OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 3 December 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 3 December 2019

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HEALTH AND SPORT COMMITTEE
29th Meeting 2019, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Terry Currie (State Hospitals Board for Scotland)
Gary Jenkins (State Hospitals Board for Scotland)
Robin McNaught (State Hospitals Board for Scotland)
Mark Richards (State Hospitals Board for Scotland)
Professor Lindsay Thomson (State Hospitals Board for Scotland)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 3 December 2019

[The Convener opened the meeting at 09:45]

European Union (Withdrawal) Act 2018

Food and Feed Hygiene and Safety (Miscellaneous Amendments) (EU Exit) (No 2) Regulations 2019

The Convener (Lewis Macdonald): Good morning, and welcome to the 29th meeting of the Health and Sport Committee in 2019. We have received apologies from David Torrance and Miles Briggs. I am delighted to welcome Sandra White back to the committee. Before we start, I ask everyone to ensure that their mobile phones are off or on silent. Please do not record or film proceedings, as we will do that ourselves.

The first item on our agenda this morning is the committee's consideration of a consent notification that has been sent by the Scottish Government relating to the Food and Feed Hygiene and Safety (Miscellaneous Amendments) (EU Exit) (No 2) Regulations 2019. The purpose of the statutory instrument is to ensure continuation of consumer protection elements of the current food and feed regulatory regime. Updates are proposed to the current body of European Union food law dealing with such matters. The committee scrutinised the regulations earlier in the year, and we are now being asked simply to consider the Scottish Government's decision to consent, rather than the specific terms of the SI, which we considered previously.

Do members have any comments or questions to raise?

Emma Harper (South Scotland) (SNP): I am quite happy to proceed as indicated. The Minister for Public Health, Sport and Wellbeing, Joe FitzPatrick, has written us a letter on the matter, but I continue to have concerns about how we will manage food and feed safety, especially given my knowledge about the Food and Drug Administration's "Food Defect Levels Handbook" in relation to certain products in our food and feed that might come from other countries. However, I am content to proceed with the regulations today.

The Convener: That is noted. I have no doubt that we will have the opportunity to discuss those wider issues in the new year when these matters next come before us.

If there are no further comments, is the committee content to make no recommendations on the instrument?

Members *indicated agreement.*

Scrutiny of NHS Boards (State Hospitals Board for Scotland)

09:47

The Convener: Item 2 is to take evidence as part of the committee's continuing programme of scrutiny of health boards. The committee has been hearing from representatives of boards around the country. Last week, we were in Perth to hear from representatives of NHS Tayside, and this morning we are hearing from the State Hospitals Board for Scotland. I am delighted to welcome Terry Currie, chairman of the board; Gary Jenkins, chief executive officer; Lindsay Thomson, medical director; Mark Richards, director of nursing and allied health professionals; David Walker, director of security, estates and facilities; and Robin McNaught, finance and performance management director. Welcome to the committee.

I will start by asking about leadership. Clearly, that issue has been important in our scrutiny of all boards, not least in this case, given that changes have been made. I wish to ask the chair or the chief executive, in particular, about the new members of senior staff and what strengths they have brought to the board.

Terry Currie (State Hospitals Board for Scotland): Thank you, convener, and I thank the committee for giving us the opportunity to come and speak to you about the work that we carry out at the state hospital.

On leadership, we have been pretty fortunate at the state hospital over the past few years to have had a strong non-executive cohort with a range of skills. The one area in which we have perhaps been less strong over the past couple of years, when we had to fill a vacancy, is financial management. When we recruited a new non-executive director, we ensured that we got someone with the requisite skills.

We have people from various different backgrounds with a total mix of skills, and they have contributed to the strength of the State Hospitals Board. The same is the case with the executive leadership. Gary Jenkins, as chief executive, just joined the state hospital in 2019, but the executive team has been in place since some time before that.

Over the past few years, we have made a number of changes. Lindsay Thomson, our medical director, has been in post for a long time and is an important anchor. We take great pleasure in the quality of the patient care that we have at the state hospital and, under her leadership, that is well recognised, both within and beyond Scotland.

We recruited Robin McNaught a number of years ago as finance and performance management director, and he has added considerably to our performance in that regard. As the committee is aware and as you will have heard from previous submissions from health boards, looking after the finances of a health board is a pretty daunting prospect. We have managed to remain in balance for a number of years. In recent years, it has been quite tight, although in the current calendar year we are making great progress.

Mark Richards joined us as director of nursing from Glasgow about three years ago and he, too, has added considerably to the experience of the management team.

We have been keen—and I have been particularly keen—to draw in people from outside the state hospital. It is a village, and many of the staff have been there for a long time. On the one hand, that is very positive from an experience point of view. On the other, we constantly need fresh thinking and innovation and bringing people in from the outside has proved to be a useful and helpful tactic for us.

David Walker, who is the most recent guy to join us, has been in post for a year as director of security. His background is in the police. The committee will not come across many directors of security in other health boards, but you will understand the need for one at the state hospital, and David Walker brings loads of experience. He has had to pick up the health connection and has done that very well over the past year.

I believe that the leadership team at both executive and non-executive level is strong.

Gary Jenkins (State Hospitals Board for Scotland): I would like to comment on leadership at a senior management level. While we recognise the leadership strengths in the executive and non-executive cohorts that the chairman has put across, as part of our initial review drawn from the Sturrock recommendations, our iMatters survey and other staff surveys, I have been looking at a theme of developing leadership in the state hospital at senior management level 2. A key focus for us internally is to empower and engage the organisation and to have front-line leaders who are skilled and able to lead the workforce at an operational level.

The Convener: Coming in as a relatively new kid on the block, what do you see as the challenges that the state hospital faces?

Gary Jenkins: We have a number of challenges, not just around leadership. Let me

expand on some of the themes that we have been looking at. One clearly relates to attendance management and support for staff and, in the most recent four to five-month period, we have seen a significant improvement in attendance management as a result of very tailored support for staff and a series of metrics that we have put in place for them.

We now have to focus on ensuring that the measures that we have are meaningful for staff and that we take the feedback from the teams and programme those into supportive measures for the organisation. Our biggest reason for absence is stress, anxiety and mental illness, so we have tailored programmes in conjunction with NHS Lanarkshire for staff members so that they can access counselling and support services and case workers. We need to evaluate that process to ensure that it is working properly and that staff feel supported, engaged and valued in the workplace. That is a key priority for us.

The second theme is the redesign of the clinical model. Through a staff survey and an engagement process, the staff highlighted dissatisfaction with the way in which the clinical model was being delivered following the transfer to the new hospital. A key piece of work has been the development of the clinical model, and staff engagement and empowerment in that model. We managed to talk to more than half of the workforce to get their thoughts, feelings and views about how we should implement and develop the clinical model. We are trying to create a more engaged culture, with more empowered staff, and with leadership development in the right areas of the organisation.

The Convener: Thank you very much. I am sure that we will talk about the clinical model later in the morning.

Terry Currie: Would it be helpful if I added a couple more challenges to what Gary Jenkins said? I think that it would be helpful to the committee.

The Convener: You may—it is always good to have the full picture.

Terry Currie: Another major challenge is the obesity levels of our patients. People with severe lifelong mental illness are likely to die 15 to 20 years prematurely, because of issues that are related to physical ill health. We are aligned to the mental health strategy, which clearly states that there should be parity of esteem between physical and mental health, and we wish to realise that aim for our patients.

About three years ago, we introduced a healthy choices plan, and virtually all the actions in that plan have been enacted and implemented. However, the fact of the matter is that we have made little impact on obesity. We took a strong stance on eliminating smoking from the hospital and—from here on in—we will have to be equally radical in our approach to controlling obesity.

Another area of challenge, which I have no doubt the committee will be familiar with, is communications. The tabloids are always willing to publish headline-grabbing stories, which often refer to particular patients and past events. Those stories can be extremely damaging to our patients and their families, to victims and their families, and to our staff. Our response to that onslaught has been to adopt a defensive posture and attempt to manage the negative publicity. We now intend to adopt a much more proactive approach to communications. As I said, we are proud of our work, and we intend to be much more forthcoming about some of the compelling issues in forensic mental health services.

Finally, the Sturrock report presented a clear warning about the need for stronger governance and greater transparency. We examined that report in great detail and are now implementing our action plan. The report gave us the impetus to pay much closer attention to values and behaviours. We already had a number of ideas in the pipeline—for example, establishing excellence awards to recognise staff—and we are determined to promote a much stronger culture of recognition and appreciation. For us, one of the key lessons from the Sturrock report is that, although all health boards are—naturally and rightly—focused on targets, sometimes that has been to the detriment of other key aspects of an organisation that contribute to performance. Values and behaviours fall into that category, and we intend to ramp those up in our work.

The Convener: That was a very interesting and comprehensive list of key challenges. We will have questions on a number of those in turn.

Brian Whittle (South Scotland) (Con): Good morning to the panel, and thank you for coming in.

Mr Jenkins has already raised the issue of a high sickness absence rate. In 2015-16, it rose from just under 6 per cent to just over 8 per cent, and that has persisted since then. Have staff absence and sickness been a problem since 2015-16, and why is that rate so persistently high?

Gary Jenkins: I will focus initially on the past six months and then talk about the other components that Brian Whittle mentioned.

The state hospital has had the highest level of sickness absence across national health service boards, with historically high figures; I think that the highest figure was 10.93 per cent in one month. As I indicated, over the past six months, there have been a number of measures to stop and examine why absence was so high; to consider the factors that are associated with

absence; to understand, from the safety review report, whether assaults and RIDDORs—incidents reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013—were on the increase; and to consider measures that could be put in place to support staff who have been subject to assault and other challenges in the workplace. Over the past six months, we have managed to achieve an absence level that ranges from 5.13 per cent to 6.10 per cent, so we have seen a significant improvement in absence and attendance.

10:00

As I mentioned earlier, we have been collaborating with NHS Lanarkshire on how we manage absence. As a small board, we need to collaborate with wider partners on how we take forward some of these issues. A number of measures that were not in place before have been introduced. For example, we have a service called EASY—early access to support for you—whereby, if a member of staff phones in and is absent, on the first day of absence, they are able to access a support worker who they can phone and seek support from in relation to mental health issues.

We have looked at strengthening policies and at trying to understand the reasons behind absence, so that we can put in place an action plan to tackle it. We have also looked at compliance with our policy in terms of return to work and staff value to see whether we can put in place any additional measures that will lead to a sustained improvement in our absence patterns.

I am pleased to report that, in the six months for which I have been involved in the state hospital, we have seen a sustained reduction in absence levels. However, there were undoubtedly challenges in the previous four-year period relating to higher than average levels of attendance management.

In my previous role, when I had a medium-secure service, I looked to see whether a 4 to 5 per cent absence rate applied to forensic mental health services in the Scottish Prison Service. I uncovered the fact that other forensic mental health services and the Scottish Prison Service have higher absence rates than NHS acute organisations. The figure for NHS Scotland is 4 per cent and our target is 5 per cent, and we are now within a percentage point of achieving that. However, as I have highlighted, we need to continually improve our support mechanisms to make sure that staff see them as mechanisms to support people to come back into the workplace, and not as management or disciplinary actions. I believe that having that appropriate infrastructure in place is helping to reduce our absence levels and sustain them at a far more acceptable compliance level.

Brian Whittle: In our examination of many boards across Scotland, a key element that keeps coming up is the cultural issue, which was mentioned in the Sturrock report. Cultural bullying seems to be endemic across the board. Is that an issue at the state hospital, and how would you address it?

Gary Jenkins: As the chairman mentioned, we looked at a number of factors, which we presented to staff. A key component is understanding how the workforce feels.

When we asked staff about the clinical service delivery model through the 2018 safety review, a lot of the feedback that we got related not to the clinical service delivery model but to how staff felt—whether they felt empowered, whether they felt that they could contribute to the organisation, whether we had structures and mechanisms in place that would support staff and whether we listened to staff.

We overlaid those themes from 2018 with the outcome of the staff survey and the Sturrock themes—we identified 40 themes from Sturrock—and, through the partnership forum, we discussed where the partnership felt that the themes in Sturrock applied to the state hospital. We shortlisted 40 and surveyed all staff to get back where staff felt we could improve on our culture, values and behaviour, and where they could feel more engaged to come and work with us on a programme that developed that journey for us. We analysed the outcome of that result and, throughout January to April, we have dedicated a specific workstream—as part of the clinical model redesign—that will look at leadership, values, behaviours and culture.

I will lead that workstream. It will take in all wards and departments and look at key metrics and measures that we can further introduce to ensure that staff do not feel intimidated or harassed, that they have the appropriate support mechanisms and that they feel that they are engaged with their employer. We will work as a collective organisation to support staff and ensure that they can develop and can discuss workplace problems or challenges.

Brian Whittle: Have you looked at whistleblowing? Do you have a mechanism in place so that, if they need to, staff feel empowered and safe to complain or raise an issue?

Gary Jenkins: We have a whistleblowing process and policy. At present, we have one whistleblowing case, which came up in the past fortnight. Our non-executive who is the whistleblowing champion is on long-term absence and, for impartiality, we have gone outwith our

board to seek another non-executive to oversee that case. Like all boards, we are involved in the recruitment process for a dedicated non-executive for whistleblowing. Through our values, cultures and behaviours process, we will promote how staff can highlight issues initially through whistleblowing.

Sandra White (Glasgow Kelvin) (SNP): I will continue on the theme of the workforce. Terry Currie mentioned that the state hospital is like a village. Many of the staff have been there for a long time. Retirement age is a huge issue, which I will come to later. He also said that you try to bring in staff from outside the health service. Gary Jenkins explained what the hospital is putting in place in order to retain staff. Does development and support help to retain staff? How do you attract staff to work at the state hospital? Once you have attracted them, how do you retain them?

Terry Currie: A key part of that is staff development. We have a strong staff development programme, through which people can work their way up through the ranks. The biggest thing is that the level of uptake of our high-calibre training is remarkable.

We also have to bear in mind where we are. We are in South Lanarkshire and we employ 600 people. We are the biggest employer in the area. Like a lot of industrial factories, many of the people who come to work at the state hospital have mothers, fathers, uncle and aunts who worked there. There is a community-orientated culture about the place. That has helped us. Historically, we have had no problem in attracting staff. However, as you can imagine, having the right balance between male and female nurses is critical, and we are struggling to attract male nurses.

Mark Richards (State Hospitals Board for Scotland): Student nurses report a positive experience of the state hospital as a learning environment and as a care environment. I am always pleased to see students who come back into the state hospital to seek jobs as registrants. We have a regular supply of students coming through that line. Increasingly, we also engage proactively with our higher education institution partners and we reach out to universities when students are in the final year of their educational programme to recruit directly off the programme. We go out and sell the state hospital offer as early as we can.

Over the past two years we have developed a positive relationship with the Open University, which has started to generate different development opportunities, for example, for nursing assistants, who can join the state hospital and, provided that they meet the criteria, have a pathway into a registrant role. We currently have seven nursing assistants doing that just now, five of whom started in the past year.

Another important factor, which was touched on by our chair or chief executive, is the importance of personal development planning for our staff as an element of retention. We do well with our personal development planning and associated activities in the state hospital, and almost 90 per cent of our staff across all areas have a personal development plan. We have challenges, but we are working actively to address them.

Gary Jenkins: Recognising that health boards should have youth employment in their workstream, the other aspect that we are looking at for 2019-20 is the role of modern apprentices. We are looking at how we could progress modern apprentices in the state hospital and help them with employability in the local area.

Sandra White: Does Professor Thomson want to come in?

Professor Lindsay Thomson (State Hospitals Board for Scotland): No. Well, I could widen the discussion out. Obviously nursing staff are by far our largest cohort of staff, but it is important that we provide an attractive environment for other staff in order to get them to travel to the state hospital. We do that in a number of ways, for example by making attractive portfolio posts with people working not just in the state hospital but in other forensic network sites—in other NHS services and prisons or wherever that might be. At times, that helps us to fill some gaps across the forensic network, but it also makes for more interesting posts and stops issues of institutionalisation, which can arise when you all work behind a big fence.

Sandra White: You mentioned the Open University and the number of students who come through. Do you record the percentage of student nurses who come to train and then come back to work?

Mark Richards: I do not do so formally.

Sandra White: It might have been helpful to know that.

Mark Richards: We could look at that.

Sandra White: You seem to be doing a lot to attract people and, obviously, it is also important to keep them.

Mr Currie mentioned retirement at the beginning, which involves a huge number of people. You said that experience is very important, and I agree with that, but most of the nursing staff are between the ages of 50 and 54, which will have a knock-on effect. Will the work that you are carrying out be successful in the short term or the

long term, given the retirement age and the ages of the nursing staff?

Gary Jenkins: You are absolutely right. There are 93 nursing staff within that age cohort. We have identified that we clearly have a risk in the coming four-year to eight-year period and that we have to be able to attract and maintain staff.

In order to understand our staff need and our workforce development plan in future, we have been doing some work on rebasing the staffing establishment as part of the clinical model so that, in the coming years, we understand the number and types of staff that we need to attract and bring to the state hospital to deliver the clinical services that are required.

We have worked through almost 60 per cent of the organisation, including the profile and staff configuration for the clinical model, which we will start to implement from April. However, we need to ensure that a number of other staff members—allied health professionals and estates, facilities and housekeeping staff—are also an integral part of that model.

We have begun that work and identified nursing as our main risk area over the coming four-year to eight-year period. Just now, we are trying to put in place a sustainable workforce plan, which we will take to the board in its December session to outline our intention. We will then look at how we work with educational establishments or the forensic network to try to bring those staff to the state hospital. There might be opportunities through the review of the forensic mental health estate to look at greater collaboration with other services. We will be aware of those opportunities in late spring next year, but we have started that work and are trying to baseline our establishment.

10:15

I will provide one example. The configuration of our intellectual disability service would move from one ward to two wards, which would mean going from 12 to 24 beds. The workforce need for intellectual disability patient management is different from the workforce need for male mental illness. Recognising that we are moving forward with that service delivery model, Mark Richards has already approached educational establishments to come in and deliver tailored training for us, so that we can develop staff with those skills. We want to have a tailored programme of work over the four-year to eight-year period that provides us with the correct staff and enables us to identify educational and other establishments, so that we can maintain the staff levels that are needed for us to deliver our rebased establishment in the state hospital.

Sandra White: I take it that it is the new workforce plan, which came out in September, that you are putting into place. Is that what you are working towards or have you instigated the work already?

Gary Jenkins: We have completed about 60 per cent of the work. Of 600 whole-time equivalents, we have gone through around 340 posts to look at what will be required in the reconfigured clinical model for the state hospital.

Perhaps more importantly, we have tried to look at staffing levels. For the first time, we are looking at benchmarking services in NHS England to see what other high and medium-secure services have as part of their staffing establishment. We have done early work using the pilot tools of the Health and Care (Staffing) (Scotland) Act 2019 to check that we are in the correct ball park with our predictions. Those are the models that we are using to give us a future-proofed model that will enable us to be absolutely confident that, when the legislation comes in and we run the tools, we are not outwith the norm. To ensure value for money and to understand our effectiveness, we are looking at other high and medium-secure providers to ensure that we are in the same range with our staffing profile.

Sandra White: One of the issues that I am interested in, which I think that you are already working towards, is the fact that you are changing your model slightly to have a wee bit more flexibility. The number of band 1 to 4 nurses has risen—they are paid at lower rates—and the number of band 5 to 9 nurses has fallen. What is the reason for that? Is it because of the flexibility or the differences that you are working towards?

Gary Jenkins: No, because we have not yet implemented that model. We do not know what the model is, but it will be used from April onwards.

I will perhaps talk about the band 4 posts. We have looked at trying to role develop other members of staff. Mark Richards might be more eloquent than I am in describing that.

With the patient active day, we ensure that, from 9 to 5, patients in our transitions ward use the full resources of the hospital to benefit themselves with physical activity and stimulation. We have been looking at a different type of role for that, which might mean that a new band 4 support worker role is developed.

We have not specifically gone through the grades to change them; rather, we are trying to profile going forward to get the most appropriate staffing levels.

Perhaps Mark Richards will describe that a little better than I did.

Mark Richards: The feedback that we regularly get in the hospital from our patient group is that they would like to be more active more often, which is perfectly understandable, and to have access to activities seven days a week. Our shift pattern, particularly for nurses in the hospital, is a traditional continental-style shift pattern of day, back and night shifts, which does not always lend itself to supporting activity, especially when that activity needs to take place off ward. Part of the planning work that we have been focused on is about how we adjust the roles that we have in the hospital—the workforce profile—to create the 9-to-5 activity-focused roles that Gary Jenkins referred to a moment ago. Through introducing those roles into the workforce, we can deliver more activity for our patients.

Going back to your earlier point about staff retention, we anticipate that those roles will be in band 4, which will allow some career progression opportunities for unregistered staff in the hospital.

Sandra White: I want to push that a wee bit. For someone to move up from band 1 to 4 is fantastic. However, we know that some activities have been closed or access to them has been restricted, and patients have had to spend more time in their rooms. More band 1 to 4 posts give patients more access to physical activity between 9 and 5. There are fewer staff in the band above that, which is the band of more experienced staff. What impact does that have on the care of patients at the state hospital?

Mark Richards: Our skills mix for the nursing workforce is still projected to be 60 per cent registrants, or qualified staff, and 40 per cent unqualified staff. That is what I am projecting in the workforce plan for the hospital.

The Convener: There is quite a range of changes in the staffing models and examinations that you have indicated. How far are staff and their representative bodies involved in those discussions and in making decisions on changes?

Gary Jenkins: As I mentioned, more than half of the workforce is involved in the consultation process through workshops or visits to wards. That goes back to how we communicate in a better way, which is another theme of the Sturrock report.

You might imagine that, because the state hospital is on one site, it is quite easy to bring people together but, because of the risk factors that are involved, we must have a critical number of staff on the wards and in patient areas at any one time. Therefore, one of the measures that we used this time was to set up a series of engagement events with all staff, rather than put out a bulletin on paper. In October and November, we went out to the wards at shift changeovers to set up presentations and have discussions with staff. In that process, we were able to answer direct questions that staff might otherwise have had concerns about and which we could not have addressed or tackled at another time.

The feedback on the approach was that it was successful, so we should embed that approach for the future. We should go out as executive sponsors to wards, be present and visible, and provide consistency for staff so that staff feel absolutely free to approach us.

All that work has been done in partnership. We have taken all the reports and updates through the partnership forum, which is fully supportive of working with us. In fact, the partnership forum has put forward very productive suggestions about how we undertake the change process, which follows on from our experience of the 2011 change process. We have been trying to embed new ways of working that make staff feel more engaged and learn lessons from the past to take into the future to deliver a far more comprehensive service.

Emma Harper: I am interested in the local delivery plan and the annual operation plan. The standards and targets have changed over the years, from health improvement, efficiency, access and treatment—HEAT—targets to local delivery plan standards, and now to the requirement to produce an annual operational plan. Those plans often focus on performance, finance and workforce. Our briefing says that the state hospital

"reached or surpassed the targets for access to psychological therapies and for access to a GP or other appropriate health professional."

It is good news that you have reached or surpassed those targets.

I am interested in the focus on continuous improvement in the annual operational plan. The state hospital has 14 strategic objectives—I will not name them all, but it is interesting that they include obesity, supporting

"a forward looking culture"

and creating

"conditions for supporting quality assurance, quality improvement and change."

There are lots of aims and actions to be measured. How will you track and measure those outcomes in order to ensure that you are meeting those objectives, standards and priorities?

Gary Jenkins: We have a very complex suite of key performance indicators that sit under the headline objectives that you have mentioned. The targets and actions are monitored through the groups, the governance committees and then the board.

We need to be cognisant of our place in a modern national health service. To that end, over the past six months, we have been refreshing our key performance indicators. That work is on-going. We hope to take a balanced-scorecard approach, with red, amber and green ratings for all our metrics. That is to improve accountability, so that we can point the governance committees to our areas of risk. We will also be able to show transparency and progress against our targets.

We probably need to refine those metrics and bring them all into one performance scorecard, which would, at a glance, provide the non-executive directors and the board with the opportunity for overall scrutiny, and would enable governance and show what our performance framework looks like.

We will continue to develop that work. We will take it to our audit committee to seek additional assurance that the measures are correct. We will continue to review all the metrics that sit beneath the headline strategic objectives.

Emma Harper: How will you move forward in relation to key performance indicators and measure the state hospital against other health boards that have similar objectives? I recognise that how care is delivered is slightly different in the state hospital. How do you communicate the state hospital's performance to the public?

Gary Jenkins: In our annual report, we need to get better at demystifying some of the work of the state hospital. We need to get better at being transparent about the detail of what we are trying to achieve, so that we can communicate that, perhaps through collaboration with the mental health directorate and by understanding the key priorities for mental health. We should start trying to focus on the particular metrics, such as psychological therapies—as you mentioned—that we are clearly very successful in delivering.

In our next three-year operational plan, we will be able to define better the metrics on which we would like to reassure the general public. We can also build in more information on our safety measures, health and safety measures and our public protection measures, to ensure that the public are reassured that the dual aspects of clinical care in a high-security environment are not only transparent, but are easily interpreted in scrutiny of what we do.

Terry Currie: The point about communications with the public is very well made. We have had some difficulty in that regard, and we are raising its priority. Historically, we have held our board meetings in the state hospital. As the committee can imagine, coming in and going through security in order to attend a board meeting is not a particularly attractive proposition for members of the public. As a result, they rarely attend. In my time, I think that a couple of press people have been present, but there have been no members of the public.

10:30

Similarly, we have tended to hold our public annual review within the confines of the state hospital. Therefore, public presentations are made primarily to staff. Indeed, it is staff who attend our board meetings—we invite staff, if they are interested in a particular board meeting, to come along and sit in.

As part of the corporate governance review that we undertook, we decided to hold two board meetings a year beyond the state hospital. In addition, for the first time ever, we will hold our public annual review outwith the state hospital. We do not know what reception we will get, but we will never know until we try, and we know that we have to make more effort to engage with the public.

Emma Harper: That sounds like a good idea to get people involved, because I am sure that it is intimidating for members of the public to go through security; I know that I am intimidated when I visit my local prison, for example.

It is hard to measure everything. You mentioned awards for excellence. If staff members are recognised for providing excellent care, the impact of that might be measurable. There could be a reduction in sickness absence, and that level of reduction could be maintained. Is that one way in which you could measure delivery of care?

Terry Currie: Yes—most definitely. In explaining the reasons why we have made such an improvement in our sickness and absence rate, we tend to quote things such as how we tightened up compliance and how we trained managers better. However, another key part of the strategy was to increase our level of recognition and appreciation. The excellence awards have been developed through this calendar year as part of our staff engagement and our improvement in values and behaviours.

Professor Thomson: As well as all our key performance indicators, we have a suite of clinical outcome measures for our patients. There are eight of those, with a wealth of other data behind each one.

An individual can have their own outcomes, and we can look at what is happening on a ward basis, a hub basis and, of course, a hospital-wide basis. The measures include mental health—that is, how an individual's health is improving in terms of psychotic symptoms, for example. We also measure physical health, for which we have a raft

of information. We use body mass index—that is, obesity and overweight levels—as a basic indicator, and we use the individual's own assessment of their wellbeing using the clinical outcomes in routine evaluation—CORE—measure. We look at social engagement—for example, visitors—we look at progression through the transfer lists, and we look at activities. In total, we look at eight measures in order to follow the progress of the individual, or of our population as a whole.

Gary Jenkins: I will make a final point. One of the other challenges that we have in the state hospital is in how we promote our work. We are entirely sensitive to the fact that, in the work of a modern healthcare establishment, we need to be cognisant that there are a number of victim issues associated with some index offences. We are very mindful that we need to be sensitive about how we promote and publicise the work.

I recognise that now is a good time for changing attitudes to mental health. We have engaged with the "See me" programme and with mental health voluntary organisations on perceptions of the state hospital and how we might promote a more active engagement and media strategy around what we do, while recognising sensitivities in the context of public opinion about mentally disordered offenders.

The Convener: When and where will your annual review take place?

Terry Currie: We do not have a specific date. The Government has indicated that it will be held during the summer of 2020.

The Convener: Your expectation is that the review will be held outwith the state hospital.

Terry Currie: Yes.

David Stewart (Highlands and Islands) (Lab): The witnesses will be aware that, after its visit in September, the Mental Welfare Commission for Scotland said that people had been detained using inappropriate levels of security on a couple of occasions. I understand that such cases fall under the provisions on exceptional circumstances provisions, whereby a patient may be held at a higher level of security because medium-secure or low-secure settings are not available. What are the implications for treatment of such patients and, which is equally important, for civil liberties?

Professor Thomson: You raise two issues. I will first talk about exceptional circumstances. Across the forensic network, we introduced the option of making a bed available in the state hospital in exceptional circumstances, if a patient clearly needed medium security. We are not talking about people who require low security or another form of psychiatric care; we are talking only about those who clearly require medium security but for whom a bed is not available in the medium-secure setting. The particular concern was for individuals who might be very unwell in—as would usually be the case—a prison setting. We wanted to develop a mechanism to allow such individuals to access care, so we developed the exceptional circumstances approach.

Over the years in which the approach has been in place, we have generally had between zero and two such cases at any one time. At present, there are four cases of people who have been admitted to the state hospital under exceptional circumstances.

You asked about the impact of that on people's care. My view is that the approach gives such people the care that they need, whether we are talking about treating their mental illness or disorder, or about meeting their psychological and rehabilitation needs and so on. It is about putting people in the right place, where they can be cared for. That is in the interests of the individual.

You also asked about civil liberties. We must acknowledge that when an individual finds themselves in a high-secure, rather than a medium-secure, environment, that will have an impact. Even with the best will in the world to make crystal clear that a person's admission was an exceptional circumstances admission, the effect might be that the individual will have the label of being someone who required care and treatment in the state hospital. We are always working to reduce the stigma of that label, but we have to recognise that it exists. There are issues in that regard and issues to do with the patient's rights of appeal and so on.

We are balancing meeting the need to find healthcare provision for individuals against issues to do with liberties and labels. Ultimately, I think that it is in patients' better interests to have the exceptional circumstances approach in place. Clearly, it would be better if we had further state developments.

David Stewart: The obvious question is why we do not have sufficient medium-secure and low-secure settings. There will clearly be issues to do with treatment, given that your staff are geared up for maximum security, although I accept that there might be some overlap with the experience of patients in a medium-secure setting.

The key question is whether admission in such circumstances is a breach of the European convention on human rights. That is a matter for the courts to decide. I understand that two appeals to the Supreme Court about excessive delay are in progress. Is that correct?

Professor Thomson: I think that you are confusing two issues. I will deal with the estate

issue from a forensic network perspective. The forensic network held a workshop on the estate issue—that is, care in high-secure, medium-secure and low-secure settings and in the community. We went to the NHS chief executives group in January 2018 with six recommendations, all of which were accepted, including a recommendation for increased medium-secure beds in the west of Scotland, which is where the primary need is. The recommendations have not all been enacted, but there were plans to look at the estate. The forensic network does the longitudinal bed planning. There are blockages in relation to the medium-secure to the low-secure beds because we cannot move people out of low-secure settings and into the community.

David Stewart: The public who are watching might not necessarily understand the technical details that you raise. Is it correct that you currently have no defined medium-secure beds in your establishment?

Professor Thomson: At the present time, we have a weekly bed report: I think that there are one or two beds for males and one bed for a female in the medium-secure estate.

David Stewart: On Scotland-wide provision—I understand that you are not responsible for all that—there is clearly a gap in medium-secure and low-secure beds, because patients are being inappropriately housed in your establishment through the exceptional circumstances approach.

Professor Thomson: I want to come to the second issue, because we are in danger of conflating two issues—exceptional circumstances and excessive security, which are completely separate.

Exceptional circumstances is a mechanism that we introduced to stop people being stuck in a prison setting. Excessive security appeals are set out in the Mental Health (Care and Treatment) (Scotland) Act 2003, which gives an individual a right of appeal against their security level. It was initially introduced purely for high security, so someone could appeal to move from high security to medium security. In recent years, it has also been used for medium security, so individuals in medium security can appeal. Those are two separate issues.

We have regular excessive security appeals at the state hospital, which are held by the Mental Health Tribunal for Scotland. At the moment, we have 26 patients on our transfer list, of whom 18 have been fully accepted by a receiving service: they have been all the way through the assessment process and have been accepted. More than half of them will have made excessive security appeals. One of those—there were three, but two have moved on—is now beyond the timescale of the excessive security appeals, which means that the local receiving health board has not found a bed in the timescale that was set out by the Mental Health Tribunal.

It is essential to separate the two issues. They are different, but they are both related to having appropriate resources in the right place.

David Stewart: Thank you for clarifying that. However, I was trying to ask whether there is a shortage of medium-secure and low-secure beds in Scotland.

Professor Thomson: Yes. In the estate as a whole, and medium-secure beds. If we could move everybody down, our medium-secure beds would be very full—it would be operating at capacity in the high 90 per cents, which we would not want any system to do. The issue would then be the low-secure provision and moving patients from the low-secure setting into the community. However, the simple answer to your question is yes—we clearly have issues with beds.

Alex Cole-Hamilton (Edinburgh Western) (LD): I would like to follow up on David Stewart's line of questioning. Lindsay Thomson, in one answer that you gave to him, you said that you thought that the Government could make changes to improve the situation with regard to exceptional circumstances or excessive security provision. What kind of changes would you like to see?

Professor Thomson: The six recommendations that went to the chief executives set out the different issues. The issue that we are addressing here is primarily to do with the medium-secure and low-secure beds. The decisions on developments sit with individual health boards. We have plans. The numbers on the longitudinal analysis of beds are in the annual report. We need to look to develop those services.

As the committee will know, the minister has commissioned an independent review of delivery of forensic mental health services. The forensic network has given all the data on beds and needs to the chair of that review, and we expect recommendations to emerge from that.

10:45

Alex Cole-Hamilton: I can understand why they happen, but I am concerned about the excessive security appeals that you have had. You mentioned one case that has gone over the period of time in which the individual concerned would have expected the appeal to have been actioned. How common is that? What recourse do the patients have to justice or representation?

Professor Thomson: That is not common. Mostly, beds are found within the period. It is most unusual that we have had three such cases, but

two of the individuals in that position have moved on in the past few weeks, which suggests a certain pressure in the system.

Ultimately, an individual can ask for judicial review of their position—

Alex Cole-Hamilton: I am sorry to interrupt, but who would fund that judicial review? Judicial reviews are not cheap.

Professor Thomson: No. That would be funded through legal aid. All our patients are well represented legally and can take such action through their lawyers. The teeth behind the excessive security appeals legislation are in the Court of Session Act 1988, which holds public bodies responsible for enacting legal decisions, such that chairs or chief executives can find themselves in the dock to answer for why something has not been enacted if it should have been.

Alex Cole-Hamilton: My final question is for Terry Currie and is about civil liberties.

In your answer to the convener's first question, you talked about the smoking ban and said that you were looking to get equally radical on obesity. I am slightly concerned about that, because there is a statutory basis on which to enact a ban on smoking in public places, but there is no such statutory basis for a ban on eating fatty or sugary foods. We are crossing a dangerous civil liberties line. Will you expand on your statement?

Terry Currie: You are quite right. That is what has enabled us to make much more progress with smoking than we have with obesity. We always recognise the element of civil liberties. When I talk about doing something more radical, I am talking about something that is within our internal control, such as the type of goods that we sell in our shop and so on. The civil liberties of individual patients are foremost in our minds.

Lindsay Thomson used the term "balance" several times, and that is what we need to apply here.

Alex Cole-Hamilton: Okay.

Professor Thomson: I would like to come in on that, because the issue of being overweight and obese is hugely important to us.

The Convener: We are going to come back to that issue.

Professor Thomson: That is fine.

The Convener: I would like to ask a bit more about the independent review of forensic medical services. So that we are clear on the current position more broadly, can you tell us how many patients are currently in the state hospital and whether there is any spare bed capacity?

Gary Jenkins: We have 108 patients in the state hospital today. That figure has increased slightly. On bed capacity, looking back over the previous four years, we have never exceeded 120 patients in that period, so we recognise that we need to rebase our clinical model on 120 patients to ensure that we make the most efficient use of resources and that we target them at the correct areas.

Two wards are closed; the hospital has capacity for 144 patients overall, in line with the new hospital model that was developed in 2011. However, we do not currently need that number of beds. Of course, having a ward closed is a good contingency for us, in that if there is a challenge in a particular ward, we can relocate patients. It is also useful in the context of contingency plans for Rowanbank clinic and other medium-secure units. If there was a catastrophic challenge at one of those units, we would be able to provide capacity for housing patients at the state hospital.

The Convener: Do the numbers suggest a decline in the demand or requirement for high-secure places? Do you predict that that decline will continue, or are the numbers over a couple of years just a question of serendipity?

Professor Thomson: I am pleased to say that we have finally got our pathways of care to a better place. We still have blockages, which we have just discussed, but in years gone by, we had beds in the state hospital and very little else around the country. Now, we have a proper pyramid of care, with high-secure, medium-secure and low-secure places, and care out in the community. It is therefore not surprising that there has been reduced demand for the high-secure service and more demand for medium-secure and low-secure services.

The Convener: What are the implications of that change for staffing and plans for the establishment?

Gary Jenkins: As we have looked at the change in patient numbers, we have tried to base our clinical model on the level of patient demand, as I said.

I want to reiterate Professor Thomson's point. The number of patients in the forensic population—in high, medium and low-secure services and in community services—has stayed broadly the same. A success of the introduction of medium-secure services has been our ability to move patients through levels of security in a way that is tailored to their needs.

Of course, as a member pointed out, there is a challenge when bottlenecks appear, as patients move from medium-secure services to low-secure services and from low-secure services to the community. The review of forensic mental health

services presents an opportunity to consider how we can manage the overall estate for Scotland more effectively, so that no patients are unnecessarily detained or blocked from progressing through the appropriate levels of security, based on their needs.

The Convener: The review will also consider services for women and for young people. There are no specific facilities at the high-secure end, and quite a number of women are in medium-secure units in England. What is the expectation in that regard, and what evidence will you provide to the review?

Gary Jenkins: The high-secure service is provided nationally at Rampton hospital in England, which has 50 beds for high-security female patients.

Professor Thomson alluded to the exercise that we undertook to look at pathways in high-secure services for females. We held a workshop and undertook options appraisals—which we will feed into the review of the forensic mental health estate—to determine where the best provision in Scotland could be for high-security services for females. We recognised that the number of cases goes from zero to three, so a very small number of patients need to access that specialist service. We looked at the risks of trying to provide such a service for such a small patient cohort in a location that would not be central.

Professor Thomson might want to expand on that.

Professor Thomson: We are talking about 60 women, and equity of provision was one of the concerns. The working group that our chief executive mentioned carried out options appraisals for high, medium and low-secure services and the community, and the decisions that were taken—

The Convener: May I clarify something? Gary Jenkins talked about there being up to three women in the most high-secure facilities. Does the figure of 60 apply to women in high, medium and low-secure services?

Professor Thomson: Yes—it is all women in secure services.

The first issue was that high-secure women have to cross the border, where they are under different legislation and far from their homes. At present, there are two women in that position in the Rampton service. The outcome of the options appraisal was a plan to co-locate high and medium-secure services, which would be conjoined, with the ability to share staff and maintain staff skills, so that there would never be a period when no women required the service, when there might be an issue to do with maintenance of staff skills.

The second issue was a decision to ensure that we always have female-only accommodation in our medium-secure units. Currently, one unit is mixed. That issue came out of the options appraisal for the medium-secure setting.

The third issue was low-secure services. At present, just over 30 of the women in Scotland who need low-secure forensic mental health services will be in the Ayr clinic, which is an independent facility. That means that those women will have been taken away from their families and home area. The proposal in that regard was for a hybrid mechanism, whereby smaller health boards would come together to have regional units and larger health boards would have local low-secure units and community services.

The three options appraisals covered issues that are clearly within the remit of the independent review, but they have gone forward to the national planning board, and a short-life working group, which will have its second meeting this week, is looking to take forward the recommendations.

The Convener: I presume that the group will come to a view on which of the options to favour and will put that to ministers—

Professor Thomson: No. The three options were all agreed by the network short-life working group, and the Scottish Government is aware of the findings and the report. Because the work was done through chief executive officers and then sent to the national planning board, the Scottish Government is aware that a short-life working group is taking the recommendations forward.

The position is slightly difficult in that, on one hand, nobody wants to stop the work, because it could take a long time for the review recommendations to be made and enacted, and on the other hand, it is open to the review to come up with different ideas from the three options that the short-life working group has set out. We are trying to make progress, while knowing that there is a review and talking to the review staff and our Scottish Government colleagues.

The Convener: Thank you. What about young people? Is there provision, or the prospect of provision, for them?

Gary Jenkins: We have no patients under the age of 20 in the state hospital. However, the national plan for mental health services talks about the development of services for young people. Lindsay Thomson has recently been involved in the working group on commissioning child and adolescent mental health services, so I ask her to

give an overview of the process, if she does not mind coming back in.

Professor Thomson: NHS Ayrshire and Arran has developed a proposal for a national secure adolescent in-patient service, and I chair the stakeholder group. The Scottish Government recently approved a move from the outline business case to a full business case. The proposed unit is for 12 young people, and it will be the first formal in-patient forensic mental health service for adolescents in Scotland.

The effect of such a unit will be broader, in that such provision for adolescents is extremely patchy across the country and, in many areas, is non-existent. Once we have a national service, there will inevitably be a networking effect, and while we can see from the numbers that we need only one in-patient service, we will strengthen the expertise and the knowledge around the country. The effect will not be confined to the number of in-patient beds; it will be broader than that.

11:00

Sandra White: I have a supplementary question that relates to what has been mentioned. Having served on the Justice Committee, I recollect a case in which the ECHR was relevant to prisoners' rights and people being able to visit prisoners. Can you clarify that the young and female patients are spread out all over England because there are no secure units for them here? That is mentioned in our notes. Does the ECHR apply in that respect? Should people be allowed to be somewhere where they are within reach of their family, so that family members are able to visit them?

Professor Thomson: There are young people in specialist units south of the border. The work of NHS Ayrshire and Arran sets that out clearly, and the needs assessments show the numbers that would be brought back to Scotland. We do not have a lot of women south of the border—

Sandra White: I know that you have been here a long time and that there are other questions to be asked. My question is whether you would be breaching the human rights of such patients by scattering them throughout the UK and not having them near their relatives.

Professor Thomson: That relates to the right to family life. As ever, I am sure that all these things can be challenged legally. There is always a balance to be struck in how we provide services for a small number of people using the expertise that is needed to deal with the issue.

Sandra White: I am not necessarily suggesting that you are in breach of human rights, but can you give a yes or no answer to whether the policy breaches human rights?

Professor Thomson: I will swerve that question, because it is one for the lawyers and the courts to decide on. I can see why such arguments could be made.

Sandra White: I might ask the committee whether it wants to write about that issue. It was in my mind because I heard evidence on it when I was on the Justice Committee.

In reply to the convener's question, Mr Jenkins mentioned moving to the new clinical model and, in reply to one of my previous questions, he mentioned the new hubs and beds that are being introduced. The notes that we have been given show that the number of violent incidents has increased. Apparently, there has been a huge increase in the number of major incidents among what is described as the "intellectual disability population". I do not know what the definition of that group is, but I am sure that you do. For my benefit and perhaps for the benefit of others, can you tell us, in layman's speak, the difference between that group and the "major mental illness population"? Is that why you have moved to the new clinical model?

Gary Jenkins: A key feature was the safety report, which looked at the trends of assaults on, and violence towards, staff from patients. There was an upwards trend over the four-year period through to 2018 that was analysed. We subdivided that trend to find within which patient cohort we are experiencing that behaviour. The statistics are quite revealing. Three patients accounted for 84 per cent of assaults, so we looked at the proportions within the patient cohort to help us to develop safety features in the new clinical model. From the benefits criteria, features relating to security and safety were staff members' number 1 concern, as we might imagine.

Sandra White mentioned the intellectual disability population in relation to the clinical model. People in that group are male mental illness patients who would be classified as having learning disabilities.

Within that cohort of patients, although it is a lot smaller—we are talking about 12 beds—they would be the most highly assaultative patients, and the patients who need the most disassociations. That means that we would try not to keep all 12 people together on the one ward, because of the challenges of doing that.

Within the clinical model, recognising that feature, we initially considered some improvement measures that we could put in place at a local level. Throughout the clinical model process, we are keen to promote the idea that that was one of the key challenges that we had to address. That is why we looked to move to two intellectual disability wards, with more tailored staffing and a more

appropriate clinical environment. We would expect to see, as one of the key measures, a subsequent reduction in the levels and patterns of violence.

The other new component that we have built in is a three-monthly review for the operations and working of the hospital. We recognise that, unlike in an acute hospital, where you can move things quickly, you multiply and exacerbate risks if you try to reorganise the state hospital overnight. We are thinking about the phasing of that model and how to ensure that we do not wait to start that approach. The multiprofessional review every 90 days will examine the trends and difficulties—or benefits—that are associated with the clinical model change, so that we can either transfer the good practice into other parts of the hospital estate or identify and quickly act on any challenges that have arisen.

You might think that the admission cohort—that is, those patients who have just been admitted—would be the most highly assaultative. However, what we found, surprisingly, is that the patients who were in the middle stage—that is, the treatment and recovery stage rather than the post-discharge stage—also presented more problems and challenges through assaultative and violent behaviours. We have not gone into the staffing details with you, but we have looked to increase the levels of staffing that are associated with those cohorts of patients. We have sophisticated measures that enable us to try to target in the clinical model measures that will be successful and also to look objectively every 90 days to ensure that our approach is working and to ensure that we can take immediate action if it is not.

Sandra White: Do you have any results from the new clinical model? Have you reached the first 90 days yet?

Gary Jenkins: The new clinical model goes in from April 2020.

Sandra White: So, we will have to wait until then.

Gary Jenkins: We have concluded the plan and, as I have mentioned, we have done the consultation with staff. At the moment, a series of working groups are in place to oversee the implementation of that clinical model.

Another relevant point is that, when we designed the clinical model, we thought that we should have a high-dependency ward so that we had a specific area in which to put patients who were very assaultative—that was a result of our managerial thinking, based on how that issue would be handled traditionally. However, when we spoke to the clinical forum to get objective advice and to seek staff for the unit, we were told that we should not do that, because that would increase the risk to the staff who would be working in that area so we should distribute those patients better. That is an example of the way in which we listen when we are designing the clinical model. We can revisit the issue as part of our review cycle, if needs determine that we should.

Sandra White: I know that time is short, but I would like to ask a supplementary question about what was said earlier about obesity. We have heard about patients being locked in their rooms and not being able to do woodwork classes and so on. Are you working towards a model in which people can come out of their wards and do other things?

Gary Jenkins: Absolutely. It is a whole-system design and process. The most beneficial aspect of that is that it enables patients to feel a sense of progression in their journey through the hospital.

Just now, there is a mixed economy, in that some wards have admission patients, treatment and recovery patients, intellectual disability patients and patients awaiting discharge. Depending on admissions and the status of the patient, that mix can disturb the therapeutic milieu of the ward.

By designing a service that keeps separate the admission and assessment processes, the treatment and recovery processes, transitions, and intellectual disabilities we can focus the resources, treatments and activities on patients in that cohort. That means that not only do staff benefit from specialisation, should they wish to work in a particular area, but the benefit to patients in their on-going treatment pathway is also tangible and they feel that they are progressing through the hospital, perhaps to a medium security service or prison service thereafter.

Sandra White: Thank you.

Emma Harper: I have some questions about tackling and challenging obesity. The committee's briefing says:

> "According to the Annual Report ... the percentage of patients who had a healthier BMI decreased from 15.8% in 2017/18 to 13.7% in 2018/19."

I know that it is challenging to manage weight because antipsychotic medications can make people crave food and there are issues of activity and managing everything together. When people are managing complex medication and such things, it is not as simple as telling them that they have to exercise more. I am interested to hear how you manage that. Are the staff skilled and trained in managing obesity in your patients?

Professor Thomson: It might seem to be rather strange, given our major purpose, but our number 1 clinical priority is to improve the physical health of our patients. Earlier, our chair said that patients with major mental illness—most of our patients

have schizophrenia—will die 15 to 20 years earlier than the norm. We have shown that in our cohort by following up our patients from the state hospital. Men lost 15 years of their lives, on average, and at the time when we looked at the women, they lost 24 years. The majority of the causes are respiratory or cardiovascular. We took steps on smoking and now our big challenge is obesity.

In 2016, the board approved a 15-point plan that went from the provision of information to increased activity and the introduction of health and wellbeing plans to more radical things. Staff are skilled in nutritional screening tools, for example, and we have access to dieticians who are members of our staff. Ours was the first hospital-based shop in Scotland to bring in the healthy retail standards. We did not go with the 50:50 requirement for healthy versus unhealthy products, but went for 80 per cent healthy and did away with external procurement.

Through the different points of the plan, we thought that we would see an improvement in our figures, which we analysed in a number of different ways. We looked at our population as a whole, in which people come in and leave, and I can tell you that people are now coming in a bit heavier, which is interesting in itself. However, we have also looked at our different populations in terms of the admission cohort and the patients who have been with us throughout and we are not seeing improvement in any of those groups.

One of our concerns—I was going to mention it earlier and it is why our chair asked whether we need to be more radical—is that it is not purely a case of people coming to us with such problems and us not managing to make them better; some of them might already have problems, but the percentage weight gain while patients are with us is of remarkable concern. Many patients come to our environment and we cause the problems. Emma Harper rightly listed some of the issues.

It is not all about medication. Even people who are not on medication will put on weight when they are with us. It is largely to do with lack of activity. I am talking not just about the gym, but about all the day-to-day activities that we all do to get up and get here in the first place that constantly use energy. That sort of activity is greatly reduced when someone is in an environment such as the state hospital. In addition, one of the pleasures in life in a place such as the state hospital will be what that person eats, which is also something over which they have a choice.

11:15

We have the outcomes and we can see that our plan was very well implemented by the supporting healthy choices group. Bits of that are on-going and there are areas where we can do more, such as in the health and wellbeing plan. We have a workshop planned for mid-January to rethink our ideas.

The majority of our patients have the capacity to choose, but we are in a difficult position. What do we do when someone who has a health and wellbeing plan, and has signed it off, continues to go to the shop and buy 8,000 calories-worth of food? That is almost four days' worth of food. We work with relatives. What does someone do when they visit? As a kindness, they tend to bring something with them. Our relatives are travelling quite a distance and they can come with bags of goods. It is meant as a kindness, but it contributes to the problem. Now we are asking whether we can challenge that, particularly for the group whose body mass index is very high—over 38—and who are morbidly obese. Can we do more with that cohort? That is where we are considering more radical ideas.

Emma Harper: Would the radical ideas include things such as Fitbits or other technology to support that approach? We are in the process of a social prescribing inquiry, which is looking at how to incentivise and help people who might be constrained by their environment to become more physically active.

Professor Thomson: We have some security constraints about devices that can communicate and send messages out into the ether. However, we brought in machines that count patients' steps. We are open to all ideas. We also have slim and trim groups and healthy weight groups. We really push activity, such as the daily mile, and our occupational therapists have a 400 yards campaign; we do all sorts of things.

However, the bottom line is that about 80 per cent of the issue is about what people consume and 20 per cent is about exercise. If someone is exercising, they will probably feel better, so their control over consumption is better, too. We need to help do something about the triggers and mechanisms that surround the individuals that we look after, so that eating is not such a constant issue.

Mark Richards: I will build on what Professor Thomson said. Although there is no doubt that the dietary element of the lives of individuals in the state hospital is a significant factor, there are rights-based challenges around that. We talked earlier about rights-based practice and there is a question about a justifiable infringement of an individual's rights in relation to their dietary intake. However, there is a huge challenge around diet.

Over the past 12 months, we have made some changes in relation to physical activity. We have

made more exercise equipment available at ward level and that has had a positive impact. We are also running a couple of projects that are focused on physical activity as part of our state hospital improvement initiative, TSH3030. One of our wards is focused on walking and in the past month the patient group has done several hundred miles. We will see what we can learn from that and how we can build on it. As Professor Thomson has already mentioned, our allied health professional group is running a 400 yard campaign, to try to ensure that everyone is walking at least 400 yards per day. There are activities going on, but it is an exceptional challenge in the state hospital environment.

Emma Harper: Lindsay Thomson said that people might be overweight before they come into the state hospital. Is that related to the fact that they are on medications that might cause them to have increased appetite? I have an article from the *Journal of Psychopharmacology* of March 2017, which says that people crave more calories and often

"report craving sweet or fatty food."

Is there a significant issue with people coming in who are already overweight because they have been prescribed medication that puts them at a higher risk of gaining weight?

Professor Thomson: Most of the damage occurs in our environment, although some patients who have been elsewhere might come to us in that category. However, within several months, patients' body weight increases markedly. You are totally correct about the medications, some of which will cause cravings for food and particularly sweet food. That is part of the issue, but only one part of the equation. The constricted environment is another part.

Emma Harper: We have talked a little about infringement on rights. If a family member comes in with two bags of groceries, which might not be the healthiest, you cannot intercept that or remove items, because it would be difficult to say that they cannot give those foods to their family member.

Professor Thomson: We have some restrictions from a security perspective, and from a food safety perspective in relation to foods that require to be refrigerated and so on. There are limitations on the number of items that can come through security. That is for reasons of efficiency and enabling everybody to have their visits—it is about getting the stuff checked and through security. However, the bottom line is that, if someone is determined to come with sweeties or biscuits, we have no powers to stop that.

Brian Whittle: That issue is a bit of a topic of mine. It is recognised that physical activity and nutrition can have a positive impact on mental health. Our papers refer to the aim of having 90 minutes of physical activity a week. That will burn 500 to 1,000 calories, against a recommended weekly intake of 17,500 calories, let alone the amounts over and above that that you have described. Therefore, 90 minutes is not enough physical activity to have any kind of reasonable impact on levels of obesity. How are you restricted in what you can offer and what can be done to improve the situation? Are the staff enabled and do they understand the impact of physical activity as a resource to tackle your patients' issues?

Professor Thomson: The staff are clear on the importance of that. We have terrific facilities in the Skye centre, which is a major activity centre. There is a gym and sports staff who are committed to the task. As well as the gym, there is a games hall and all sorts of sporting activities take place, such as football and volleyball. In each of the hubs, which comprise three wards, there is also a small gym. We have found that moving the equipment into the ward areas means that it is used more.

There is a commitment to the issue but, clearly, the 90 minutes is not adequate, and we do not meet it. The aim is to meet it for 60 per cent of our patients, but we are at about 53 per cent. One can see at a glance that it should be more than that.

We have tremendous variation. About 70 of our patients have what we call grounds access, so they can go out and walk during daylight hours. Obviously, that is a little more restricted at this time of year but, during the summer months, it goes on into the evening. We have extensive grounds. There is even the potential for people to run in the grounds, wearing a running vest, if they so wish.

One of the good things that the supporting healthy choices group brought in was a weekly report on how many hours my patients exercise and at what level. I might get a report for one of my patients saying that they have done six and a half hours of activity, which might be three and a half hours of walking plus one and a half hours at a high intensity. We have great variation in patients. Of course, that reflects their mental health, which affects whether they can get out and about to exercise.

I agree with Mr Whittle that the big challenge for us is how we work towards increasing levels of activity and get everybody out. The group has reduced significantly the time that it takes from someone being admitted to their getting their sports induction. We have taken about 60 days off that, but to my eyes we should be looking to reduce it further so that, as soon as a person's health allows them to move safely into that environment, we start them on a fitness and activity programme.

Brian Whittle: Do you actively encourage patients to be more active and to be cognisant of their nutrition?

Mark Richards: Yes, absolutely. Another important aspect is our more recent focus on vocational role development for patients in the hospital. We are starting to train a cohort of sports leaders. It is a small number, but they are important nevertheless. Those patients are developing a skill set around sports leadership in the state hospital, and from that we are starting to deliver more of a co-produced approach to activity. It is early days with that, but I am hopeful that we will see benefits through time.

The Convener: Mr McNaught, will you comment on the state hospital's savings plans? I understand that you intend to make further savings, so where might those be found?

Robin McNaught (State Hospitals Board for Scotland): We work on the savings plans through individual budgetary meetings with each of the directors across all the directorates to identify what can be achieved in those areas. Over the past few years, we have had challenging savings targets, but we have achieved them every year.

In recent years, the strong focus for us has been to redress the balance away from the non-recurring to the recurring, to enable a more sustainable position. The pressure that we are under in that regard is that, compared to other boards, particularly territorial boards, we have the highest proportion of staff costs as a percentage of our total costs. The current figure is just under 85 per cent, whereas other national or special boards tend to be at between 60 and 70 per cent and the territorial boards tend to be at around 30 or 40 per cent. When we look at longer-term sustainable savings plans, we are very restricted, in that only about 15 per cent of our costs are non-staff costs on which we can work for future economies.

Going forward, one factor is that, although there was an extensive appraisal in the clinical model review of potential and desired benefits from the new clinical model, the financial element of that did not kick in until the various options of the clinical model had been evaluated. We did not want the focus of the new clinical model to be financial. Obviously, once the options were identified, they then had to be evaluated to assess their affordability so that we could be sure that the model that was taken forward was within our resources. When that was looked at, in an extensive appraisal led by Mark Richards from the nursing-costs perspective, we identified the potential for the model, when it is introduced in April 2020, to provide some savings on the staffing side and the structure of nursing and related services, which we will be able to bring into our recurring balance.

I would not say that it is a constant exercise, but work on savings takes place throughout the year. We are assessed at the beginning of the year and we get estimates from each of the directorates of what can be achieved and what they plan to achieve. As you will have seen from our financial reports, we tend to have a level of savings that are unidentified at the start of the year, which we then have to work through during the year. Quite often, they are addressed by vacancy management, where we make a level of recurring non-recurring savings—that phrase perhaps sounds inconsistent, but we know that, each year, an element of non-recurring savings will come from vacancy management.

When we combine that with the slight additional pressure of making savings from the national boards collaborative exercise, it gives us a challenging position. However, we have improved in the past two years, and we expect to continue to make improvements into 2020-21.

11:30

The Convener: You are confident that the unidentified savings that were still around a few months ago will be identified and delivered in the current financial year.

Robin McNaught: Yes. For 2019-20, we are confident that we will achieve those.

David Stewart: I have a question about media reports. Your annual report mentions significant negative press in 2018, particularly involving the *Daily Record*. I have had an opportunity to review its comments, and I will quote some of them. These are not my words. It said:

"Whistleblowers say patients at Carstairs are able to hold parties with smuggled-in drugs".

The second comment was:

"A wife-killer was out with escorts enjoying a shopping trip in Glasgow."

The third one was:

"A violent patient was goaded into attacking a vulnerable man."

I do not know how accurate those three statements are. Were there any particular factors in 2018 that led to such negative contributions from the press, and particularly the *Daily Record*?

Terry Currie: I would like to ensure that the strength of our partnership working comes across to the committee. You are right that, during a particular period in 2018-19, we went through a horrible time with negative press. It is always difficult to determine exactly what causes such things, but I suspect that we were trying to introduce some new ways of working—this was

before the new clinical model work—that some members of staff were unhappy with.

Historically, the tabloids have always been willing recipients of snippets from the state hospital, some of which will be true and some of which will be false. On the statements that you quoted, I think that the reference to "parties" was totally false, while the point about the shopping trip was true. When patients are ready to go from high-secure to medium-secure care, they go through a preparatory phase and we take them out into the community. We are always guarded about where someone will be going. In that particular case, we have to acknowledge that some inside information must have been transmitted to the paper so that, when our people took a particular patient to a particular venue, the *Daily Record* was there with photographers. I believe that to be absolutely appalling practice. However, it happened.

As many people will know better than I do right now, when you get into a downward cycle of negative media, it is difficult to break out of it. However, we have managed to break out of it and it is noticeable that, since that period last autumn, there have been virtually no negative press comments. I suspect that that is down to a marked increase in staff engagement. I guess that the lesson that we have to learn is that staff engagement should always be right up there as a priority. We perhaps have to acknowledge that we were not paying enough attention to that.

David Stewart: Thank you for that honest and open answer. You mentioned that your board meetings are going to be held outwith Carstairs, which seems sensible. I assume that you will engage with the press at the venues. Do you have press professionals in your organisation?

Terry Currie: We have a public relations officer, who is excellent. The main thrust of her efforts is internal communications, but she also handles the numerous press inquiries that we get. In the past fortnight, we have probably been mentioned in the press three or four times, simply because one patient or another has a national profile as a result of court appearances and so on.

As I said in my opening remarks, we think that the right approach is to be much more proactive in our communications. We do a lot of interesting stuff, particularly research, and we think that there is an appetite out there for more information, although probably not on the part of the tabloid newspapers, I must say, but among medical journalists and the broadsheets, who I think would welcome more comment from us. That is the route that we intend to go down.

Gary Jenkins might want to add to that.

Gary Jenkins: In relation to the breaches that David Stewart mentioned, we reported ourselves to the Information Commissioner's Office as well as to Police Scotland, and the ICO told us that it was satisfied that no action should be taken against us, as long as we implemented the recommendations that we had made following that incident.

We have three or four old ring-binders that are full of historical media reports about the state hospital over the past 10 or 15 years. In all that information, I would struggle to find anything positive that has been published about the state hospital. The reports use outdated terms and reflect an archaic understanding of a modern mental health organisation.

As I said earlier, the difficulty is in how we promote the state hospital's work in a way that is not seen to be challenging for victims or people with other issues associated with our patient cohort. At a private session of the board, I suggested that we develop media relations or work with media sponsors to find a better way to communicate what the hospital does so that we can promote that work while recognising that the area is very sensitive for the public.

There is also, of course, the general internal stuff about reminding staff of the need for confidentiality. We all have to sign documents in that regard when we come into post. There are also the rules about patient dignity and respect.

David Stewart: Sure. I realise that the state hospital is in a unique situation. From speaking to territorial boards, I understand that a key factor is regionalisation, which in other words means talking to neighbouring boards about best practice. Can you learn from the way in which other boards deal with the media and internal communications? The development with your own staff is positive, but have you learned anything from other boards?

Gary Jenkins: My previous employment was with NHS Greater Glasgow and Clyde, and the Beatson west of Scotland cancer centre was in my portfolio. Members might be aware of the positive documentary series that promoted the work of the Beatson, which tried to take an empowering approach that would remove some of the fear and stigma around the centre.

I still have contacts in the production company and among the media officers who were involved in guiding us through that process. The work that I just mentioned would involve talking to media relations officers about how we handle our public profile, how we can link in with and be seen to be apace with the developing and emerging mental health strategy for Scotland and how we can promote in a positive way, where it is palatable, the work that the hospital does. That approach

was presented at the private session of the board, in an attempt to improve the perception of what we do in the state hospital.

The Convener: I thank the witnesses for their evidence, which was much appreciated. We will probably follow up one or two issues, so you will hear from us shortly. If you feel that there is something that we should know that you have not had the opportunity to put on the record today, feel free to say so.

Gary Jenkins: May I make a final point? It is difficult for someone who has not visited the state hospital to understand the work and how the whole environment operates. If any member wants to visit the hospital, we would be happy to accommodate you.

The Convener: That is much appreciated. Thank you very much.

11:40

Meeting continued in private until 12:23.

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