the report and commented on the helpful information received in terms of assurance.

The Committee:

1. Noted the Implementation for Health and Care Staffing Act and eRostering Update.

11 WORKFORCE GOVERNANCE GROUP UPDATE

Members received and noted the Workforce Governance Group update report and Ms Nisbet provided members with a summary of the content, which included an update of the last meeting held since the last Committee. Members acknowledged that a further meeting of the Workforce Governance Group took place on 6 February and that an update would be provided at a later date.

Ms Fallon took the opportunity to commend the work carried out to date, particularly in relation to succession planning and the menopause policy.

Ms Radage commented on the work around the 36-hour working week, which was also a topic of discussion at the Clinical Governance Committee which had taken place in the previous week and appreciated it was live and active, whilst the hospital await information on the way forward.

The Committee were content to note the report.

The Committee:

1. Noted the Workforce Governance Group update Report.

12 ORGANISATIONAL DEVELOPMENT, LEARNING AND WELLBEING REPORT

The Committee received and noted the Organisational Development, Learning and Wellbeing Report, which provide an update on key workstreams and associated activities throughout November and December 2023. Ms Dunlop provided an overview and gave updates on areas such as PDPR compliance, Corporate Induction, Healthcare Support worker Mandatory Inductions, Coaching Provision, Staff Wellbeing Activities, and Staff Engagement and Recognition.

Mr Currie commented on the November Staff Wellbeing Initiatives - the Coffee, Cake and Conversations, which were positively received. He commended the high PDPR compliance rate and of the beneficial, encouraging and importance of conversations at these reviews. In relation to Peer Support Groups, he encouraged the progress made in this area.

Ms Fallon also commended the overall work carried out during this period and likewise, mentioned the work of the Peer Support Group which she considered excellent. In terms of the Learning and Wellbeing Centre, she acknowledge dedicated staff were available in the department from 9am to 5pm, though questioned how this affected staff who were on night duty and how they were able to access the Staff Care Specialist given the hours they worked. Ms Dunlop explained that the Staff Wellbeing Centre could be accessed 24 hours a day, seven days a week. The Staff Care Specialist provides a contact telephone number for staff who may wish to access the service out of hours or make contact when not on-site.

Ms Radage commented on the helpful report and the great achievement in PDPR compliance rates back up in the 90% levels. She considered it a heartening report given the extensive list of opportunities and activities available to staff at the Wellbeing Centre and expressed her thanks to all staff involved.

The Committee:

1. Noted the Organisational Development, Learning and Wellbeing Report.

13 IMATTER UPDATE REPORT

The Committee received and noted the iMatter 2023 National Report which provided an update on the results of the national iMatter Health and Social Care Staff Experience Report 2023. The report also detailed the comparison with the hospital's iMatter survey results, and results from previous years. Ms Dunlop gave a detailed summary of the report and advised the national report provided an opportunity to benchmark elements of staff experience within the hospital, in comparison with other Boards. Positively, at 72% the hospital was above the national response rate of 59%.

Ms Raghavan commented on the Raising Concerns section within the report and queried whether this information and statistics was shared with other NHS Boards, specifically in relation to the questions listed. She explained that at the last Network meeting this had not been raised, therefore wondered if it had been shared or was going to be shared in future. Secondly, in terms of interrogation of information around the statistics, what did this look like in terms of the Organisational Development team's approach to this. Ms Dunlop advised that in terms of sharing the data, the national report was in the public domain. In relation to the teams approach to raising concerns, she advised they would consider this in the broader context of the Whistleblowing and OD Strategy.

Ms Fallon advised she found the report very helpful, however was disappointed in the 79% who felt they were 'not well informed'. She explained at the amount of papers presented at the Clinical Governance Committee, Staff Governance Committee and Partnership Forum, alongside Staff Newsletters and wondered why this was not higher. Mr Blackwood shared this frustration given the positive messages and information communicated across several areas such as Staff Bulletins, Posters, screens in the staff Key Room, community and staff meetings. He suggested consideration be given to how we communicate information, at what level this was pitched at and the sequence of how it was disseminated. Mr Jenkins commented on effective targeted

communication and suggested there be a refresh of what a good-targeted approach on the communication strategy would look like, in order to not saturate and ensure information was targeted to the correct people.

Action: Sandra Dunlop / Graeme Anderson

Mr Anderson took the opportunity to update Members on the Organisational Development (OD) Strategy. He advised that a session was held with the Director group on 15 January 2024 where he advised of the two dual goals: (1) making the organisation more effective and (2) making the organisation a healthy place to work. He explained that he then met with each Directorate individually to carry out an exercise on what organisational health consisted of within the nine key dimensions. He added that there seemed a real appetite for this and felt encouraged following the directorate sessions and looked forward to building the strategy. Ms Radage thanked Mr Anderson for the helpful update in terms of work on the horizon. Ms Fallon added that it would be useful to hold a Board Development session on the OD Strategy development. Ms Smith agreed to take this forward as Board Secretary.

Action: Margaret Smith

Ms Radage thanked Ms Dunlop for the high-level detailed report and acknowledged the plan to take forward a refresh of targeted communication strategy in hope to increase the statistic around staff not feeling involved in information shared. She explained she felt the results interesting given they were a snapshot of information back in May 2023 and it was unknown how things had progressed to date. She suggested a midway point review of the information and feedback was provided around actions taken within the six-month period. Ms Dunlop and Mr Anderson both confirmed this was an area of work being reviewed as part of the OD Strategy and would be taken forward via this route.

The Committee:

1. Noted the iMatter 2023 National Report.

14 NURSE PRACTICE DEVELOPMENT UPDATE REPORT

The Committee received and noted the Nursing Practice Development Service update report, which provided an update on the key priorities identified for the service throughout 2023. Six key priorities were identified:

1. To recruit to vacant Practice Education Facilitator (PEF) post;
2. Embed the new clinical care policy into practice and ensure its alignment with the revised clinical model structure;
3. Work with colleagues from NHS Education Scotland to undertake a pathfinding project to explore and develop a framework for the delivery of a sustainable model for the delivery of nursing clinical supervision;
4. Development of a Peer Support Network that would consist of both clinical and non-clinical peer support workers throughout the organization;
5. Review the current nursing induction process (including secondary induction) with the dual aim of streamlining processes whilst also increasing the number of inductions carried out each year;
6. Work to increase delivery of nursing assessment and care planning.

Ms Clark gave a detailed summary update on each of the above areas, as well as the planned work over the following year.

Ms Fallon commended Ms Clark on all the work achieved to date and the planned work over 2024, in particular, the positive impact on clinical care, the planned work around recruitment and University of the West of Scotland. She added that she was she was also impressed with the first year support programme and thanked Ms Clark for a comprehensive report.

Ms Radage commented on the return of 50% of Year Three Nurses was a good positive starting point. Ms Clark advised that the figures vary from year to year and that the 50% figure was for 2023. She advised that going forward, this would be set out in future reports to capture the number of nurses who come through the training, and then return to work within the hospital.

Action: Josie Clark

Ms Radage also commented on the Peer Support Network and the positive traction this had gained and thanked Ms Clark for a very thorough report.

The Committee:

1. Noted the Nursing Practice Development update.

15 WHISTLEBLOWING QUARTER THREE REPORT

The Committee received and noted the Whistleblowing Report, which provided members with an update on the current situation of outstanding whistleblowing investigations. Members noted that the Quarter Three update covered the period 1 October to 31 December 2023 and that no formal whistleblowing cases were raised during the quarter, nor were there any ongoing cases to report. Ms Nisbet advised that nationally, colleagues from the Independent National Whistleblowing Office (INWO) had been in touch with the HR Directors group requesting an update meeting to consider what was working well and what was working less well in relation to standards and any suggested improvements. She advised that further updates would be provided on any national developments when available.

Mr Moore commented that previously it had been mentioned about having conversations with other Boards to aid a collaborative approach, particularly regarding investigations, and asked if there was an update on this. Ms Nisbet advised this had not been a conversation that had developed to date however, she intended to meet with Ms Raghavan to discuss how the standards were operated and would form part of the workplan to explore this.

The Committee:

1. Noted the Whistleblowing Update Report for Quarter 3.

16 REVIEW 2024 WORKPLAN

The Committee received and noted the Committee Workplan for 2024.

In the interest of producing higher level and succinct reporting, Ms Nisbet suggested that the Wellbeing, Training and Learning, and the Organisational Development reports be combined. Members agreed rather than having three individual reports listed on the workplan, these should be amalgamated to reduce the list. Secretariat agreed to update the workplan in advance of the next meeting.

Action: Secretariat

The Committee:

1. Noted the Committee Workplan and of the agreed updates noted above.

17 PARTNERSHIP FORUM APPROVED MINUTES SEPTEMBER, OCTOBER AND NOVEMBER 2023

Members received and noted the approved Partnership Forum minutes dated 26 September 2023, 24 October 2023 and 22 November 2023.

Ms Fallon commented that there was only one staff side representative in attendance at the September meeting, which seemed an intense resource. Mr Blackwood advised that the Employee Director also attended the meeting as a POA Staff Side Representative and disseminates information to colleagues; therefore, the Unison Representative was not there in isolation. Mr Jenkins highlighted that at the start of the meeting the Chair of sense checks representatives in attendance and on occasions, meetings had been stood down.

The Committee:

1. Noted the approved minutes of the Partnership Forum held on 26 September 2023, 24 October 2023 and 22 November 2023.

18 AREAS OF GOOD PRACTICE / AREAS OF IMPROVEMENT

Mr Jenkins remarked on earlier comments made by Ms Fallon on the recharged opportunity the hospital had from an Organisational Development opportunity and perspective given the newly appointed Organisational Development Manager and looked forward to the change in direction.

Mr Currie suggested positive areas of trends such as the reduction of long-term sickness absence and increase in PDRP compliance rates.

Ms Fallon highlighted areas of good practice such as the Peer Support Network Programme, which should be commended.

The Committee:

1. Noted the update.

19 ANY ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTIEES

Ms Radage advised there would be future cognisance amongst the Board Committees in terms of discussions around financial spending and saving matters.

The Committee:

1. Noted the update.

20 ANY OTHER BUSINESS

There was no other business raised.

21 DATE OF NEXT MEETING

The next meeting will take place at 9.30am on Thursday 16 May 2024.

Meeting concluded 1235 hours.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item No: 21
Title of Report:	Staff Governance Committee – Highlight Report
Purpose of Report:	For Noting

This report provides an update on the key points arising from the Staff Governance Committee meeting that took place on 16 May 2024.

1	Corporate Risk Register Quarterly Update	The Committee received the quarterly report regarding the corporate risks assigned to the Workforce Directorate. The Committee agreed that this as a statement of risk and noted the mitigations in place. Further, that there had been improvement in the position on the job evaluation process.
2	Once for Scotland Policy	The Committee considered the potential impacts for the State Hospital (TSH) and took assurance that no significant differences or impacts were apparent, and that the post implementation period would monitor the usage of the policies within the organisation.
3	Staff Governance Monitoring Return	Reporting highlighted many positives in terms of what was already in place such as the visibility of leadership, communication and the wellness framework. This would be linked to the Committee's workplan, as well as the iMatter survey.
4	Staff Governance Committee Annual Report	The Committee approved the report, and agreed that it demonstrated the range of work conducted throughout the year. The report helped to show the positive developments across a number of areas. There were some minor amendments agreed to the wording, to be made before the report was finalised for the Board.
5	Fitness to Practice Annual Report	Reporting confirmed that there had been no significant issues in registration throughout the year, and the Committee noted it would also be helpful to record any organisational impacts should registration lapse.
6	Workforce Report	The Committee received reporting which provided updates in terms of the full range of activity across the directorate including Human Resources, Organisational Development, Learning and Wellbeing.

		This included metrics across workforce data, and the Committee discussed the improvement in long terms sickness absence and the challenges presented for Return to Work interviews being carried out, particularly with front line staff working shift patterns. The Committee also noted good performance in PDPR compliance overall but that there were departments in which specific focus was being taken presently to improve their performance.
7	Sickness Absence Task and Finish Group	The Committee noted the improvements made, albeit that the overall target of a rate of no more than 5% sickness absence had not yet been reached. The Committee agreed that there should now be a focus on making sure there was an embedded process within the business as usual process to continue to improve the position.
8	Whistleblowing	Reporting for Quarter 4 of 2023/24 confirmed that there had been no new cases for consideration. It was noted that Speak Up Week was scheduled for September 2024, and that work was progressing to review the delivery of the standards within TSH, with a suggested move away from this being from within the Workforce directorate.
9	Implementation of Health and Care (Staffing) Scotland Act: and e-rostering	The Committee was pleased to note that Quarter 3 reporting had been submitted to government, and that there had been no areas of concern prior to moving into enactment on 1 April 2024. There would now be compliance monitoring, and annual reporting would be prepared at the end of the current financial year. The e-Rostering project would move into business as usual practice at the end of June.
10	Areas of good practice / Concerns	The Committee noted the engagement and communication with staff following the cyber attack on NHS Dumfries & Galloway, which had also impacted TSH staff due to the service level agreement in place for occupational health services. The effective work led by the Task & Finish Group on sickness absence was also commended. Finally the continued progress on the Organisational Development Strategy, which demonstrated a wide range of engagement activity.

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	None
Financial Implications	None
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board requested, pending approval of formal minutes
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item No: 22
Sponsoring Director:	Director of Finance and eHealth
Author:	Director of Finance and eHealth
Title of Report:	Audit Committee – Annual Report 2023/24
Purpose of Report:	For Decision

1 SITUATION

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

2 BACKGROUND

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

The report outlines the work of the Committee, including:

- Frequency of meetings
- The activities of the Committee
- Areas of Best Practice
- Review of Terms of Reference

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

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

3 ASSESSMENT

This report is presented to the Board for consideration, as approved by the Audit & Risk Committee at this morning's Committee Meeting.

4 RECOMMENDATION

The Board is asked to note the Audit Committee Annual Report for 2023/24.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Year end reporting to demonstrate that the committee has met its remit
Workforce Implications	None identified as part of reporting
Financial Implications	None identified as part of reporting
Route To Audit Committee Which groups were involved in contributing to the paper and recommendations	Submitted for noting by the Board
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	No impact identified
Equality Impact Assessment	Nor 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).	No impacts 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

AUDIT AND RISK COMMITTEE ANNUAL REPORT

1 April 2023 – 31 March 2024

DRAFT

1. Introduction

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

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

The committee periodically assesses its own effectiveness to ensure that the Committee fulfils its remit, this may involve assessing the attendance and performance of each member.
New members receive a suitable induction and declare his/ her business interests.

The duties of the Audit Committee are in accordance with the Audit Committee Handbook, July 2008. http://www.scotland.gov.uk/Publications/2008/08/08140346/

2. Committee Chair, Committee Members and Attendees

Committee Chair:
David McConnell (Chair of Committee, Non Executive Director)

Committee Members:
Allan Connor (Employee Director)
Stuart Currie (Non-Executive Director)
Pam Radage (Non-Executive Director)

In attendance:
Gary Jenkins (Chief Executive)
Monica Merson (Head of Planning and Performance)
Brian Moore (Board Chair)
Margaret Smith (Head of Corporate Governance/Board Secretary)

Where required by the Chair or by other members of the Committee, appropriate members of staff were invited to be in attendance for the purposes of verbal updates, information sharing and presentations.

3. Meetings 1 April 2023 – 31 March 2024

During 2023/24 the Audit and Risk Committee met on four occasions, in line with its terms of reference (Appendix 1).

Meetings were held on:

22 June 2023
28 September 2023
25 January 2024
21 March 2024

Attendance of Committee members were as follows:

	Number of Meetings Present
David McConnell	4
Allan Connor	4
Stuart Currie	4
Pam Radage	4

DRAFT

4. Summary of Reporting

The Committee received and considered reports as undernoted and made recommendations and/or monitored areas as required:

Internal Audit Reports:

- Workforce Planning and Rostering
- Data Quality - Performance Management
- Incident Management
- Environmental, Social and Governance Review Report
- Patient Monies Report
- Payroll

Workplan Reporting

- Risk Strategy
- Adverse Events Action Tracker
- Attendance Management – Risk Report
- Cyber Security Report
- Committee Workplan 2024
- Financial Report

4.1 Annual Reports

Annual Reports from Governance Committees

- Audit and Risk Committee
- Remuneration Committee
- Clinical Governance
- Staff Governance

Annual Accounts

- Statutory Annual Accounts
- Patient Funds Accounts

Annual Reports

- External Audit Annual Report to the Board and the Auditor General for Scotland
- NHS in Scotland 2022
- Review of Scheme of Delegation and Standing Financial Instructions
- Review of Accounting Policies
- Review of Board Standing Orders and Code of Conduct
- Review of Committee Terms of Reference
- Risk and Resilience Annual Report
- Internal Audit Annual Report 2022/23
- National Single Instance (NSI) and NSS Audits
- Annual Audit Committee Assurance Statement to the Board
- Audit Scotland Reporting
- Review of Effectiveness of Committee
- Climate Emergency and Sustainability Annual Report 2022/23
- Procurement Annual Report 2022/23
- Legal Claims Annual Report 2022/23
- Summary of Losses and Special Payments
- Report on Waivers of SFI Tendering Requirements

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4.2 Progress Updates

The Committee also received regular updates on the following –

- Completion of audit actions
- Policy review completions
- Risk register reviews
- Outcomes of fraud reports
- Adverse events
- Cyber security matters

4.3 Standing Items Considered by the Committee during the Year

Standing Items

- Internal Audit Tracking Report
- External Audit Updae
- Policy Update
- Corporate Risk Register
- Fraud Update and Action Plan

4.4 Notes of updates from other meetings

The Committee received and noted minutes/reports from the following:

- Security, Resilience, Health and Safety Oversight Group Update
- Finance, eHealth and Audit Group Update
- Sustainability Management Group Update

5. Activities / Risk Management

5.1 Corporate Risk Register

An update on the latest progress of the Corporate Risk Register went to each Audit and Risk Committee in the 2023/24 period. The paper details any changes to current grade of the approved risks, updates on any current high and very high risks, any new risks for consideration and updates on the general development of the risk register. The latest paper in March 2024 showed that all approved risks were within their review period. The latest updates of the 3 'High Graded' risks were given: MD30 – Failure to prevent/mitigate obesity, ND70 – Failure to utilise our resources to optimise excellent patient care and FD90 – Failure to implement a sustainable long term model. Updates included the latest progress on the control measures in place to reduce the risk back to an acceptable level. The paper provides assurance to the Audit and Risk Committee with regards to any increased areas of concern within the Corporate Risk Register as well as ensuring risks are regularly updated and reviewed.

5.2 Category 1 and 2 Action Tracker

After the conclusion of a Category 1 or 2 Adverse Event Review recommendations are made to reduce the chances of the adverse event recurring. The tracker provides assurance to the Audit and Risk Committee that all actions have been appropriately considered and either actioned or reason given for being unable to implement an agreed recommendation. The report also provides an update on any ongoing reviews and new reviews that have been commissioned by the Corporate Management Team. The latest report detailed 2 outstanding recommendations that are due for action alongside 4 new recommendations that are awaiting allocation to an action officer. The report was provided to each meeting of the Audit and Risk Committee in 2023/24 allowing the group to have sight of current progress of the recommendations made.

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6. Areas of Best Practice

Improvement

- Regular reporting now from Finance, eHealth and Audit Group, and Security, Resilience, Health and Safety Oversight Group
- Regular reporting on TSH financial position

Concern

- The members reviewed Committee effectiveness through formal assessment in September 2023, reporting to the Audit & Risk Committee that month – there were no matter of significant concern noted. It was noted that there was a potential lack of full independence of Committee members from other Governance Committees and Board, but that was acknowledged as an inevitable consequence of the size of the Board.

7. Conclusion

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

I offer my thanks for the continuing support and encouragement of Committee members and also to those members of staff who have worked on the Committee's behalf during 2023/24**.**

DRAFT

David McConnell
AUDIT AND RISK COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Audit and Risk Governance Committee

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item No: 23
Sponsoring Director:	Audit & Risk Committee Chair
Author(s):	Director of Finance and eHealth
Title of Report:	Report on the Annual Accounts for the year ended 31 March 2024
Purpose of Report:	For Decision

1 SITUATION

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

2 BACKGROUND

There is a requirement to have the Annual Accounts formally adopted by the Board, certified by external audit and submitted to the Scottish Government Health and Social Care Directorate by 30 June 2024.

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

3 ASSESSMENT

KPMG have concluded the audit of the Annual Accounts and issued a report to approve signing of the accounts. This was considered at the Audit & Risk Committee on 20 June 2024, and confirms that the Annual Accounts for the year ended 31 March 2024 will be unqualified in respect of a true and fair opinion. Their opinion on regularity is unqualified, and their report on the Board's Governance Statement is also unqualified.

The Audit & Risk Committee considered this final accounts letter and certificate, together with the Annual Accounts, at its meeting on 20 June 2024.

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

The Annual Report section of the accounts includes a Performance Report and Accountability Report. The Accountability Report includes a Corporate Governance Report which comprises of

the Directors' Report, Statement of Accounting Officer's Responsibilities, Statement of Board Members' Responsibilities and the Governance Statement. The Accountability Report also includes a Remuneration and Staff Report and Parliamentary Accountability Report.

3.1 REVIEW OF SYSTEM OF INTERNAL CONTROL

The Statutory Annual Accounts for the year 2023/24 include a Governance Statement. The system of Internal Control is based on a framework of regular management information, administrative procedures including the segregation of duties and a system of delegation and accountability.

The Governance Statement covers:

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

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

The Governance Statement included in the Annual Accounts complies with a letter from Scottish Government Health and Social Care Department (SGHSCD).

3.2 STATEMENT OF HEALTH BOARD MEMBERS RESPONSIBILITIES

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

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

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

3.3 AUDIT COMMITTEE REMIT

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

In recognition of this remit, the Audit & Risk Committee has received the results of the work of Internal Audit during the year 2023/24 and has considered the Annual Internal Audit Report presented by the Chief Internal Auditor.

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

3.4 ASSURANCE STATEMENT

On the basis of work undertaken by the Audit & Risk Committee in respect of the financial year 2023/24, the Committee considers the control environment and systems of internal control to be adequate. They can be relied on by the Board in approving the signing of the Performance Report and Accountability Report in respect of the Accounts, and the adoption of the Annual Accounts for the year ended 31 March 2024 by the Board.

4 RECOMMENDATION

The Audit & Risk Committee recommend that the Board:

Adopt the Annual Accounts for the year ended 31 March 2024 and **approve** submission to the Scottish Government Health and Social Care Directorate.

Authorise:

a) the Chief Executive to sign the Performance Report
b) the Chief Executive to sign the Accountability Report
c) the Chief Executive and Finance and eHealth Director to sign the Statement of Financial Position.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Scottish Government requirement to publish the Accounts of the Board.
Workforce Implications	None
Financial Implications	None
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Paper prepared by Finance & eHealth Director
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No identified implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No identified implications
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ✓ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item No. 25
Sponsoring Director:	Finance & eHealth Director
Author(s):	Finance & eHealth Director
Title of Report:	Patients' Funds Accounts
Purpose of Report:	For Decision

1 SITUATION

The Board is required to approve the Patients' Funds Annual Accounts. These were approved by the Audit & Risk Committee at their meeting of 20 June 2024 for presentation to the Board.

2 BACKGROUND

Patients' funds are the balances of money held by TSH on behalf of patients. The Board's Patients' Funds Annual Accounts are presented in a format directed by the Scottish Government Health & Social Care Directorate (SGHSCD) and require to be audited by external auditors, approved by the Audit Committee and authorised by the Chief Executive and Finance & eHealth Director. The 31 March 2024 audit is now complete and the accounts are presented to this meeting for approval.

3 ASSESSMENT

The accounts generally show unpredictable fluctuations in average funds held – simply due to the level of patients' spending and income being fairly inconsistent from one year to the next. The average balance held per patient therefore also fluctuates, with a second consecutive year of a net outflow of funds.

	March 2024	March 2023	March 2022	March 2021	March 2020
Opening Balance	£670,191	£677,098	£568,095	£432,617	£459,476
Receipts	£527,390	£614,305	£559,727	£513,243	£441,804
Payments	£551,456	£621,212	£450,724	£377,765	£468,663
Net in/(out)flow of funds	£(24,067)	£(6,907)	£109,003	£135,478	£(26,859)
Closing Balance	£646,124	£670,191	£677,098	£568,095	£432,617
No. of patients at 31 March	98	109	113	114	113
Average funds per patient	£6,593.10	£6,148.54	£5,992.02	£4,983.29	£3,828.47

The Patients' Funds Accounts are audited by Wylie and Bisset who have issued an unqualified audit opinion.

4 RECOMMENDATION

The Board is asked to **approve** the abstract of receipts and payments of Patients' Private Funds for the year ended 31 March 2024, for signature by the Chief Executive and Director of Finance & eHealth.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Annual accounts for the Board require to be presented to Audit Committee for approval.
Workforce Implications	None
Financial Implications	None
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Paper prepared by Finance & eHealth Director
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No identified implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No identified implications
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

STATE HOSPITAL **SFR 19.0**

PATIENTS PRIVATE FUNDS

FOR YEAR ENDED 31 MARCH 2024

ABSTRACT OF RECEIPTS AND PAYMENTS

2023 £		2024 £
	RECEIPTS	
	Opening Balances:	
671,106	Cash in Bank	665,066
4,092	Cash on Hand	3,225
1,900	Other Funds	1,900
677,098		670,191
611,023	From or on behalf of Patients	515,548
3,283	Interest on Patients' Fund Account	11,841
0		
1,291,403	**Total Receipts**	**1,197,581**
	PAYMENTS	
621,212	To or on behalf of Patients	551,456
	Extra Comforts etc.	0
	Closing Balances:	
665,066	Cash in Bank	641,124
1,900	Cash on Hand	1,900
3,225	Other Funds	3,101
670,191		**646,124**
1,291,403	**Total Payments**	**1,197,581**
	Closing Balances accounted for as:	
	Patients' Personal Accounts	
670,191	Credit Balances	646,124
-	Less: Debit Balances	0
670,191		646,124
-	Interest Received but not Credited	
670,191	**Total Closing Balance**	**646,124**

I certify that the above abstract of Receipts and Payments is correct, and in accordance with the Books of Account and that the Register of Valuables has been inspected and checked with property held.

Director of Finance _____ Date _____

The abstract of Receipts and Payments was submitted at the Board Meeting on 20th of June 2024 and duly approved.

Chief Executive _____ Date _____

1. Note to SFR19

The Scottish Government Health Directorate requires The State Hospitals Board for Scotland to pre
on an annual basis, an abstract of receipts and payments of patients' private funds administered by
Board. The abstract of receipts and payments of the patients' private funds has been prepared by t
Board, on a cash basis, in accordance with the requirements of the 2023/24 NHS Board Accounts
Manual.

Paper No: 24/57

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item no: 25
Sponsoring Director:	Chief Executive
Author:	Head of Corporate Planning and Performance Corporate Planning, Performance and Quality Project Support Manager
Title of Report:	Performance Report 2023/2024 and Comparative Annual Figures.
Purpose of Report:	For Decision

1 SITUATION

This report presents a high-level summary of organisational performance for the year from 1st April 2023 until 31st March 2024. Trend data is provided to enable comparison with previous performance. The national standards directly relevant to the State Hospital are Psychological Therapies, Waiting Times, and Sickness Absence. Additional local Key Performance Indicators (KPIs) are reported to the Board and are included in this report. Board planning and performance are monitored by Scottish Government through the Annual Delivery Plan (ADP) and Annual Delivery Plan Framework.

2 BACKGROUND

Members receive quarterly updates on Key Performance Indicator (KPI) performance as well as an Annual Overview of performance and a Year-on-Year comparison at the Board meeting each June.

3 ASSESSMENT

The following section contains the KPI data for 2023/24 and highlights any areas for improvement through a deep dive analysis for KPI's that have missed their targets.

There are seven updated KPIs for 2023/2024 that have achieved target, these are:

- Patients will be engaged in psychological treatment.
- Patients will be engaged in off-hub activities.
- Patients will undertake an annual health review.
- Staff have an approved PDR.
- Patients Transferred/ Discharged using CPA.
- Patients required primary care will have access within 48 hours.
- Patients will commence psychological therapies ,18 weeks from referral date

There are five KPIs that have missed their target this year, these are:

- Patients will have their care and treatment plans reviewed at 6 monthly intervals.
- Patients will have a healthier BMI.
- Sickness absence
- Patients will undertake 150 minutes of exercise each week.
- Patients have their clinical risk assessment reviewed annually

Item	Performance Indicator	Target	RAG	23/24	22/23	21/22	20/21	19/20	18/19		LEAD
1	Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	R	87.92 %	91.70 %	92.67 %	94.40 %	91.73 %	96.9%	Average figure from April 2023 – March 2024.	LT
2	Patients will be engaged in psychological treatment	85%	G	82.21 %	83.2%	85.56 %	86.74 %	87.93 %	92.8%	Average figure from April 2023 – March 2024.	KMcC
3	Patients will be engaged in off-hub activity centres	90%	-	-	-	-	-	83%	81.7%	This indicator was closed in June 2020 to accommodate engagement during restrictions (see 3.1).	KMcC
3.1	Patients will be engaged in off-hub activity centres	90%	G	94.50 %	90.92 %	92.47 %	83.33 %	-	-	Average figure from April 2023 – March 2024.	KMcC
4	Patients will be offered an annual physical health review.	90%	-	-	-	51.78 %	56.67 %	98.48 %	93%	This indicator was closed in March 2022 with restructured reporting commencing in April 22 (see 4.1).	LT
4.1	Patients will undertake an annual physical health review	90%	G	100%	98.2%	-	-	-	-	Average figure from April 2023 – March 2024.	LT

5	Patients will undertake 90 minutes of moderate exercise each week (Annual Audit)	80%	**-**	-	-	78.75 %	75.00 %	60.70 %	56.3%	This indicator was closed in March 2022 to accommodate new guidance with reporting commencing in April 2022 (see 5.1).	**KMc C**
5.1	Patients will undertake 150 minutes of moderate exercise each week (Annual Audit)	60%	**G**	-	63.35 %	-	-	-	-	Average figure from April 2022 – March 2023. This indicator was closed in March 2023 as the target was increased (See 5.2)	**KMc C**
5.2	Patients will undertake 150 minutes of moderate exercise each week (Annual Audit)	70%	**A**	61.48 %	-	-	-	-	-	Average figure from April 2023 – March 2024	**LT**
6	Patients will have a healthier BMI	25%	**R**	8.92%	9.5%	10%	10.50 %	8.75%	13.7%	Average figure from April 2023 – March 2024.	**LT**
7	Sickness absence	5%	**R**	7.81%	7.68%	6.39%	5.30%	5.92%	8.26	Average figure from April 2022 – March 2023.	**SW**
8	Staff have an approved PDR	80%	**G**	85.93 %	83.35 %	85.25 %	80.58 %	86.68 %	80.9%	Average figure from April 2023 – March 2024.	**SW**
9	Patients transferred/discharged using CPA	100%	**G**	100%	100%	100%	100%	100%	97%	Average figure from April 2023 – March 2024.	**SW**
10	Patients requiring primary care services will have access within 48 hours	100%	**G**	100%	100%	100%	100%	100%	100%	Average figure from April 2023 – March 2024.	**LT**
11	Patients will commence psychological therapies <18 weeks from referral date	100%	**G**	99.12 %	91.43 %	98.66 %	97.66 %	99.78 %	98.5%	Average figure from April 2023 – March 2024.	**KMc C**
14	Patients have their clinical risk assessment reviewed annually.	100%	**A**	93.79 %	95.42 %	96.49 %	95.35 %	97.68 %	99%	Average figure from April 2023 – March 2024.	**LT**
15	Attendance by all clinical staff at case reviews	Individual	**-**	67% overall	63.7% overall	69.3% overall	67.40 % overall	71.5% overall	65.6% overall	Average figure from April 2023 – March 2024.	**All Leads**

No 1: Patients Have their Care and Treatment Plans Reviewed at 6 Monthly Intervals

Target: 100%

Data for 2022/23: 87.92%

Performance Zone: Red

The Mental Health Act 2003 requires the preparation of documented care plans for people who are subject to compulsion. The Scottish Government CEL 13 (2007) identifies that the CPA is the appropriate tool for all restricted patients. The Code of Practice for the 2003 Act gives guidance on the RMO's responsibilities and required content of the care plans.

This indicator measures the assurance of patients receiving intermediate and annual case reviews. Care and Treatment Plans are reviewed by the multidisciplinary teams at case reviews and objectives are set for the next 6 months.

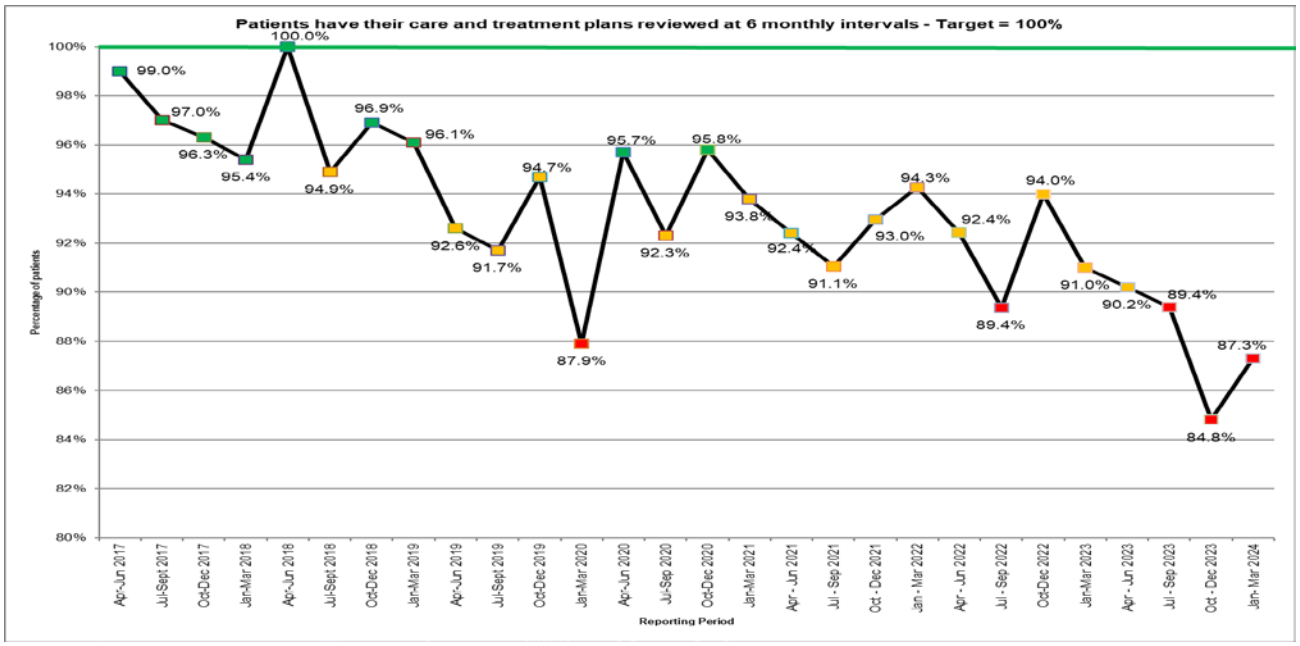
Performance Indicator	Target	RAG Q1 23/24	RAG Q2 23/24	RAG Q3 23/24	RAG Q4 23/24	23/24	22/23	21/22	20/21	19/20	18/19
Patients have their care and treatment plans reviewed at 6 monthly intervals	100 %	A	R	R	R	87.92 %	91.7 %	92.67 %	94.40 %	91.73 %	96.9 %

Performance has continued to decrease in 2023/24 as the annual average for this indicator was 3.78% lower than that of 2022/23. Q1 of 23/24 was within the amber performance zone and Q2, Q3 & Q4 were in the red performance zone, with the overall annual performance changing from amber in 2022/23 to red in 2023/24.

There were 27 separate instances during this reporting year where a patient waited beyond the specified 6 months of reviewing their care and treatment plans. This is a decrease of 1 from the 28 instances the previous year. In addition, there were 66 separate instances of patients who did not have their documentation uploaded to RiO within the specified period for their care and treatment plan at that time.

All dates are set in line with the relevant date of an annual review or renewal followed by a 6 monthly review after that. A review of the process for uploading documents is currently underway with a process mapping exercise being carried out by the Clinical Admin Co-ordinator. The data definition lead has also been updated to reflect current job roles.

Chart 1: Patients Have their Care and Treatment Plans Reviewed at 6 Monthly Intervals



No 2: Patients will be engaged in Psychological Treatment

Target: 85%

Data for 2023/24: 82.21%

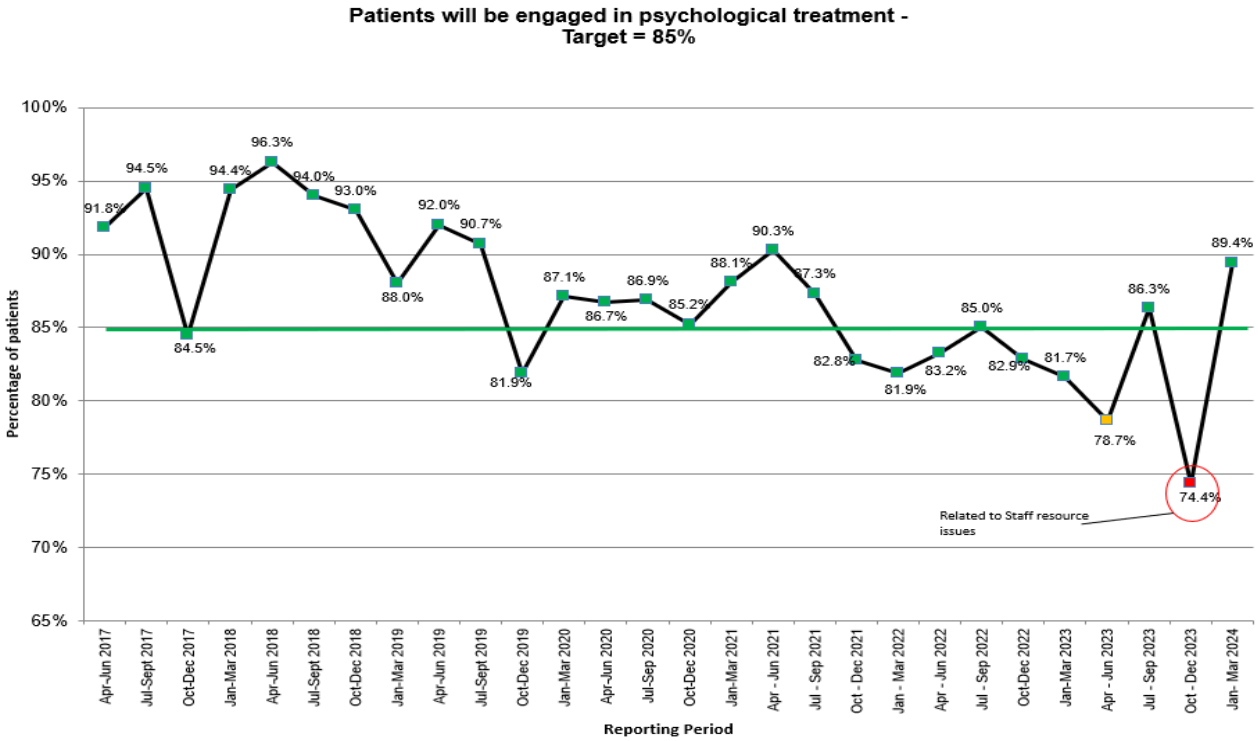
Performance Zone: Green

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

Performance Indicator	Target	RAG Q1 23/24	RAG Q2 23/24	RAG Q3 23/24	RAG Q4 23/24	23/24	22/23	21/22	20/21	19/20	18/19
Patients will be engaged in psychological treatment	85%	A	G	R	G	82.21 %	83.2 %	85.56 %	86.74 %	87.93 %	92.8 %

Performance has fluctuated over the course of this year. The annual average of 82.21% has continued to reduce year on year from 92.8% in 2018/19.

Chart 2: Patients will be engaged in Psychological Treatment



No 3.1: Patients will be engaged in Off-Hub Activity Centers

Target: 90%

Data for 2023/24: 94.5%

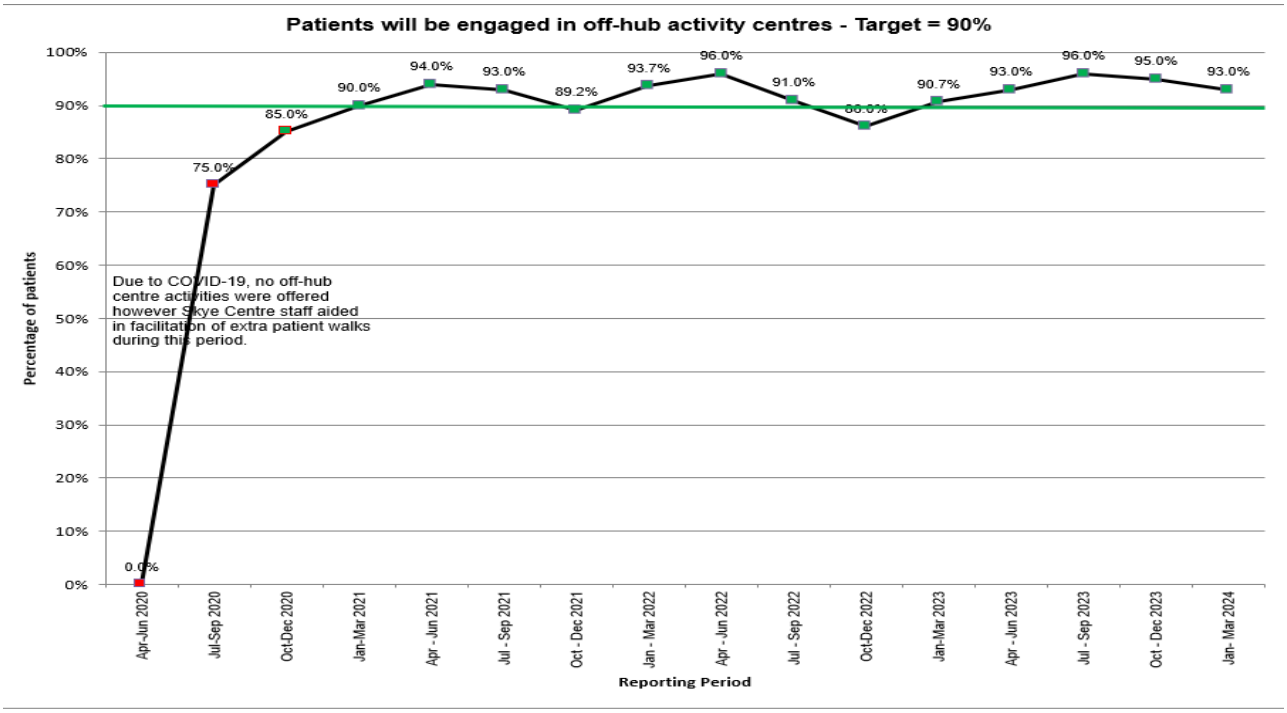
Performance Zone: Green

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 relate to the objectives in their care plan however are recognised as therapeutic activities. Work has started to explore amending this KPI to include all forms engagement in activity not just off hub.

Performance Indicator	Target	RAG Q1 23/24	RAG Q2 23/24	RAG Q3 23/24	RAG Q4 23/24	23/24	22/23	21/22	20/21	19/20	18/19
Patients will be engaged in off-hub activity centers	90%	G	G	G	G	94.5 %	90.92 %	92.47 %	83.33 %	-	-

This indicator averaged at 94.50% for this reporting year; a 3.58% increase on last years' figure.

Chart 3: Patients will be engaged in Off-Hub Activity Centres



No 4.1: Patients will undertake an Annual Physical Health Review

Target: 90%

Data for 2023/24: 100%

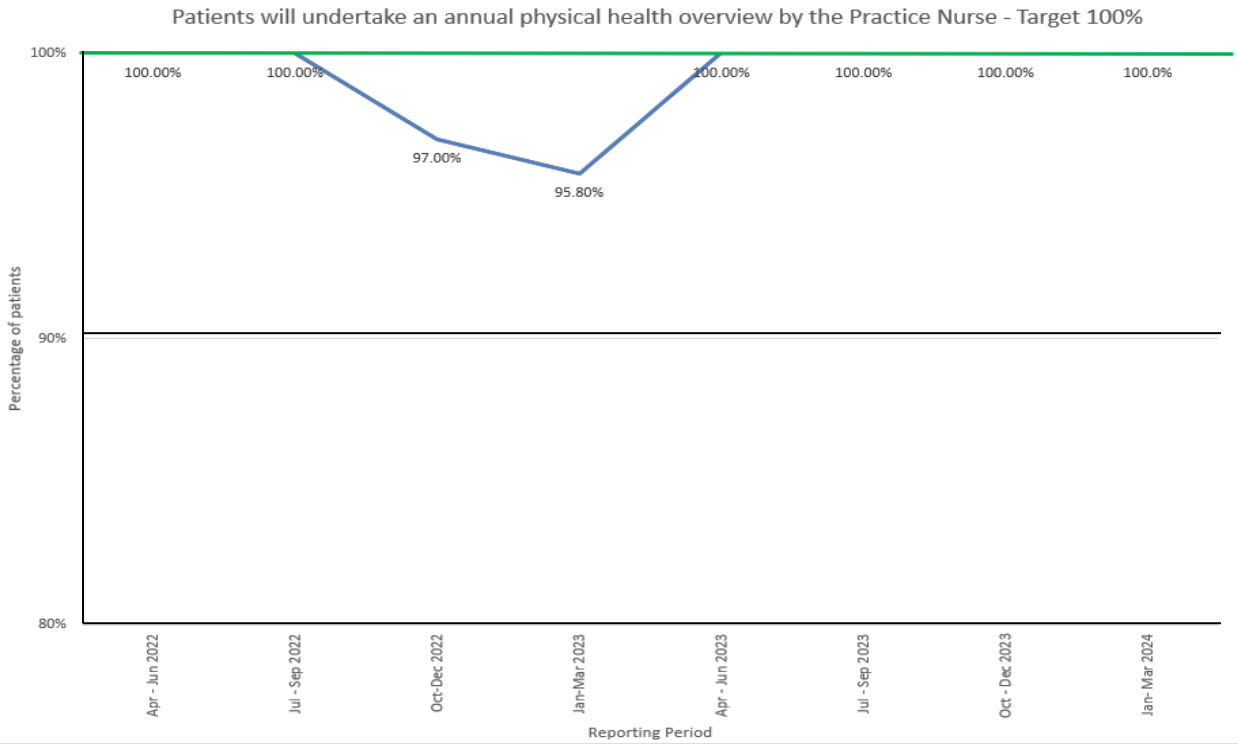
Performance Zone: Green

This indicator is linked to the National Health and Social Care Standards produced by Healthcare Improvement Scotland (HIS).

Performance Indicator	Target	RAG Q1 23/24	RAG Q2 23/24	RAG Q3 23/24	RAG Q4 23/24	23/24	22/23
Patients will undertake an annual physical health review	90%	G	G	G	G	100%	98.2%

This KPI charts the completion of an annual physical health overview by the Practice Nurse. The Practice Nurse will identify any patients that require to be reviewed face-to-face by the GP and these reviews will be conducted during the normal clinic sessions.

Chart 4: Patients will undertake an Annual Physical Health Review



No 5.2: Patients will undertake 150 Minutes of moderate exercise each week

Target: 70%

Data for 2023/24: 61.48%

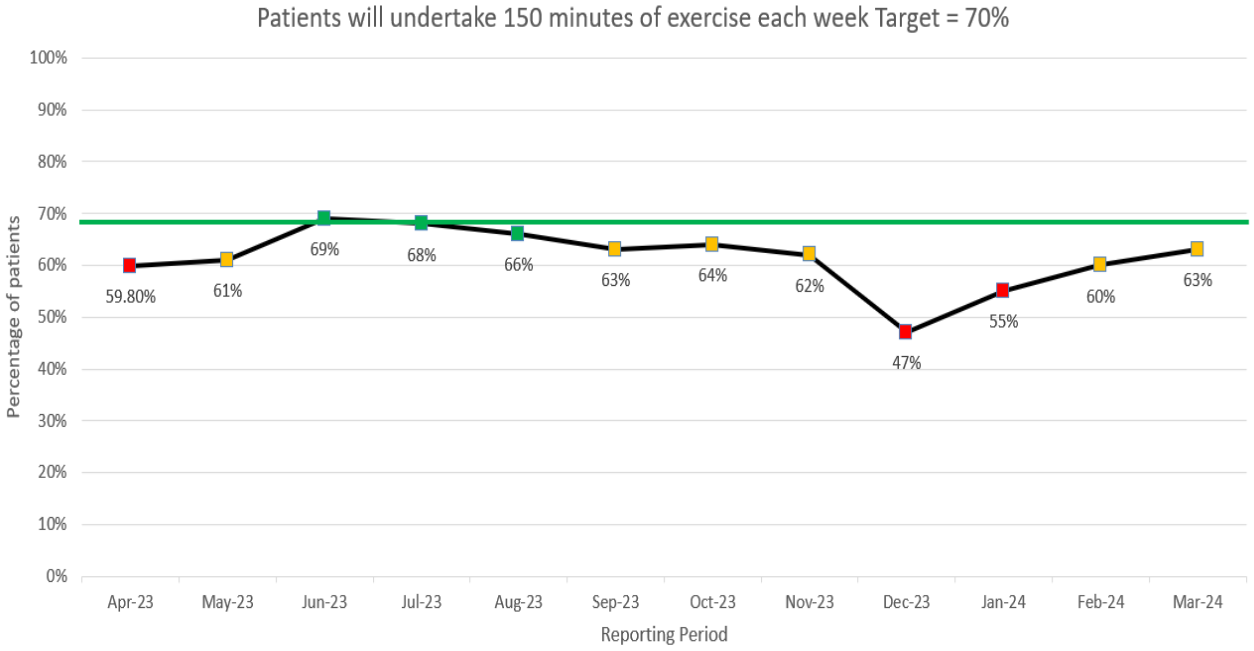
Performance Zone: Amber

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

Performance Indicator	Target	RAG Q1 23/24	RAG Q2 23/24	RAG Q3 23/24	RAG Q4 23/43	23/24
Patients will undertake 150 minutes of moderate exercise each week	70%	**A (63%)**	**G (66%)**	**R (58%)**	**R(59%)**	61.48%

At the Board meeting in June 2022, the Board agreed to change the corporate KPI from 80% of patients will achieve 90 minutes of moderate physical activity per week to 60% of patients will achieve 150 minutes of moderate physical activity per week following guidance released by WHO and reviewed by the Physical Health Steering Group (PHSG). At the Board Meeting in June 2023, it was agreed to increase the target further to 70% of patients will undertake 150 minutes of moderate exercise each week. Given that this is a stretch target we recommend that it remains unchanged for reporting year 2024/25.

Chart 5: Patients will undertake 150 Minutes of moderate exercise each week



No 6: Patients will have a Healthy BMI

Target: 25%

Data for 2023/24: 8.92%

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 our patient group.

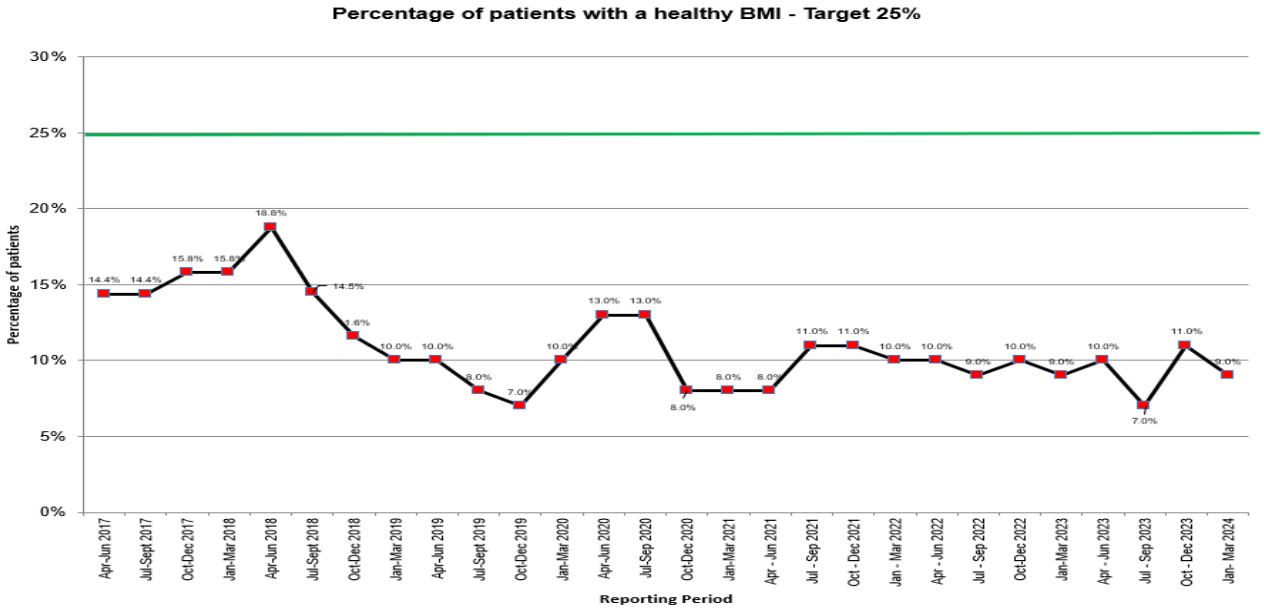
Performance Indicator	Target	RAG Q1 23/24	RAG Q2 23/24	RAG Q3 23/24	RAG Q4 23/24	23/24	22/23	21/22	20/21	19/20	18/19
Patients will have a healthier BMI	25%	R	R	R	R	8.92 %	9.5 %	10%	10.50 %	8.75 %	13.7 %

The average percentage of patients who have a healthier BMI decreased from 9.5% in the previous year to 8.92% in this reporting year. Q3 showed the highest increase of 11% throughout the year, the last time 11% had been achieved was in Q3 of 2021

The Physical Health Steering Group (PHSG) requested monthly monitoring reports to regularly review the data. The Supporting Healthy Choices Implementation Group (SHCIG) remit is to change the culture in TSH to maximise physical activity and promote healthier lifestyles, including dietary changes where appropriate. Engagement with Public Health Scotland on the adaptation of national

guidance for TSH has been positive with an agreement for TSH to develop best practice guidance ‘Moving towards a healthier State Hospital’.

Chart 6: Patients will have a Healthy BMI



No 7: Sickness Absence

Target: 5%

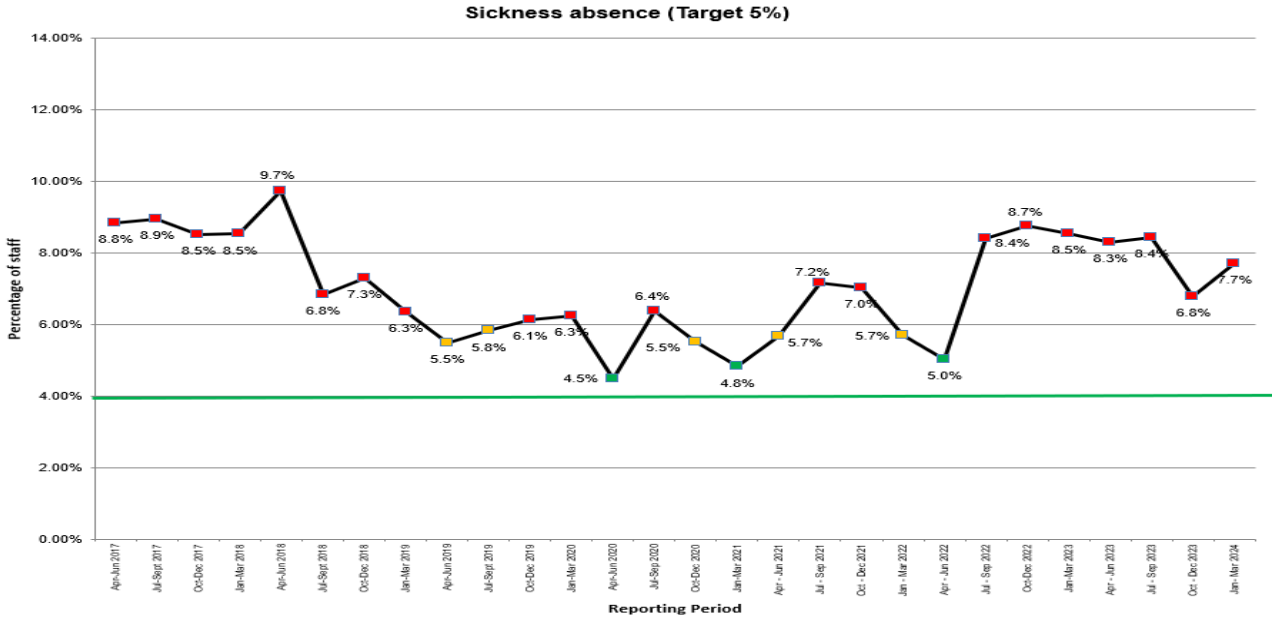
Data for 2023/24: 7.81%

Performance Zone: Red

Performance Indicator	Target	RAG Q1 23/24	RAG Q2 23/24	RAG Q3 23/24	RAG Q4 23/24	23/24	22/23	21/22	20/21	19/20	18/19
Sickness absence rate (National HEAT standard is 4%)	5%	R	R	R	R	7.81 %	7.68 %	6.39 %	5.30 %	5.92 %	8.26 %

In the reporting period 1 April 2023 to 31 March 2024, the rate of absence was 7.81% compared to 7.68% in the previous year - this is an increase of sickness absence levels by 0.13%, against a 5% target. TSH remains in the red performance zone for this reporting year.

Chart 7: Sickness Absence



Levels of absence across NHS Scotland have escalated significantly since COVID and a key focus and priority for Scottish Government remains reducing levels of absence to 5% in the case of the State Hospital (and 4% across the broader NHS).

The Staff Governance Committee agreed to establish a Task and Finish Group over 2023/24 to develop and co-ordinate an action plan with a range of activities to address attendance management and support staff. This group has implemented actions with local teams, which include:

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

There continues to be an ongoing focus on adherence to policy and accountability for performance managed within existing performance framework. Quarterly Directorate Performance Review meetings are held with Directorates and absence management is a focus for these meetings in areas where performance can be improved.

No 8: Staff have an Approved PDR

Target: 80%

Data for 2023/24: 85.93%

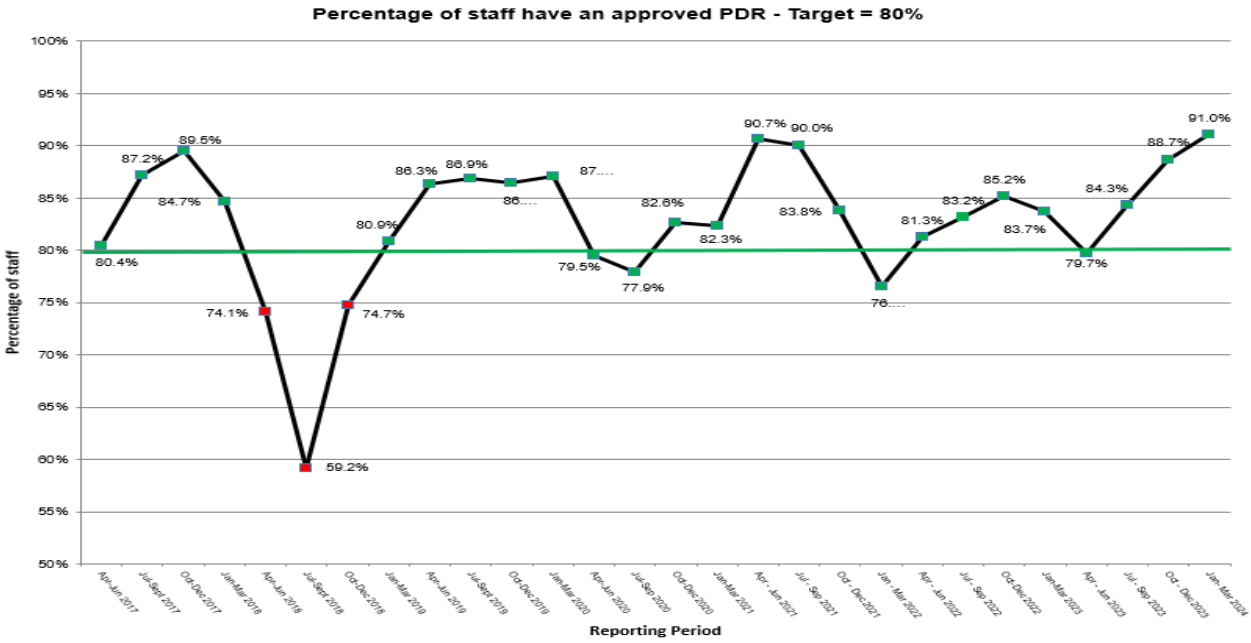
Performance Zone: Green

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

Performance Indicator	Target	RAG Q1 23/24	RAG Q2 23/24	RAG Q3 23/24	RAG Q4 23/24	23/24	22/23	21/22	20/21	19/20	18/19
Staff have an approved PDR	80%	G	G	G	G	85.93 %	83.35 %	85.25 %	80.58 %	86.68 %	80.9 %

The PDR compliance for this reporting year averaging at 85.93%. This is an increase of 2.58% from the 2022/23. This indicator has consistently been within the green zone since March of 2019. Fluctuations have occurred throughout this time however compliance has been maintained.

Chart 8: Staff have an Approved PDR



No 9: Patients are Transferred/Discharged using CPA

Target: 100%

Data for 2022/23: 100%

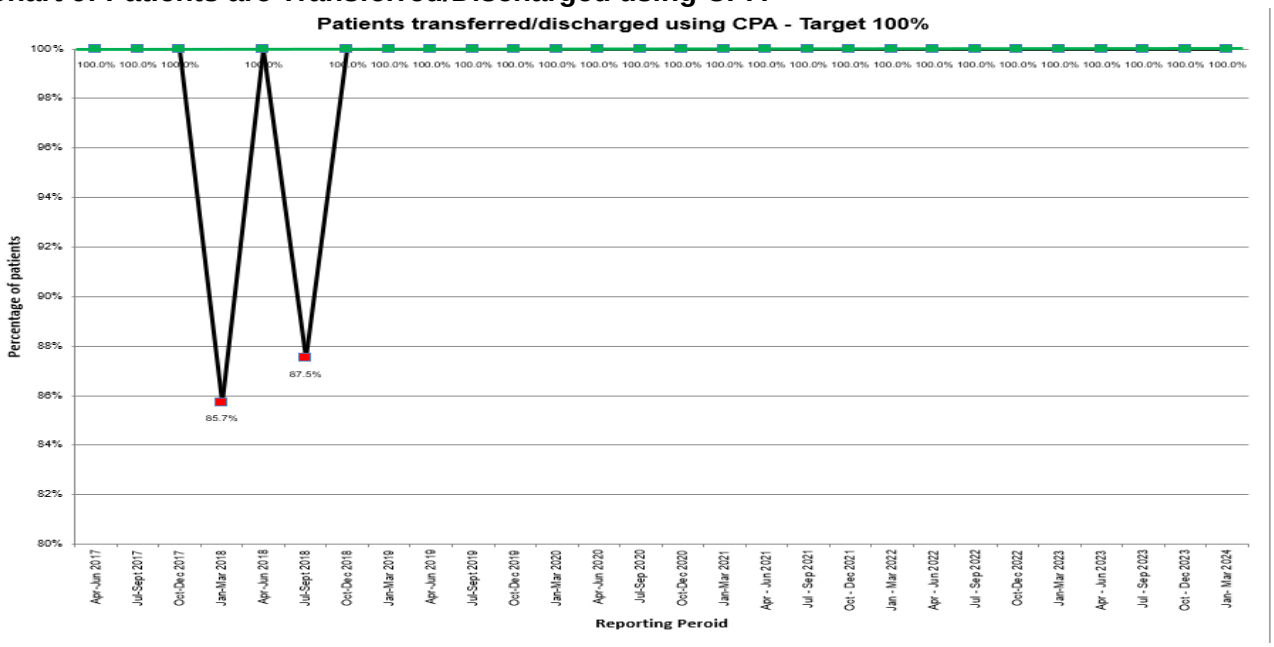
Performance Zone: Green

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.

Performance Indicator	Target	RAG Q1 23/24	RAG Q2 23/24	RAG Q3 23/24	RAG Q4 23/24	23/24	22/23	21/22	20/21	19/20	18/19
Patients transferred/discharged using CPA	100 %	G	G	G	G	100 %	100 %	100 %	100 %	100 %	97%

100% of patients were discharged / transferred using the Care Programme Approach (CPA).

Chart 9: Patients are Transferred/Discharged using CPA



No 10: Patients requiring Primary Care Services will have access within 48 Hours

Target: 100%

Data for 2023/24: 100%

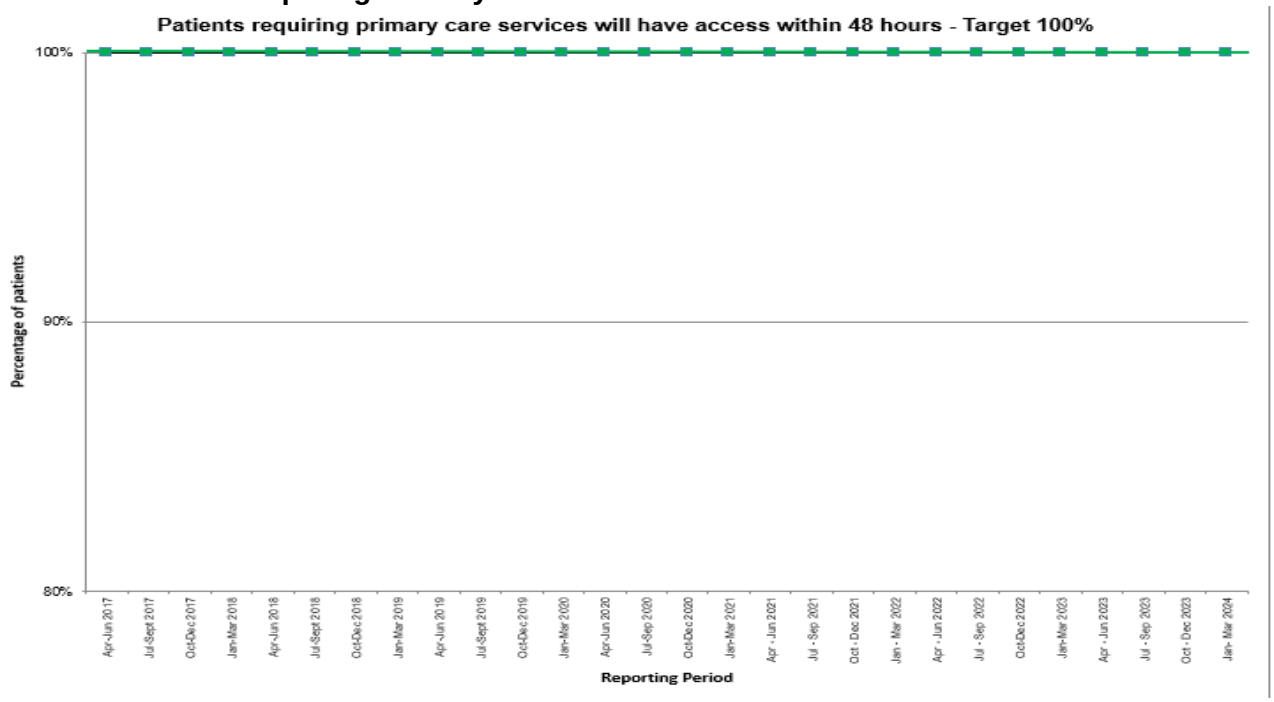
Performance Zone: Green

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 the Health Centre including triage.

Performance Indicator	Target	RAG Q1 23/24	RAG Q2 23/24	RAG Q3 23/24	RAG Q4 23/24	23/24	22/23	21/22	20/21	19/20	18/19
Patients requiring primary care services will have access within 48 hours	*100 %	G	G	G	G	100 %	100 %	100 %	100 %	100 %	100 %

This indicator has consistently stayed at full compliance since its data collection began.

Chart 10: Patients requiring Primary Care Services will have access within 48 Hours



No 11: Patients will commence Psychological Therapies <18 weeks from referral date

Target: 100%

Data for 2023/24: 99.12%

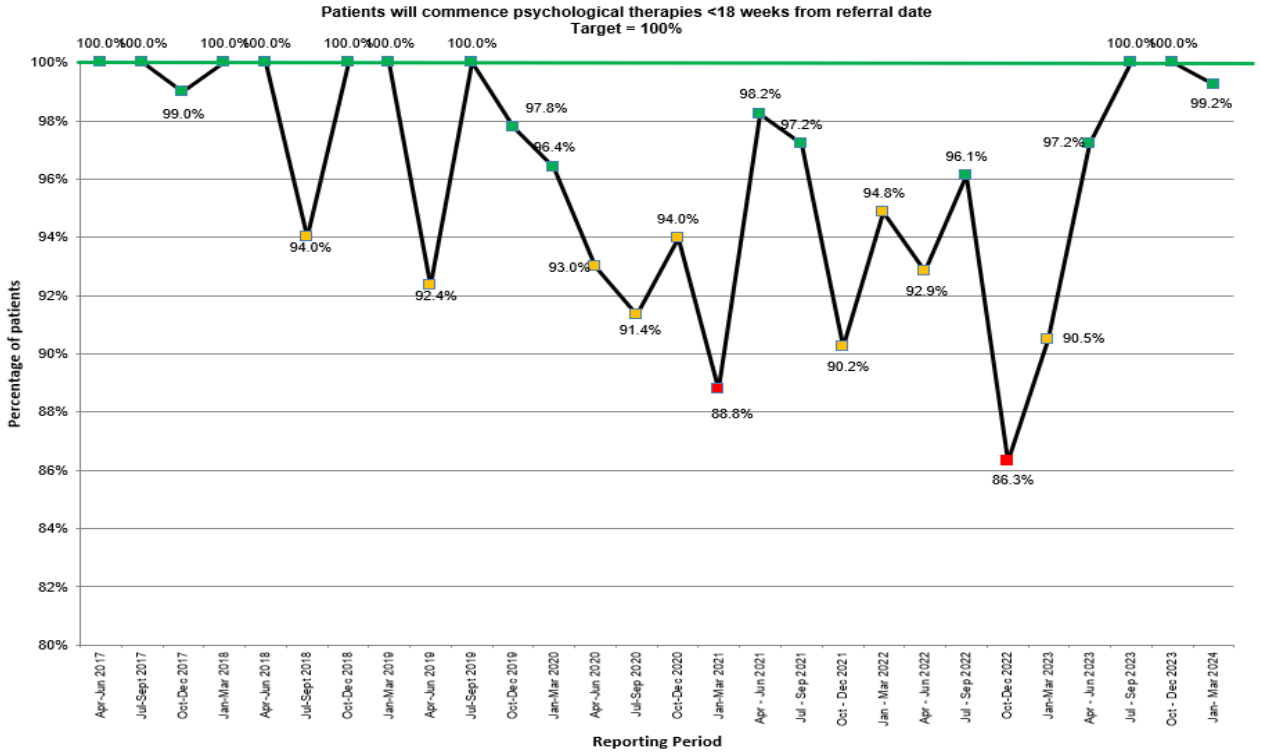
Performance Zone: Green

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 Scottish Government Target for this KPI is 90%.

Performance Indicator	Target	RAG Q1 23/24	RAG Q2 23/24	RAG Q3 23/24	RAG Q4 23/24	23/24	22/23	21/22	20/21	19/20	18/19
Patients will commence psychological therapies <18 weeks from referral date	100 %	G	G	G	G	99.12 %	91.43 %	98.66 %	97.66 %	99.78 %	98.5 %

There was an increase of 7.69% in this year's figure against 2022/23's figure. Compliance has moved into the green zone for this indicator. Work has been completed in year to collate this data from the electronic patient record (RiO) to ensure consistency and quality of data. Monthly review of patient needs is also planned, as part of the regular consultant meetings.

Chart 11: Patients will commence Psychological Therapies <18 weeks from referral date



No 14: Patients have their Clinical Risk Assessment reviewed annually

Target: 100%

Data for 2023/24: 93.79%

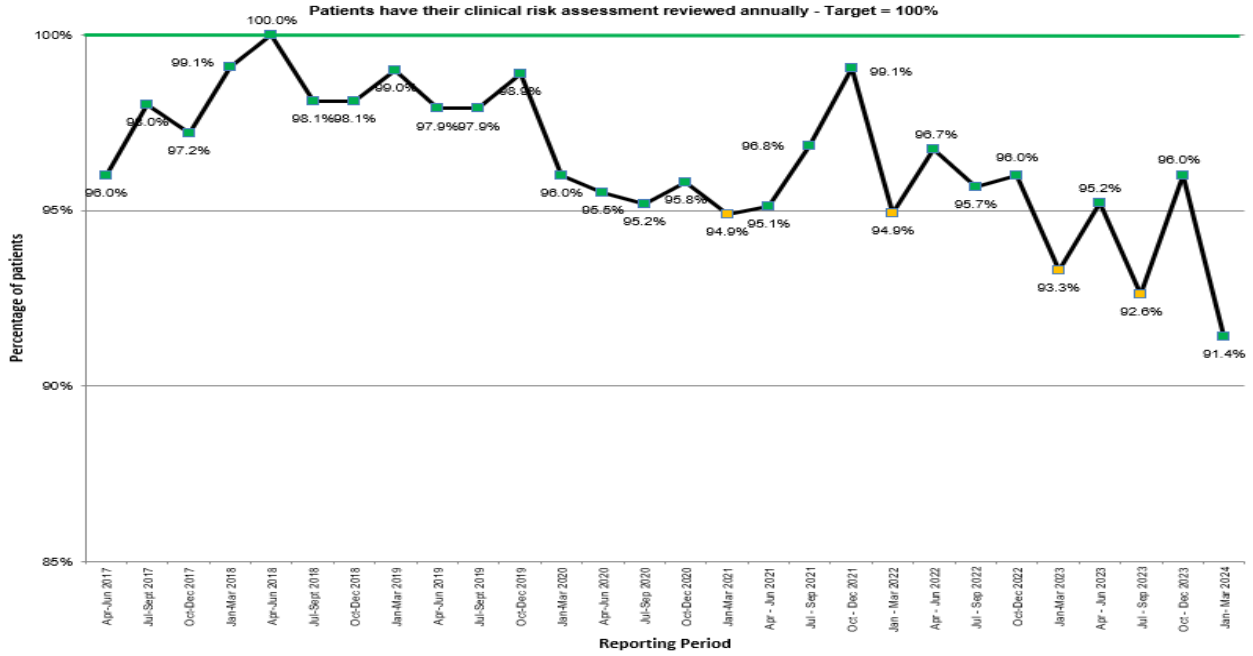
Performance Zone: Amber

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

Performance Indicator	Target	RAG Q1 23/24	RAG Q2 23/24	RAG Q3 23/24	RAG Q4 23/24	23/24	22/23	21/22	20/21	19/20	18/19
Patients have their clinical risk assessment reviewed annually.	100 %	G	A	G	A	93.79 %	95.42 %	96.49 %	95.35 %	97.68 %	99%

The average figure for this indicator in year 2023/24 is 93.79% this is a decrease of 1.63% on the review period last year.

Chart 12: Patients have their Clinical Risk Assessment reviewed annually



An issue has been identified with the timely sign off of the clinical risk assessments on RiO, with 7 of the 10 outstanding risk assessments in Q4 were completed however showing delayed sign off. This is being reviewed with actions to support improvement identified.

No 15: Attendance by clinical staff at case reviews.

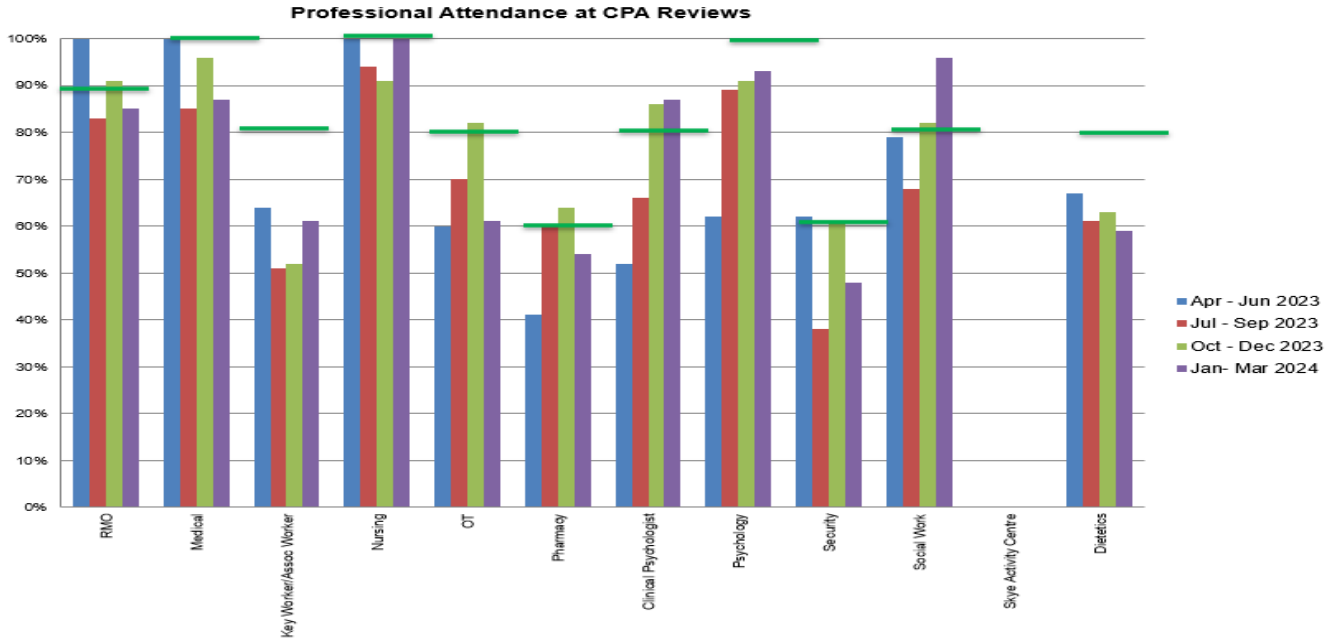
The table below provides comparative data on the extent to which professions met their attendance target. The targets for attendance are set to reflect what is reasonable to expect from each discipline and have been in place for over 5 years.

Attendance by clinical staff at case reviews

Professional Group	Target	18/19	19/20	20/21	21/22	22/23	23/24	Increase/Decrease from previous year
RMO	90%	90.9%	90%	78.5 %	87.25 %	84%	89.5%	Increase of 5.5% on previous year
Medical	100%	97%	96%	79%	90.5%	91.75 %	91.7%	Increase of 0.05% om previous year
KW/AW	80%	63.6%	78.3%	66%	58.75 %	58.75 %	56.9%	Decrease of 1.85% on previous year
Nursing	100%	96.5%	97.8%	92.3 %	97%	97.25 %	96.2%	Decrease of 1.05% on previous year
OT	80%	64.2%	86.3%	77.8 %	77.5%	42.25 %	67%	Increase of 24.75% on previous year
Pharmacy	60%	59.4%	61.3%	63.5 %	81.5%	59%	55%	Decrease of 4% on previous year

Professional Group	Target	18/19	19/20	20/21	21/22	22/23	23/24	Increase/Decrease from previous year
Clinical Psychologist	80%	84.3%	71.3%	67.8 %	68.25 %	59.25 %	73%	Increase of 13.75% on previous year
Psychology	100%	84.5%	87.8%	78.3 %	84.75 %	80%	84.2%	Increase of 4.2% on previous year
Security	60%	41.2%	52.5%	41.8 %	40.75 %	44.75 %	51.9%	Increase of 7.15% on previous year
Social Work	80%	80.8%	73.8%	87%	86%	80.75 %	81.2%	Increase of 0.45% on previous year
Dietetics	80%	23.6%	60.8%	77.3 %	59.75 %	66.25 %	61.9%	Decrease of 4.85% on previous year
Skye Centre Activity	tbc	1.1%	2.3%	0%	0%	0%	0%	No change
Hospital Wide	**n/a**	**65.6%**	**71.5%**	**67.4 %**	**69.3%**	**63.67 %**	**67%**	+3.33%

Chart 13: Attendance by clinical staff at case reviews



RMO – during 2023/24, there was an increase in RMO attendance at case reviews: the figure increased by 5.4%. This profession's average remained in the green zone for this reporting year.

Medical – during 2023/24, there was 0.25% rise in medical attendance at case reviews. This profession's average remains in the green zone for this reporting year.

Key Worker/Associate Worker – During 2023/24, there was a decrease of 1.75% in Keyworker/Associate Working Attendance at case review. This means that they remain in the red zone for this reporting year.

Nursing – Attendance from nursing during 2023/24 has increased by 1.25%. This profession remains in the green zone for this reporting year.

Occupational Therapy – during 2023/24, attendance from occupational therapy has significantly increased by 24.75% from the previous year. However, this profession remains in the red zone for this reporting year.

Pharmacy – During this reporting year this professional attend continues to decrease by 4% from the previous year. However, remained in the green zone for this reporting year.

Clinical Psychologist – there has been a significant increase of 13.75% attendance for 2023/24. This means that this profession changes to the amber from the red zone for this reporting year.

Psychology – during 2023/24, there was an increase of 4% in attendance for this department. This profession remains in the red zone.

Security – there was a 4% increase in Security attendance during 2022/23. The profession remains in the red zone for this reporting year.

Social Work – there has been a 7.25% increase in attendance at case reviews. This profession remains in the amber zone for this reporting year.

Dietetics – during 2023/24, attendance from dietetics has decreased by 3.25%. This profession is in the red zone for this reporting year.

Skye Centre Activity – during 2022/23, there was no attendance from Skye Centre staff at case reviews. This figure is the same as the previous reporting year. There is no target for this group as of yet.

4 RECOMMENDATION

The Board are asked to note the contents of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of Key Performance Indicator Performance in the TSH Annual Delivery Plan and Workforce Strategy is a key metric in supporting attendance management.
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?	Strategic Planning and Performance Group / CMT
Risk Assessment (Outline any significant risks and associated mitigation)	No implications identified.
Assessment of Impact on Stakeholder Experience	The gaps in KPI data which make it difficult to assess.
Equality Impact Assessment	No implications identified.
Fairer Scotland Duty	n/a

(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. ϒ There are privacy implications, but full DPIA not needed ϒ There are privacy implications, full DPIA included.

Paper No: 24/58

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item no: 26
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Director of Finance and eHealth
Title of Report:	Patient Digital Inclusion update
Purpose of Report:	For Noting

1 SITUATION

Driven by the SG Health & Care Strategy, which aims to harness the power of digital services and technology within our healthcare services, the State Hospital (TSH) wishes to ensure that all patients are provided with appropriate opportunities with regard to digital technology and devices.

2 BACKGROUND

The State Hospital already recognises the need for staff, patients, and visitors to own and use technology within the Hospital, whilst also providing a safe and secure environment. A framework is provided through the Technology and Electronic Devices within the State Hospital Policy and Procedures. This sets out the detail of technology/devices authorised for use within the Hospital, and any restrictions that may apply to the use of such technology or devices.

Patients within the State Hospital have limited access to digital technology and opportunities. Current areas of digital inclusion are:

- Use of PCs and supervised access to the internet through the Patient Learning Centre.
- Limited online catalogue browsing as part of an 'enhanced' shopping experience.
- Use of technology to assist/augment communication (there is one device in use).
- As a result of COVID, the rapid introduction and ongoing development of video visiting.

If Digital Exclusion is not tackled further, however, the gap between those with and without digital skills or access to technology will potentially continue to grow.

3 ASSESSMENT AND OUTCOMES

Led by the eHealth Project Managers, an extensive exercise was undertaken in 2023 – engaging with a broad range of stakeholders both patient and staff, and with other high secure services in the UK – providing a detailed “Options Appraisal” for Digital Inclusion.

After this extensive consultation, the Options Appraisal and strategy was presented to TSH governance groups, including at the October 2023 Board meeting, and was approved for being taken forward as a blueprint for implementation – providing a roadmap with timescales and potential costings.

However, since this approval was given, the Scottish Government financial position has unfortunately changed for the worse, with a resultant impact on nationwide capital funding.

SG have issued notification that all additional capital project funding intended for 2023/24 is on hold, with the exception only of a small number of specified national areas of work. All other funding, including many projects already approved, are therefore on hold, and no new business cases are to be presented.

Accordingly, the overall digital inclusion programme for TSH is therefore currently on hold, as it cannot be taken forward in full without application for funding for both capital and revenue (staffing / resourcing) support.

It is important to note that we will ensure that awareness is maintained of any potential new SG funding routes which arise in-year or for future consideration, and for which this project may be eligible – although expectations of this are low and none have yet been raised. In the meantime, every effort will be made to address any elements of the strategy which may be affordable within our existing funding and resources, for example potentially the upgrade of the patient banking system.

4 RECOMMENDATION

The Board is asked to note the update.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	20 June 2024
Agenda Reference:	Item No: 27
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 16th May 2024; The next Project Oversight Board is scheduled for 27th June 2024. At the meeting of 16th May the Programme Director provided an update on the current status on the project, the Project Risk Register and financial details.

3. ASSESSMENT

a) General Project Update:

The project is in the final stages. All quality targets are being met; project completion is now scheduled for August 2024 (see Project Timescales for a detailed overview of current progress at 3b below) and costs are projected to overspend (See Finance – Project Cost at point 3c below).

b) Project Timescales

Programme revision 58 has been accepted and revision 59 is in development. A verbal update on Revision 59 will be available to the Board.

The installation of technology is substantially complete. Remaining works are final elements of installation, Site Acceptance Testing of the installation and production of documentation; difficulties in addressing CCTV problems have been the primary cause of recent programme delays. Other final elements of installation include commissioning of external perimeter cameras and minor works; the quantity of these have the potential to further impact on the programme, particularly if Site Acceptance Testing needs to move into holiday periods for critical staff. Mitigation for this potential problem is being explored.

c) Finance – Project cost

The project is proceeding according to the current projected cost plan, in that the contract with Securitas is due to underspend against budget, including available contingencies. Project management costs and associated contingencies have been affected by changes in the project timescale. The project currently has a potential overspend (exclusive of VAT) of approximately £680k. This has increased by approximately £34k since the April report to the Board.

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

Project Start Date:	April 2020
Planned Completion Date:	August 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 08/06/24:	£9,473,068
Total costs to date (exc. VAT & retention) at 08/06/24:	£9,312,234
Total costs to end of project (Exc. VAT & retention)	£ 159,834

The cash flow schedule planned for the months to come is confirmed on a rolling basis in order to ensure that the Hospital's cash flow forecast is aligned and that our SG funding drawdown is scheduled accordingly. All project payments are processed only once certification is received confirming completion of works to date.

While it is not a prerequisite of the project, regular reports to the SG Capital team are also being provided to notify of progress against total budget. A letter to Scottish Government was issued week commencing 29 January 2024 as part of the financial planning for 2024 – 2025 outlining the projected spend from April 2024 to anticipated end date and this has been accepted.

A Rounded breakdown of actual spend to date (Exc. VAT) at 08/06/24 is:

Securitas	£ 7.274m
Thomson Gray	£ 1.079m
Doig & Smith	£ 0.008m
HVM	£ 0.192m
Staff Costs	£ 0.863m
Income	-£ 0.103m
Total	**£ 9.312m**

VAT has been excluded from calculations of amounts paid due to the need for the reclaim to be applied for and assessed.

4 RECOMMENDATION

That the Board **note** the current status of the Project.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Update paper on previously approved project
Workforce Implications	N/A
Financial Implications	***The projected overspend is regularly communicated to Scottish Government and is an ongoing action at Project Oversight Board.***
Route to the Board Which groups were involved in contributing to the paper and recommendations?	Project Oversight Board
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	***Contract agreement stipulates compliance with Fairer Duty in respect of the remuneration of staff and contractors.***
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ϒ There are privacy implications, but full DPIA not needed ϒ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

AUDIT AND RISK COMMITTEE **ARC(M) 24/02**

Minutes of the meeting of the Audit and Risk Committee held on Thursday 21 March 2024

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

Chair:	
Non-Executive Director	David McConnell
Present:	
Employee Director	Allan Connor
Executive Director	Stuart Currie
Non-Executive Director	Pam Radage
In Attendance:	
Head of Estates and Facilities	Kenny Andress
External Auditor, KPMG	John Blewett
Internal Auditor, RSMUK	Victoria Gould
Head of Risk and Resilience	Allan Hardy (from Item 7)
Internal Auditor, RSMUK	Asam Hussain
Chief Executive	Gary Jenkins
Director of Finance and eHealth	Robin McNaught
Head of Corporate Planning, Performance & Quality	Monica Merson
Chair	Brian Moore
Head of Procurement	Stuart Paterson
Head of Corporate Governance/Board Secretary	Margaret Smith
Director of Security, Estates, and Resilience	David Walker
External Audit Director KPMG	Michael Wilkie (from Item 17)

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting, and advised that there were no apologies submitted for today's meeting.

2 CONFLICTS OF INTEREST

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

3 MINUTES OF THE PREVIOUS MEETING

The Committee approved the Minutes of the previous meeting held on 25 January 2024 subject to the following amendments:

On page eight, Mr Jenkins suggested the removal of figure quoted and of discussion surrounding this due to the confusion this may cause.

The Committee:

a) Approved the minutes held on 25 January 2024 subject to the amendments noted above.

4 MATTERS ARISING – ACTION PLAN UPDATE

There were no additional urgent matters which arose for discussion.

The Committee received the action list and noted progress on the action points from the last meeting with Mr McConnell seeking clarification on three areas:

1. Wording of fraud action point 2: Mr McNaught clarified that this point was closed and then updated.
2. Financial report, point 6 on action plan, would evolve on an ongoing basis.
3. Relevant information in relation to the Fraud action update to be passed on at future meeting

The Committee:

1. Noted the updated action list.

INTERNAL AUDIT

5 INTERNAL AUDIT PROGRESS REPORT

a) Audit Progress Report

Mr Asam Hussain from RSMUK directed members to page 20 of the progress report highlighting the work which has been undertaken and informed the Committee that good progress is being made as set out on the action tracking paper.

Mr Assam stated that a draft report on the new clinical model review was scheduled to be issued following a debrief on 2 April 2024.

Mr Hussain advised that due to delays with the security project impacting the completion of the 2023/2024 review, following discussions, it had been agreed to go forward with the Complaints Audit from next year's plan to allow the Board to receive the annual Internal Audit opinion for 2023/24.

Mr Hussain discussed the briefing papers contained within the report, highlighted the key changes and updates on the changes to the global internal audit services on page 26, and stated that RSMUK are aligned with the Global Internal Audit standards and would continue to undergo external quality assessments every five years. There would also be a further three updates throughout the year, which will be shared with the Committee, and guidance given on the impact these may have and requirements needed to meet the standards.

Mr Hussain also highlighted the briefing on page 28 discussing the emergency risk radar to Committee members for their information.

The final briefing note highlighted by Mr Hussain was on page 38 around action to manage risks and driving improvements. This outlined the key areas for management to think about when an audit is planned for their area. It also outlined what the management role is in an audit scoping process and will be a useful tool to share with new auditees.

b) Tracking Report

Mr Hussain discussed the actions within the tracking paper advising that only two of the eleven actions were due. He provided an update on both, stating one had been closed as being implemented and the other, which related to patient care plans from the clinical observation audit, was in progress.

Mr Hussain noted that a further two actions were closed and one was superseded by changes to Scottish Government guidance. There will also be three Environmental, Social and Governance actions deferred by six months due to the focus on the security project. Mr Jenkins thanked Mr Hussain for the updates and highlighted the outstanding action surrounding the clinical observation policy acknowledging that this has been a challenging policy due to its complexity but wanted to assure the Committee that we are at the completion stage and expect that by next year this outstanding action would be removed. Mr Jenkins also stated that budget depending, there may be more work carried out surrounding the Environmental Sustainability Group actions.

Mr Currie thanked everyone for their hard work on completing actions and conveyed that he found the paper and explanation within very helpful.

Chair and Committee noted that this was a positive report and echoed Mr Currie's view.

The Committee:

1. Noted the Internal Audit Progress Report and Support and agreed to bring the Complaints Audit forward.
2. Noted the updates provided on the briefing notes.
3. Noted Tracking Report.

6 INTERNAL AUDIT REPORTS

There were no finalised audits to be presented to today's meeting.

The Committee:

1. Noted that there were no finalised audits to be presented to today's meeting.

7 DRAFT INTERNAL AUDIT PLAN

Mr Hussain advised how discussion with Executives, Mr Jenkins and Mr McNaught helped prioritise which areas to focus on, included within page 61 which shows what areas had been prioritised for the coming year. He highlighted that one of these areas will be around Physical Health as this area is one of the highest risks on the Corporate Risk Register.

Another area planned was around consultant discretionary points, including a review of the governance and decision-making arrangements as well as consistent application.

Further to the point made in the internal audit progress report the security review would be substituted in favour of a review surrounding complaints management. A review of statutory and mandatory training would also take place, which will include how the risks of non-compliance are being managed. The clinical care policy application and roll out would also be reviewed.

Mr Jenkins explained the reasoning for the above areas being identified as the ones to focus on as opposed to finance, stating that there are already robust finance processes in place for this year.

Mr Currie stated that he was happy with the areas identified and felt it beneficial to focus on areas other than finance. Mr McConnell thanked Mr Hussain for the update and found the plan very helpful, and he sought clarity on how the review of the consultants discretionary points would be carried out given that it is quite an unusual area.

Mr Jenkins explained that the review was to ensure that our processes are aligned with other health boards and to look at who sits on the Committee, how it works and to ensure we have the right level of governance. The audit will provide advice to enable us to make changes and assess where we are in relation to other boards.

The Committee:

1. Noted and approved draft Internal Audit Plan.

INTERNAL CONTROL AND CORPORATE GOVERNANCE

8 CORPORATE RISK REGISTER UPDATE

Mr David Walker provided an update on the Corporate Risk Register and, referring to Section 3, explained that there are no out of date risks and no proposed risks for inclusion.

Mr Walker highlighted that were three risks graded as being high, including FD 90 relating to the financial position. The COVID-19 risk assessment had been reduced to minor/rare. Monthly updates of the three high graded risks were also contained within the paper. Mr Walker pointed out that there was one minor error within CEL – 'risk grading has been reviewed and has changed to minor/unlikely' this should be moderate/unlikely with the target grade as minor/rare.

Mr Walker informed the Committee that work is ongoing on the development of the Corporate Risk Register and that the Risk and Resilience Team are working towards migrating the risks across to the Datix system. This will help to better manage risks and to better use the data to interrogate and manage risks.

Mr Walker stated that the next Directorate to be reviewed would be Security.

Ms Radage thanked Mr Walker for the update and raised a point surrounding the risk around Physical Health and the timing of the audit in June, as part of the internal audit plan, asking whether this timing was beneficial. Mr Walker commented that this would be a point for the risk owner. Mr Hussain thanked Ms Radage for highlighting this and would discuss with the Medical Director to ensure the timing is appropriate.

Action: Mr Hussain to discuss timing of physical health audit with Medical Director.

The Committee:

1. Noted the update to Corporate Risk Register, the changes and comments.

9 FINANCIAL POSITION UPDATE REPORT

Mr Robin McNaught discussed the finance report and stated that as we are close to year-end our forecast remains for the State Hospital (TSH) to achieve break even and our savings target. Mr McNaught informed the meeting that there have been weekly Capital Group meetings to ensure that capital spend is fully utilised for the year.

Mr McNaught stated that the budgeting meeting with all Directorates and senior staff for 2024/2025 was almost complete and that the updated draft will shortly be submitted to the Scottish Government with the detail of this being brought to the Board in April. Mr McNaught asked the Committee if there was any further information they would like to see in terms of the financial report being brought before the Audit and Risk Committee.

Mr Currie commented that it is worth noting that TSH was projected to make break even and savings targets for this year and this will have a positive impact going into new financial year and asked that Mr McNaught keep the Board updated as the year goes on regarding recurring and non-recurring savings pressures.

Mr Currie also asked for clarification around staffing levels and budget constraints impacting on the financial position. Mr McNaught advised that staffing levels do form part of budget reviews and discussions were held with Directors to determine if their current staffing structure is fit for purpose. Mr McNaught added that progress against savings would be monitored and carefully managed on a month-by-month basis and if any Directorate was falling behind on their savings they would be required to explore what could be done to redress this.

Mr Jenkins replied to Mr Currie by saying that 23% was built into funding for frontline nursing posts and noted the impact of staff absence and the challenge of overtime required. Mr Jenkins stated that a proactive push would be needed this year to maintain and sustain a break-even position in 2024/25. Mr Jenkins reiterated Mr Currie's point of needing pre-emptive planning and control in terms of future recruitment.

Ms Radage asked for clarification around whether there is sufficient funding in relation to the e-Rostering project referenced in point 3.2. Ms Radage also agreed with a more proactive approach and more scrutiny when approving posts and made to reference to practices used during COVID-19 in which we were able to ascertain useful disciplines and ways of working.

Mr McNaught advised that in relation to e-Rostering the implementation cost was factored into the future budget. In addition, if there was an element from COVID practices that we wish to take forward, this will be factored in as will practices which would provide additional scrutiny. Work has also been undertaken to engage staff beyond Director level to think more frequently about the financial consequences when making operational or managerial decisions.

Mr Jenkins reiterated that there will be a close focus on finance in the coming year and all workings and findings will be brought to the Board and its Committees. Mr Jenkins and Mr McNaught both stated that no specific pay increase has as yet been included in the budget forecast under instruction from Scottish Government.

Members were happy with level of detail held within the report.

The Committee:

1. Noted the Financial Position Update.

10 CAT 1 AND CAT 2 ANNUAL UPDATE ON OUTSTANDING ACTIONS

Mr Walker presented the adverse events tracker and explained the guidance followed to identify when an incident would meet the category one or category two criteria. He explained that a weekly risk report was provided to the Corporate Management Team (CMT) who decide whether to commission a category one or two investigation, in response to incidents. If a review is commissioned, the final report is submitted to CMT for approval on any proposed actions and recommendations. Thereafter the Organisational Management Teams have responsibility for monthly monitoring of actions. This governance structure has been put in place to mitigate any delays in actions being progressed and to allow oversight across the organisation and ties in with corporate risk SD 57 - failure to complete actions within an appropriate timescale.

Mr Walker explained that there were currently two actions outstanding and provided background in relation to these, both are being progressed. One Cat1 investigation, in relation to a medication incident is outstanding, due to a key member of staff being unavailable for interview.

Mr Walker stated that there have been a number of recommendations in relation to the investigation in 3.3, which was an email incident, and the actions had been agreed by CMT. There were two recently commissioned reviews, noted in 3.4. One related to incident command arrangements following a recent incident, and was currently being reviewed. The other related to a staff and patient assault and the terms of reference were being developed.

Mr Walker provided assurance that progress was being made on any relevant actions and asked the Committee to note content of report.

Mr McConnell thanked Mr Walker for the update.

The Committee:

1. Noted the Cat 1 and Cat 2 annual update on outstanding actions.

11 SECURITY AUDIT 2022/2023

Mr Walker provided background detail on how the security audits were carried out stating that there are two separate audits. One was the audit of practice, undertaken by the Forensic Network every 18 months and focused on specific security arrangements, and the other was of the physical security measures undertaken annually by an independent specialist security advisor.

Mr Walker explained that in March 2022 the Forensic Network advised that they were reviewing their audit process so in the interim we carried out our own internal audit, identifying seven minor actions that have all since been implemented through the Security, Risk, Health and Safety Oversight Group. Due to the ongoing upgrade of physical security systems, the need for that audit has been on hold. However, since these various elements had now been successfully installed, TSH could start to undertake the physical security element of the audit process.

Mr Walker informed the Committee that in relation to the audit of practice audit some staff visited the High Secure Hospitals in England, who have a robust annual audit process based on the findings in the Tilt Report of 2000. TSH had acquired and adapted their peer review audit so that it could fit with TSH processes and procedures, given the different framework applicable in Scotland.

Mr Walker provided some background information on the recommendations of the Tilt Report and the reasons why TSH did not implement it in full – and that a request had been made to peers from NHS England's High Secure Hospitals to carry out a mock audit. The mock audit was currently taking place and a report would be provided which would then be assessed to ensure that this provides us with assurance that the way in which we audit would identify any weaknesses in practice and procedures. This final report would then be brought to CMT for any next steps and then onto the Audit and Risk Committee.

Mr Jenkins highlighted that this is a developing piece of work and outlined the reasoning behind keeping this to a small group to take forward. Ms Radage commented that it is very helpful to have a working relationship with the other High Secure Hospitals and commended Mr Walker and his team for keeping up this relationship. Mr McConnell echoed this and asked if the Committee would expect to see an update of the mock audit at the next meeting in June.

Mr Walker advised the mock audit report would be due within 5 to 6 weeks of the audit and would then need to be reviewed and considered by the relevant members of staff. Mr Jenkins clarified that any feedback would be a report on the areas we are looking into rather than a report of the audit.

The Committee:

1. Noted the Security update 2022/2023.

12 POLICY UPDATE

Mr McNaught provided an update in regard to outstanding policy reviews noting there was a slight upturn in policies pending, which was being closely monitored but was not cause for concern. The

Policy Approval Group continue to provide leadership for this and also consider where appropriate, if their extensions are required for some of the review times.
Mr McNaught noted that there are number of reviews in relation to Once for Scotland which were still ongoing so this had an impact on HR Policies, adding that progress continued to be effective overall and there was strong engagement with policy holders.

Mr McConnell noted the slight upturn in outstanding reviews and the background provided within reporting.

The Committee:

1. Noted the Policy Update.

13 FRAUD UPDATE AND ACTION PLAN

Mr McNaught advised the Committee about the work that continued to make staff aware of warning signs and what to be looking out for in relation to fraud. Mr McNaught made reference to matters which have arisen in the last quarter as noted in the report and stated that all that required to be reviewed had been resolved satisfactorily with no follow ups required.

Mr Moore asked for clarification surrounding staff contacting Counter Fraud Services (CFS) in appropriate areas. Mr Connor clarified that there had been instances of reports made around flexible working and support provided to staff to help them return to work after an absence. Mr Connor also asked for some assurance that each of the cases reported to CFS had been investigated and found to be unfounded as the report given is brief in detail. Mr McNaught confirmed that due to confidentiality the report had to be brief but confirmed that cases reported had an audit trail of each set of circumstances, reported along with all details of what investigation had been carried out.

Mr Currie asked if this could be a staff governance issue to make staff aware of the appropriate channels to report such matters to and to the reasons why the option of reporting to CFS seemed to be the preferred option to staff. Mr Jenkins asked Ms Radage as the Chair of the Staff Governance Committee if it would be helpful to highlight to staff the whistleblowing policy and procedures as well as other avenues open to staff. Ms Radage agreed and Mr Moore informed the meeting that one of the proposed actions from a recent development sessions was to raise the profile of the whistleblowing policy.

Action: Staff Governance Committee to raise profile of whistleblowing policy and procedure.

The Committee:

1. Noted the Fraud Update and Action Plan.

14 CYBER SECURITY CRIME REPORT

Mr McNaught discussed the Cyber Security Crime Report advising that there has been no issues reported. Mr McNaught assured the Committee that despite the report not flagging up any issues, there was a strong awareness of current risks and that TSH had been successful in detecting and quarantining any threats. Mr McNaught also made reference to the recent Dumfries and Galloway Health Board security issue and explained that this Health Board provides TSH with Occupational Health Services, he added that at this time with the information available to us there was no indication that that any TSH staff records had been compromised.

Mr McNaught added that cyber security mandatory training continued throughout the hospital, and that there has recently been a positive outcome on completion of an extensive penetration test

which was undertaken by a third party. The penetration test resulted in a number of recommended actions which have been prioritised and any high priority actions would be promptly addressed.

Ms Radage asked for clarity on whether the number of incidents had increased or decreased and if there were sufficient resources available to the infrastructure team in order to deal with cyber security issues. Mr McNaught clarified that incidents had gone up and as such the additional systems and measures that need to be put in place does cause financial pressure as well as staffing pressures. Mr Hussain noted that if the eHealth team resources were under pressure then digital solutions may be of assistance. Mr Jenkins assured the Committee that an informed judgement would be taken in respect of eHealth resources within the confines of the budget without compromising cyber security.

The Committee:

1. Noted the Cyber Security Crime Report.

15 ANCHORS STRATEGY UPDATE REPORT

Ms Monica Merson briefed the Committee on the Anchors Strategy, providing background as to what this entailed. She advised that the Anchors Strategy was submitted to the Scottish Government in October 2023 with feedback being received in January 2024 with a request to provide baseline metrics. Ms Merson explained that the Scottish Government would like aims and actions to be stated explicitly, and to demonstrate how TSH could reach realise its full potential in this regard.

The feedback also requested a self-assessment into the progression framework be carried out. All feedback will be reviewed and where possible adjustments made going forward.

Ms Merson explained that the baseline metrics were based on the year 2022/23 and were broken down into three areas: Workforce, Procurement and Land and Assets. Ms Merson asked for feedback in relation to the baseline metrics as outlined in the report so these could then be submitted to the Scottish Government. Ms Radage asked, in relation to the workforce baseline statistics, if there were any cost effective actions that may help in this area. Ms Merson agreed and stated that she is currently working with colleagues in the Workforce Directorate in relation to the areas identified for progression.

Mr Jenkins agreed on points made that some areas within the Anchors Strategy may be challenging but added that there were initiatives that were positive and would be a benefit to TSH as well as the local economy.

The Committee:

1. Noted the Anchor Strategy Update alongside the baseline metrics for submission to Scottish Government.

EXTERNAL AUDIT

16 INTERIM AUDIT UPDATE 2023/24

Mr Blewett briefed the Committee on the interim audit by stating that the majority of risk assessment work was complete with the audit team on track for the planned visit to TSH in May.

The Committee:

1. Noted the Audit Update.

17 AUDIT PLAN 2023/2024

Mr Blewett discussed the audit plan making reference to page 137 in the audit pack stating that the risks which were added to this in January had settled into position, and adding that the only update that has just been added in this area is around the valuation of land and buildings. The Plan however has been updated to add a "wider scope" element.

Mr Blewett stated that due to the security upgrade project running longer than expected, focus would be on the elements surrounding this that had been completed. He delivered the audit plan updates as detailed on page 8 of agenda and stated that no significant risks had been raised.

Mr McConnell observed in terms of finance that costs and figures quoted would change over time and asked if the national discussions surrounding the audit fee were still ongoing. Mr McNaught confirmed that this discussion was still ongoing.

The Committee:

1. Noted the Audit Plan 2023/2024.

STANDING DOCUMENTATION / GOVERNANCE STATEMENT

18 DRAFT GOVERNANCE STATEMENT

Mr McNaught briefed the Committee on the draft governance statement advising that the content had been updated in regard to the Board's activity during the year. Once internal and external audits have been concluded the relevant wording would then be updated.

The Committee:

1. Agreed the Draft Governance Statement and that this should be presented to the Board at its meeting in June 2024.

19 REVIEW of SCHEME of DELEGATION and STANDING FINANCIAL INSTRUCTIONS

Mr McNaught briefed the Committee on the standing documentation advising that no significant changes have been made with the exception of minor procedural wording and a correction and update of references to the Audit and Risk Committee. Mr McNaught informed the Committee that there was a comprehensive and full review in terms of legislative updates in the last year and gave assurance that apart from the updates highlighted, there are no further to note for this year.

Ms Radage asked if there might be a further review in the light of potential authority figures decreasing. Mr McNaught advised that a number of individual directorates were looking at how authorisation levels were set within their own teams.

Mr McConnell asked if this would be seen in future versions of the Standing Financial Instructions (SFIs). Mr McNaught explained that depending on the situation at individual level it may be reflected on in the SFIs as appropriate.

Mr Moore asked if there should be something added in respect the Chief Executive's authority to overspend in a particular situation, should this arise, and how this related to Board oversight. Mr Jenkins advised that within the documentation it did state that Chief Executive would have approval.

Mr McConnell agreed that future clarification and discussion on this point would be worthwhile, as overspends against financial targets could have audit implications.

Action: Mr McNaught

Mr Blewett confirmed that if any overspend that was not agreed with Scottish Government would be something that would then be included in the Audit Opinion.

The Committee:

1. Agreed for submission of Scheme of Delegation and Standing Financial Instructions to the Board.
2. Requested further clarification on the CEO authority for additional spending, and relating this to Board oversight.

20 REVIEW of ACCOUNTING POLICIES

Mr McNaught delivered the update on the accounting policies and highlighted that there were no major amendments from 2023 but added that these would be reviewed and checked through the audit process. There were no major matters to highlight prior to the Committee's approval.

The Committee:

1. Agreed the Review of the Accounting Policies.

21 REVIEW of BOARD STANDING ORDERS and CODE of CONDUCT

Ms Smith presented the review of annual board Standing Orders and the Members Code of Conduct stating that there have been no further proposed changes since the Standing Orders were last updated in 2020 to align with national guidance, and there were no proposed changes to be made. Ms Smith added in relation the code of conduct there were no changes to this either but highlighted that the Standards Commission had recently amended the councillors code following a series of recommendations.

Ms Smith advised that she had recently attended a workshop led by the Standards Commission in relation to code of conduct and briefed the Committee on key issues surrounding the explanatory guides to aid members understand the code of conduct, and how it applied to them, as well as the potential consequences should these be breached.

Ms Smith informed the Committee that as things stand there are no amendments to be made and asked committees to approve this to go forward to the Board.

The Committee:

1. Approved the Standing Orders and Code of Conduct, recommending that these be presented to the Board for approval.

22 REVIEW of COMMITTEE TERMS of REFRENCE

Ms Smith informed the Committee that there were no recommended changes to the review at this time stating that this would form part of the annual report that would be prepared this year to go forward to the Board. There have been no difficulties with meetings throughout this year and the Committee have been quorate on each occasion.

The Committee:

1. Approved the Committee Terms of Reference.

INTERNAL UPDATES FOR INFORMATION

23 SECURITY, RISK AND RESILIENCE, HEALTH AND SAFETY GROUP UPDATE

Members received and noted the Security, Risk and Resilience, Health and Safety oversight group update, which Mr Walker provided an overview. No issues or concerns were raised.

The Committee:

1. Noted the Security, Risk and Resilience, Health and Safety Oversight Group update.

24 FINANCE, EHEALTH AND AUDIT GROUP UPDATE

Members received and noted the Finance, eHealth and Audit Group update as was presented by Mr McNaught. Members noted the content of the report and recognised no areas of escalation were required.

The Committee:

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

25 ANY RELEVANT ISSUES ARISING TO BE SHARED WITH GOVERNANCE COMMITTIEES

Mr McConnell noted the following actions from the meeting:

- In relation to the clinical model work and the internal audit reports some co-ordination work was required in terms of timing.
- In relation to timing around Physical Health internal audits to be flagged to Cathy Fallon for awareness at the Clinical Governance Committee.
- Ms Radage and Mr Jenkins to approach the Staff Governance Committee in relation to the use of the Whistleblowing procedure.

26 ANY OTHER BUSINESS

There was no other business.

27 DATE AND TIME OF NEXT MEETING

The next meeting will take place on Thursday 20 June 2024 at 9.00am via MS Teams.

End of meeting 12:30 hours.