THE STATE HOSPITALS BOARD FOR SCOTLAND TSH (M) 22/01

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 24 February 2022. Meeting conducted virtually by way of MS Teams and commenced at 10am.

Chair:	Brian Moore

Present:

Employee Director	Allan Connor
Non-Executive Director	Stuart Currie [Items 1 -17]
Chief Executive	Gary Jenkins
Vice Chair	David McConnell
Director of Finance and eHealth	Robin McNaught
Non-Executive Director	Pam Radage
Director of Nursing, AHPs and Operations	Mark Richards
Medical Director	Lindsay Thomson

In attendance:

Director of Workforce	Linda Davidson
Clinical Forum Chair	Sheila Howitt [for Items 1 -14]
Head of Communications	Caroline McCarron
Head of Corporate Planning and Business Support	Monica Merson
Board Secretary	Margaret Smith [Minutes]
Director of Security, Resilience and Estates	David Walker

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone to the meeting, and apologies were noted from Ms Cathy Fallon, Non –Executive Director. It was also noted that Mr David Hamilton, Social Work Manager was unable to attend the meeting today.

2 CONFLICTS OF INTEREST

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

3 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 23 December 2021 were agreed to be a full and accurate record of the meeting.

The Board:

1. Approved the minute of the meeting held on 23 December 2021: TSH(M)21/12.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board received the action list (Paper No. 22/01) and noted progress on the action points from the last meeting, with actions either being completed or progressed satisfactorily.

The Board:

1. Noted the updated action list.

5 CHAIR'S REPORT

Mr Moore provided an update to the Board in relation to his activities as Board Chair over the previous two-month period since the date of the last Board meeting. He advised that he had continued to attend scheduled meetings led by the Cabinet Secretary for Health and Social Care, with NHS Chairs and Chief Executives, where the focus has been on national system pressures around capacity, workforce and performance issues.

In addition, he had attended two NHS Board Chairs meetings since the last State Hospital Board meeting with focus on the draft national Workforce Strategy for Health & Social Care, and on planning and investment in public sector leadership development with emphasis on the relaunch of Project Lift and succession planning, and taking a whole system approach. He had also attended meetings with the Chairs of the other National Boards.

Mr Moore advised that both he and Mr McConnell had attended a meeting of the Patient Partnership Group (PPG) which was very helpful in providing an opportunity to hear first-hand from patients. The Chair noted the positive welcome they had received, as well as the engaging and interesting discussions. He had also made a visit to the Family Centre and reflected that it was a comfortable setting for visiting, creating a positive setting for both patients and carers. He encouraged al of the Non-executives to visit the centre, when possible.

He confirmed that the Annual Review had been re-scheduled to 5 April, and would be led by the Minister for Mental Welling and Social Care, Mr Kevin Stewart, who would also visit the hospital in the coming months. In addition, Ms Caroline Lamb, Chief Executive of NHS Scotland and Director-General Health and Social Care would be visiting the hospital this year.

The Chair advised that David McConnell, Vice Chair of the Board had been re-appointed by the Cabinet Secretary for another four years, and confirmed the new date of 5 April 2022 for the State Hospital's Annual Review for 2020/21.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins provided an update to the Board on his activities and on key national issues as well as local updates, since the date of the last Board meeting.

He confirmed that NHS Chief Executives continued to meet every weekly as part of the Gold, Silver and Bronze Incident Command structure, and that like Mr Moore he continued to attend the scheduled systems pressures meeting with the Cabinet Secretary for Health and Social Care. The

impact from Omicron remained the most significant challenge, with risk to the workforce in terms of capacity pressures relating to the delivery of services. Particular emphasis being placed on system pressures and modelling, delayed discharges, and resilience arrangements.

Mr Jenkins confirmed that Ms Karen McCaffrey had been appointed as Director of Nursing and Operations on a one-year secondment, with handover arrangements in place with Mr Richards. There continued to be significant focus on recruitment site wide.

He highlighted the difficult period experienced at the end of December and into the January, due to the extreme event and staffing pressures, and that a full report on the hospital's response formed part of today's meeting. However, he wished to underline the work by the operational teams, supported by colleagues in risk and resilience to ensure that the hospital was ready to respond to the very high risk presented to service delivery. He added his extreme appreciation to all staff and teams for their continued positive approach during these challenging times.

The Board:

1. Noted the update from the Chief Executive.

7a COVID 19 RESPONSE - RESILIENCE REPORTING

A paper was received from the Chief Executive (Paper No. 22/02) to provide the Board with a detailed summary overview of the key factors in the response to Covid-19 since the date of its last meeting.

He emphasised the impact that the Omicron variant has had over the seasonal period in December 2021 and in to January 2022, and confirmed that NHS Scotland would remain on emergency footing until at least 31 March 2022.

This phase of the pandemic had meant that the Audit Committee which had been due to take place on 23 January 2022 had necessarily been postponed. On an operational level, the hospital had moved to a full incident command arrangement with a core service focus. Nonetheless it had been possible to retain some critical business functions throughout including oversight of the security re-fresh project, key clinical governance workstreams, as well as taking forward preparations for the upgrade in the electronic patient record system (RiO). Mr Jenkins reflected on the experience the organisations had gained in standing up incident command arrangements rapidly when required, and also being able to phase these out as soon as it was safe to do so. It appeared that the peak in infections rates in the staff cohort came in late December and early January and this confirmed that the move to incident command had been the right one at that time.

He provided a summary of the changes made to the delivery of clinical operations, briefly returning to a 6 plus 6 household model, with patients being able to return to mixing across wards and hubs by 10 February 2022. Two small local outbreaks within the patient cohort had been managed appropriately through Incident Management Teams, and at the present time there were no outbreaks within the hospital. Mr Jenkins confirmed the continuing high uptake of vaccinations by patients, with all patients being supported and encouraged to take up this offer. NHS Lanarkshire had been able to confirm that TSH patients who required acute hospital care could be accommodated within their services.

Following the change in national guidance on 22 February, healthcare professional had reverted to twice weekly lateral flow device testing, and contractor staff continued to test in this way before coming on site.

Mr Jenkins advised that the Family Centre continued to be a very popular setting for in-person visits and that structural changes had been identified as being required to enable this setting to be used in the longer terms as a visiting centre. A Short Life Working Group was developing a capital case around this. At the same time, it was recognised that for some patients, the ward setting was more

appropriate. Carers of newly admitted patients may also find it beneficial to be able to see the ward environment for their loved one.

Moving on the workforce issues, Mr Jenkins acknowledged again how challenging the recent period had been in term of staffing capacity. The Risk and Resilience Team had led a significant piece of work on how the organisation would cope in the event of an extreme loss of staff being experienced, with detailed contingency planning in place. This was absolutely vital as in this situation, with challenges across the public sector, TSH would not be able to source multi-agency assistance and would need to seek internal solutions especially through redeployment of staff.

Recruitment continued to be a key area of focus for both registrant and non-registrant nurses. This was progressing well with targeted advertising and promotion of TSH as a good place to work and develop a nursing career at recruitment fayres. It was hoped to be possible to reduce vacancies for registrant nurses (band 5) whole time equivalents; whilst at the same overcompensating for this by additional recruitment to non –registrant Nursing assistant roles (band 3) on a temporary basis. New recruits were being inducted and on-boarded into the organisations as quickly as possible with expedited induction and training programmes. This was also being supplemented through the nursing pool, use of the retire and return policy, as well as recruitment of students to part-time contracts. He also advised that work was progressing on the nurse bank, with engagement with staff on this.

In terms of staff wellbeing, good progress was being made on the Wellbeing Strategy including engaging with staff across the organisation, and the draft strategy would be brought to the next meeting of the Board on 28 April. A healthcare pastoral support worker had been appointed through a service level agreement with NHS Lanarkshire and would commence work in the hospital shortly. The Wellbeing Centre continued to promote a very wide range of activities supporting staff through this challenging times.

Mr Jenkins acknowledged the reduction in Personal Development Planning and Reviews (PDPRs) being completed for staff as a legacy issue from the recent period of challenge in service delivery, and that improvement should be made in the coming months in this area.

Hr highlighted the continued prioritisation of the digital strategy even during this difficult period, especially on significant projects including Outlook 365, RiO (electronic patient record) and HEPMA (electronic prescribing) and suggested that it may be beneficial to include this in a board development session this year.

Mr Moore thanked Mr Jenkins for this presentation and opened the session to questions.

Mr McConnell queried whether there was a timeframe around restructure of in-person visiting within the hospital. Mr Walker advised that an assessment of the capital works required to make the site secure was being carried out, and that this would inform planning and timescale. The Short Life Working Group would take forward a detailed review of costings to build a capital case and plan of works. The indicative timescale at this stage was therefore at least six months to a year.

Mr Currie noted the need to consider what recovery would mean following the pandemic i.e. what would this mean for the organisation and wider NHS in terms of a comparator to the pre-covid position as well as the ability to take learning and possible innovation from the experience. He cited digital innovation as an area where progress had been made more rapidly as a necessary response to events. Mr Jenkins agreed and added that it would be important not to make a false start to recovery in the face of continuing challenge, and also that there may be areas which would need to be re-considered, for example the new clinical model. This would be considered on today's meeting agenda and may require to take into account new or changed priorities. The organisation had a range of key priorities in the coming year where it would pay to be both mindful and active in the light of learning taken over the past two years, whilst still retaining core principles. He added that this could also be evidenced in the Supporting Healthy Choices programme as well as in the digital agenda and staff wellbeing workstream.

Mr Moore thanked Mr Jenkins for the reporting, and commented on the helpful detailed information produced following Incident Command meetings over the December 2021 to January 2022 period. He recognised the flexibility of staff and expressed his appreciation to all levels of staff within the hospital for their dedication, resilience and commitment to the service, all of which had been exemplary.

Mr Jenkins took the opportunity to thank the Executive Team in their extensive efforts in maintaining a secure service during this time, and particularly Mr Richards for his work delivering clinical operations. He also thanked Mr Connor and partnership colleagues for their commitment which had been greatly appreciated.

The Board:

1. Discussed and endorsed the position outlined in this report in respect to the ongoing operational management and governance of the organisation in response to the global Covid-19 pandemic.

7b COVID-19 RESPONSE - FINANCIAL GOVERNANCE

A paper was received from the Finance and eHealth Director (Paper No. 22/03) to provide the Board with an update on reporting of specific Covid-19 related costs to Scottish Government.

Mr McNaught summarised the position, advising that there had been little change since previous reporting in December 2021. It was unlikely that the position for Quarter 4 would vary with scope for this to be taken into account in 2022/23 as previously reported, and some possibility for positive variance in covid funding. Work was progressing on draft budgets for 2022/23, pending confirmation of the funding position nationally.

Mr Currie commented that there may be an opportunity to re-calibrate dependent on spending review nationally, and also noted that agreement of definition of areas of spending included in recurring or non-recurring categories would be helpful.

On behalf of the Board, Mr Moore thanked Mr McNaught for this update.

The Board:

1. Noted the content of the report, and of specific Covid-19 related costs reported to Scottish Government.

8 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 22/04) from the Director of Security, Resilience and Estates, which provided an overview of the medium, high and very high risks featuring on the Corporate Risk Register, and provided assurance that these were being addressed appropriately.

Mr Moore commented on the importance of this item and that it had therefore been brought forward on the agenda. Mr Walker confirmed that all corporate risks had been reviewed and that the associated risk assessments had been updated appropriately. He highlighted that the Risk and Resilience Team had undertaken a review of digital risk with the eHealth Team, and that as a result it was proposed that Risk FD91 – Risk of IT system failure or breach should be split into three identified risks: Maintenance of System Backups, IT System Failure and Failure to Comply with Data Protection Arrangements, and asked the Board for their view on this.

Additionally, he highlighted updates in relation to assessment of the following risks: SD53, Serious

security breached, FD97, Management of Smartphone access to hospital and systems, as well as FD96, Cyber Security Breach. Mr Walker acknowledged that in terms of risk distribution, further work was required towards corporate risks achieving target grading, with a work plan to do so in place over the next two quarters.

Ms Radage commented on the accessible nature of the report, which was helpful. In terms of risk distribution and appetite, she noted the importance of realistic target setting and that this may merit further consideration by the Board. Mr Walker agreed and advised that the Risk and Resilience Team are working with colleagues to support consideration of whether the target level is still appropriate and if control measures have moved to ensure that there is active management of risk. He noted that should the Board find it helpful, this aspect could form part of a future Board development session.

Mr McNaught echoed this, adding that the eHealth Team had found the support and exercise undertaken in terms of their risk portfolio to have been very useful.

Mr Moore thanked Mr Walker for reporting, noting that the refinement and structure of the reporting was helpful, and summarised the Board's agreement to the recommendations made. He noted agreement for a future Board Seminar focused on the developing work within risk.

Action – Ms Smith/ Mr Walker

The Board:

1. Agreed the updates made to the Corporate Risk Register as presented.

2. Agreed that no further addition or amendment was required to the register.

3. Agreed that a session on the developing work being taken forward on risk should be added to the programme of Board Seminars.

9 CLINICAL MODEL IMPLEMENTATION – PROGRESS UPDATE

The Board received a paper (Paper No. 22/05) from the Medical Director, which provided an overview of works in progress in terms of planning for the implementation of the new clinical model in the hospital. Professor Thomson introduced this paper referring to the original timescale for this workstream and the necessary pausing due to the impact of the pandemic. She advised the Board that following further mapping exercised conducted in 2021, it was clear that the model still fitted the hospital population. Work was now being planned as to how to take this forward for implementation.

Ms Merson then provided a summary for the Board in this respect highlighting the five priority actions to progress planning and sequencing of work for the implementation stage. She focused in particular on the importance of wider engagements as well as the need for detailed financial analysis, and the need for clarity on the management model required to deliver the model.

There was agreement around the table that this was a reasonable way forward, and that the Board would receive detailed reporting on each of the five key areas outlined as the work developed.

The Board:

1. Noted the update on progress within his report.
2. Noted the proposed next steps for the restart of implementation of the clinical model.

10 SUPPORTING HEALTHY CHOICES – PROGRESS UPDATE

The Board received a paper (Paper No. 22/06) from the Medical Director, which provided an overview of current progress of the Supporting Healthy Choices Group which supported the focus in managing obesity rates for patients. This paper provided the Board with an update on the re-start of this programme. Professor Thomson highlighted the importance of this work, especially as obesity levels within the patient population continued to be a major concern. As part of the focus on this workstream, it was proposed to appoint a dedicated Project Manager to the programme.

Mr Moore asked about the potential source for funding for the Counterweight Plus initiative, and Professor Thomson confirmed that this was through Scottish Government, with a bid being prepared for the continuation of funding into the coming year.

Mr Moore summed up the position for the Board in noting this update, and being content with the work being taken forward to appoint a dedicated Project Manager.

The Board:

1. Noted the content of this report in terms of current progress and situation.

2. Supported the recruitment of a project manager during 2022/3.

11 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

A paper was received from the Head of Corporate Planning and Business Support (Paper No. 22/07) to provide the Board with an update on the progress made towards quality assurance and improvement activities since the last Board meeting in December 2021.

Ms Merson provided the Board with a summary of the key highlights from the report detailing the work within Quality Assurance through the progress of a range of clinical audits, which was working well in identifying and supporting areas for improvement as well as areas of good practice. She also asked the Board to note the detailed work on daily and weekly indicator reports by the Clinical Quality team which provided assurance on safe continuation of the interim clinical operating model. She paused at this point for questions and discussion.

Mr Moore commented on the usefulness of being able to see the data on impacts on patient activity, particularly ward closures and this was echoed by Mr Currie. He noted that the granularity of the data aided understanding and provided an appropriate evidence base for the reasons behind temporary changes in service delivery which were not part of the regular policy. Mr Richards offered the view that there is twin focus in clinical operations on both safety of service delivery which may entail reduced patient activity, as well as of staff awareness by front line staff on the benefit of engaging patients in activity within the current challenges experienced.

Ms Merson continued in presenting reporting by summarising the work of the Quality Forum and in Realistic Medicine as well as the range of evidence reviews undertaken to ensure that all guidance received and published is checked for relevancy for the hospital.

Mr Moore asked about the proposed repeat of the Post Physical Intervention Audit, and Ms Merson advised that this should take place in the next few months to allow time for improvement work to be taken forward, prior to further audit.

The Board:

1. Noted the content the report and the range of work described.

12 CLINICAL GOVERNANCE COMMITTEE

The Board received the approved minutes of the meetings of the Clinical Governance Committee that took place on 11 November 2021 (CGC(M)21/04).

Mr McConnell also provided a verbal update on the most recent meeting had taken place on 10 February 2022, and the wide range of items considered.

The Board:

1. Noted the approved minutes of the Clinical Governance Committee from 11 November 2021, and the update from the meeting on 10 February 2022.

13 ATTENDANCE PERFORMANCE REPORT

The Board received a paper from the Director of Workforce (Paper No. 22/08) which summarised the position on staff attendance for the most recently reported period to 31 December 2021. Ms Davidson provided an overview of the reporting data as well as the managing staff attendance training being provided to line managers to support them in this role. This has been focused in particular on the new cohort of Senior Charge Nurses in the hospital. She also advised that a new Head of HR had been appointed and would commence her employ in March 2022.

Mr Moore summed up by noting that this was an area that had been discussed in detail at the Staff Governance Committee, and that to was positive to see increased capacity within the HR Team.

The Board:

1. Noted the content of the Attendance Performance Report.

14 WHISTLEBLOWING REPORTING – QUARTER 3 UPDATE

The Board received a paper from the Director of Workforce (Paper No. 22/09) which provided an overview of activity within TSH related to the NHS Scotland Whistleblowing Policy. Ms Davidson provided an update in respect of this, with one case currently under investigation at Stage 2 of the policy.

Mr Currie asked for further input as to what the initial expectations had been for use of this policy, and how these compared to the experience of the past year. He also noted that it could be challenging to distinguish clearly between matters that should be considered as whistleblowing; and concerns that may be raised under the suite of human resources policies. Mr Currie added that it should always to be remembered that individuals are involved in the raising of any concerns, and this could be very impactive. Therefore, the emphasis should always be on getting concerns resolved.

Ms Davidson agreed with this sentiment, and noted the support mechanisms available for staff through a range of means including the wellbeing workstream. She also noted the intention to invite the Independent National Whistleblowing Officer to a further development session for the Board, and this would be a good opportunity to consider the implementation of the policy further. Mr Moore also noted that the annual reporting required for whistleblowing would be a helpful means through which to reflect on learning.

Additionally, he advised that the Cabinet Secretary for Health and Social Care would be meeting with NHS Chairs and Non-Executive Whistleblowing Champions in April. Further that Public Appointments were taking forward recruitment of a Non- Executive Whistleblowing Champion for TSH Board, with an engagement session in this regard taking place on 28 February.

The Board:

1. Noted the content of the report.

15 iMATTER REPORTING

The Board received a paper from the Director of Workforce (Paper No. 22/10) which provided an overview of the end of year iMatter report for 2021/22.

Ms Davidson confirmed that the Staff Governance Committee reviewed the detail of this report at its meeting on 17 February; and provided a high level summary of the data for the Board. She noted that the areas of challenge and of strength remained broadly similar to reporting from previous years. She though that it would be essential to link these findings to the Wellbeing Strategy. She also advised that planning was in place for the next iMatter cycle for 2022/23, at the current time.

Mr McConnell queried the finding that 75% of respondents were female as opposed to only 19% male, and whether this was anomalous compared to the overall demographics of the hospital. Ms Davidson confirmed that this did appear to be the case, and that it may be that there was difference in the way women and men were responding. Work would be progressed to ensure that all staff were encourage to take part on the next cycle.

Mr Connor advised that he had the opportunity to take part in a session for Employee Directors, which had received a presentation on the wider national picture across all NHS Boards, and in which the TSH performance on completion of action plans did not perform particularly well and he was concerned about progress in this area for the organisation. Ms Davidson confirmed that managers would be encouraged to work on these with their local teams.

Mr McConnell noted the feedback on Board Member visibility, and the challenges with this due to the pandemic. Mr Jenkins agreed with this, especially given the lack of on-site presence as had been appropriate.

Mr Currie noted the difficulty of taking short term data at a particular time to inform long term planning, and this was echoed around the table in terms of the past year having been very dynamic in terms of a changing landscape. Ms Davidson noted that the next cycle may provide a more opportunity for comparative data as the survey cycle would be more consistent across all NHS Boards. Mr Moore added that there were a number of different ways and forums through which staff views were sought; but this remained a useful snapshot.

The Board:

1. Noted the content of the report.

16 STAFF GOVERNANCE COMMITTEE

The Board received the approved minutes of the meetings of the Staff Governance Committee that took place on 18 November 2021 (SGC(M)21/04).
As chair of the Staff Governance Committee, Ms Radage also provided a verbal update on the most recent meeting of the committee on 17 February 2022. This had included focus on PDPR performance, and iMatter reporting, occupational health service delivery as well as an update form the Lead Nurse Professional Advisor.

The Board:

1. Noted the approved minutes of the Staff Governance Committee from 18 November 2021, and the update from the meeting on 17 February 2022.

17 CORPORATE OBJECTIVES 2022 / 2023

The Board received a paper from the Board Secretary (Paper No. 22/11) which set out the draft Corporate Objectives for The State Hospitals Board for Scotland for the period 1 April 2022 until 31 March 2023 for consideration and approval.

Ms Smith presented an overview in this regard, advising that these had been developed through the Corporate Management Team to ensure that they represent a high level cohesive summary of the Board's mission for the coming year. They were underpinned by the refreshed performance framework to give a structured plan for each objective and its responsible executive lead. In this way, this framework would also be a means through which to set individual objectives for executives and senior managers and the leadership team overall. This should provide assurance to the Board in its work to review performance throughout the year, as well as for the Annual Review undertaken by Scottish Government.

She also highlighted the risk factor that may be presented by Covid-19 for the coming year. To the achievement of these objectives; as well as national drivers of potential change in the review of the delivery of forensic mental health services including the female pathway.

Mr McConnell picked up on the last point, asking if it would be wise to include these national drivers as an additional objective in terms of how the Board engages with these whilst recognising that these are external factors of influence. It was agreed around the table that this would be an appropriate way to recognise this. Mr Moore also suggested adding the responsibility for ensuring sustainability and climate change action, and it was agreed that this should be the case given the importance of this area.

Mr Moore also sought assurance that the clinical model would be capable of being implemented within the next financial year, and Mr Jenkins underlined that this was the most important objective and that this should be capable of successful implementation depending on environmental factors and financial position.

There was discussion on how to take the objectives forward, and Ms Smith confirmed that they would be amended as outlined by the Board and published for onward use in managing the Board's business in the coming year.

Actions – Ms Smith

<u>The Board:</u>

1. Reviewed the draft Corporate Objectives and made recommendations for an additional two objectives: Engagement with national workstream on review of delivery of forensic mental health services, and for sustainability and climate change focus.

2. Agreed that these should now be published on behalf of the Board, setting out its mission for the coming year.

18 FINANCE REPORT AS AT 31 JANUARY 2022

A paper was submitted to the Board (Paper No. 22/12) by the Finance and eHealth Director, which presented the financial position to 31 January 2022.

Mr McNaught provided a summary of the report, advising a small underspend position of £223k to

the end of Month 10, and that year end forecasting remained for a breakeven position. As advised earlier in today's meeting, costs not named within the current year would be tracked into the 2022/23 draft budget. He advised that the forecast was to fully utilise the capital budget.

He provided assurance that work was progressing well for the year end reporting of accounts, with external audit underway and a timetable agreed for the work required post 31 March.

Mr McConnell referred specially to table 3.3 in reporting, asking to what extent the figure of £223k variance (budget less actual spend) contingent on the overall capital charges figure. Mr McNaught advised that he did not see this as a contingent risk for the current year-end.

Mr Moore asked if there had been any development to date in terms of the requirement for National Board savings, and also whether a link was likely between unrealised savings and covid funding in the present year. Mr McNaught advised that these were areas awaiting national guidance and that an update would be brought to the Board as soon as possible.

The Board was content to note this update report.

The Board:

1. Noted the content of the Finance Report, to Month 10.

19 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

A report was received from the Director of Security, Resilience and Estates (Paper No. 22/13) which provided an update in relation to the Perimeter Security and Enhanced Internal Security Systems Project.

Mr Walker advised that the Project Oversight Board last met on 17 February, and that there remained some potential for slippage in the final completion date currently anticipated to be mid-June of this year.

The Board were content to note the content of this update, and that further updates would be required within a private session of the Board due to security information and commercial sensitivities involved.

The Board:

1. Noted the content of this report.

20 PERFORMANCE REPORT QUARTER 3 – 2021/22

A paper was submitted to the Board (Paper No. 22/14) by the Head of Corporate Planning and Business Support, which provided a high level summary of organisational performance through the reporting of Key Performance Indicators (KPIs) for Quarter 3 of the current financial year.

Ms Merson confirmed that seven KPIs had been reached or exceeded, and that five were off target. She provided a more detailed assessment of these five areas.

She advised that improvement action was underway in respect of recording reviews of care and treatment plans, with improvement being sought in this respect.

For annual health checks, the definition of the KPI had been bench-marked against other high secure hospitals, and learning and development taken. The intention was to have completed this review

work for the end of Quarter 4 and that an update would be brought to the Board.

The KPI relating to 90 minutes of activity each week had slipped in performance for this quarter, although this was the best Quarter 3 performance for this indicator for a number of years. A wide range of work was being progressed in this respect to help understand the drivers as well as what learning could be taken for improvement.

Patient BMI rates had remained at same level as the previous quarter, albeit with movement within the data with some patients showing improvement in their BMI whilst others had unfortunately deteriorated. She noted that the Board had received an update at today's meeting on the Supporting Healthy Choices programme.

Ms Merson also noted that sickness absence rates had shown a slight improvement but were still off target.

She advised that, in relation to professional attendance at CPAs reviews, there had been some deterioration in this quarter which may in part be due to impacts from staffing capacity and Covid-19. Action was being taken forward through the Organisational Management Team to ensure that Heads of Service were aware of the need for improvement in this area.

Ms Radage noted the target for physical activity was 90 minutes within the hospital, whilst the national standard was 150 minutes a week, and that there was difficulty in meeting this lowered target. Professor Thomson agreed that this was an important area in which to make improvement and that it was hoped to be able to make concrete progress in the first quarter of the next year, given the actions take in respect of staff capacity. She added that although seasonal dip can occur in Quarter 3, it was also important to look at alternative ways of offering activity and exercise to patients.

Mr Moore commented that the graph recording professional attendance at CPA was congested, and asked for those areas in which meeting the target was problematic were extracted so that this could be demonstrated more clearly.

Action – Ms Merson

Professor Thomson added assurance for the Board that CPAs were taking place and that the problem identified for meeting the target was in recording and uploading of the relevant information administratively. This was under review for improvement so that it could be more clearly reported that this target was being met.

The Board:

1. Noted the content of this report.

21 REMUNERATION COMMITTEE - UPDATE

A paper was submitted to the Board (Paper No. 22/15) by the Board Secretary, which confirmed a change to the Chair of the Remuneration Committee.

Ms Smith provided the background to this change which had been agreed previously by way of electronic communication.

The Board:

1. Noted the content of this report.

22 ANY OTHER BUSINESS

No other business was raised.

23 DATE AND TIME OF NEXT MEETING

The next meeting would take place on Thursday 28 April 2022, by way of MS Teams.

The meeting ended at 1300 hours.

ADOPTED BY THE BOARD

CHAIR _____

(Signed Mr Brian Moore)

DATE _____

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	February 2021/April 2021	Resilience Report – Covid-19 (Item 7a)	Provide benchmarking comparison to other organisations on use of virtual visiting	R McNaught/ D Walker	Re – adjusted to April 2022	August: Update included in Covid response report at Item 7a. Full report to be brought to October meeting Update: trial of new system used in other high secure hospitals pending start date = delayed due to need for full DPIA to be completed. Update to Board in December. **Update – Work progressing to pilot following completion of DPIA- update on today's agenda as part of digital strategy**
2	August 2021	Covid Resilience Report (Item 7a)	To progress work on link between performance metrics and the governance structure e.g. how do individual metrics get tracked.	M Merson/ M Smith	Re-adjusted to May 2022	Work in progress as part of performance metrics / active governance and update to be brought back to board. **Update - Active Governance session scheduled for Jan 2022 postponed by agreement,**

						and rescheduled for 3 May session.
3	December 2021	Patient, Carer Volunteer Story (Item 8)	Request that stories return to being presented first hand, using digital means if possible, as soon as service delivery allows.	M Richards	April 2022	**The use of 'digital touchpoints' will be a feature of the presentation the April Board. <u>On today's agenda.</u>**
4	December 2021	PCIS Report (Item 9)	Request for update back to Board on succession planning for the service.	M Richards	March 2022	**To ensure service capacity and leadership resilience, a new Charge Nurse is being created for the PCIS. This is now under active recruitment and action can be closed.**
5	February 2022	Resilience Report – Covid-19 (Item 7a)	Updating on positon on Family Centre infrastructure/ capital plan and progress of SLWG	D Walker	April 2022	**Update as part of Covid reporting – <u>on today's agenda</u>**
6	February 2022	Resilience Report – Covid-19 (Item 7a)	Digital Agenda – ensure added as topic to Board Seminar programme for 2022 - to agree timing/ content.	R McNaught/ M Smith	April 2022	**Added to Board Seminar topics schedule for 2022 – September /November Seminar. Close action.**
7	February 2022	Corporate Risk Reg (Item 8)	Update on directorate review of risks with Risk team – ensure added as topic to Board Seminar programme for 2022 - to agree timing/ content.	D Walker/ M Smith	June 2022	**Internal Auditors have offered to support session, and this is being taken forward, meeting with them in May, with**

						dates/programme to be confirmed.
8	February 2022	Corporate Objectives (Item 17)	Amend the Corporate Objectives as discussed and agreed and publish on web. Ensure reporting back to Board throughout year linked to national framework for potential change in FMH services.	M Smith	March 2022	**Corporate objectives updated and published, added to workplan linked to board updates on national work on FMH services. Close action**
9	February 2022	Performance report Q3 (Item 20)	Review presentation of data re professional attendance at CPAs to give more clarity.	M Merson	June 2022	**On agenda for June Board when next performance report is due.**

Last updated – 21.04.22 – M Smith

Author:
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Board Secretary
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Paper No. 22/21

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 April 2022
Agenda Reference:	Item No: 7a
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	TSH Response to Covid 19 Global Pandemic – Update
Purpose of Report:	For Decision

1 SITUATION

The Board receives an update report at each of its meetings in respect of the continuing response to the global Covid-19 pandemic by The State Hospital (TSH).

NHS Scotland will remain on an emergency footing until at least 30 April 2022, and TSH is following Scottish Government guidance in relation to any requirement for restrictions within the health and care setting. Mitigation to this risk continues to be managed through prioritisation of strategies to protect the health and wellbeing of both patients and staff, and to minimise as far as possible, the risk of transmission of the virus through staff and patient populations

2 BACKGROUND

This report will provide the Board with a detailed update on the framework through which TSH has continued to manage its response to Covid-19, since the date of the last Board meeting.

2.1 Board Governance

Throughout the Covid pandemic The State Hospitals Board for Scotland has been able to maintain all aspects of board governance, including its regular schedule of Board and Committee meetings. The only exception to this has been the Audit Committee, scheduled to take place on 27 January 2022, which was postponed due to the extreme systems pressures being experienced at the time and the temporary move back into an incident command framework. However, this represented a short postponement only and a lengthened Audit Committee then took place on the next scheduled date of 17 March, which amalgamated the business of each meeting and took this forward.

2.2 Senior Leadership and Management Structure

At its last meeting on 24 February 2022, the Board was advised that an Incident Command Structure was stood up during December and January, led by the Chief Executive, in view of the global developments around the Covid-19 Omicron variant, and the impacts this may have on service delivery for TSH. As the position gradually improved, this was stood down on 27 January 2022, and the organisation has since continued to operate through normal governance arrangements led through the Corporate Management Team (CMT) and its wider reporting groups.

The CMT continues to receive the full range of reporting previously received relating to the impacts of Covid-19, including formal assessment of risk, care delivery impacts and surveillance /modelling reporting. This also includes links to NHS Lanarkshire's Horizon Scanning Group. In addition, national guidance is reviewed to ensure an appropriate TSH response, and to ensure alignment with NHS Scotland strategy. The hospital has experienced outbreaks of Covid-19 during March and April, and oversight of these has been taken through the Problem Assessment Group/ Incident Management Team structure. Further detail is included in the following section.

It is also recognised that the national position with respect to the pandemic may change in the future, and do so quickly, and that this may have an associated impact on assessment of risk. TSH continues to be in a position to respond to any new emerging risk in a structured way through Incident Command.

3 ASSESSMENT

This aims to provide the Board with a review of the key decisions taken and how these align with the framework outlined in the previous section.

3.1 TSH Route Map and the Interim Clinical and Support Services Operational Policy

The Board has been kept advised on decision-making for the delivery of care within TSH through adjustment of the Interim Clinical and Support Services Operational Policy. This has included scrutiny and review of the data gathered by the Clinical Quality team, focused on impacts on patients.

The Board is aware that the hospital moved to a household model on 31 January, and then to supporting a model of patient mixing as of 10 February. The model is being kept under review by the Corporate Management Team to ensure continued focused consideration of how best to ensure that patient activity is delivered most effectively.

3.2 Infection Control Committee

The Infection Control Committee has continued to meet monthly providing oversight for the management of Covid -19 within TSH, and additional support continues to be received from NHS Lanarkshire. This includes detailed review of National Guidance on infection control requirements for any impact on TSH.

The programme of Covid-19 audit work is embedded as part of the wider programme of infection control audit. Infection Control support is routinely provided to all staff around the importance of following guidance and the appropriate use of PPE.

3.3 Covid-19 Incidence

There are clear guidelines in place for incidence of Covid-19 in both the patient and staff cohorts following national guidance and including isolation, testing and contact tracing.

Table 1 provides the data for testing and confirmed cases of Covid-19 within the patient population in TSH over the past six months.

Month	Oct	Nov	Dec	Jan	Feb	March
Total Tests	62	153	125	64	23	144
Positive results	3	6	10	4	22	15
Negative results	59	147	115	60	1	127

Table 1: Patient Tests and Results August 21 – Feb 2022

Table 2 below provides the updated position on staff testing and incidence of Covid-19. To the end of January, this provides the total number of PCR tests reported for staff members, in numerical and percentage terms across each month as well as an indicator of the positivity rate as compared to the whole staff group numbers.

However, as most testing is now conducted via LFT, the figures for February and March represent the number of staff who reported covid infection, following either type of testing.

	Total	Positive results	Negative results	% positive tests (of all tests)	% positive rate (of staff *wte n650*)
October	72	18	54	25%	0.03%
November	77	12	65	15.6%	0.02%
December	140	39	101	27.9%	0.06%
January	114	54	60	52.6%	0.08%
February	64	49	15	76.6%	0.08%
March	123	111	12	90.2%	0.17%

Table 2: Staff testing and results

This situation impacted staffing capacity, with increased levels of staff absence, and was managed carefully through the Safe to Start mechanism. This ensured close operational control and oversight, and allowed the adjustments to be made staffing in each area, to minimise the impact on patient care as much as possible, especially in respect to the delivery of meaningful patient activity.

3.4 Response to Outbreaks

During March and April, the hospital has experienced covid infections in seven wards, and two of these were formal outbreaks with two or more patients affected. These outbreaks were managed through the standing up of an Incident Management Team (IMT) with colleagues from NHS Lanarkshire and the Outbreak Management Team from Scottish Government. The hypothesis reached was that the outbreaks were a consequence of high levels of community based transmission, with subsequent staff to patient transmission.

The actions taken included patient testing and isolation of wards, reinforcement of the message regarding PPE compliance, as well as continuation of the enhanced cleaning measure in place by both housekeeping and ward staff. Ward closures were managed throughout the course of this period in line with well-established practice for infection prevention and control.

All wards were able to re-open by 14 April 2022. At the time of reporting, there are currently no patients testing positive for Covid-19.

3.5 Covid-19 Vaccination Programme

TSH has continued to deliver its programme of vaccination as part of the national roll out of the Covid–19 vaccination programme.

With respect to patient vaccinations, all newly admitted patients continue to be offered vaccination, depending on their individual stage within the vaccination cycle. Uptake is monitored and patients are supported and advised on the importance of vaccination.

At the time of reporting, 99 patients have received three doses of the vaccine, representing 88% of patients overall. Two patients have now received four doses, due to their age or vulnerability.

3.6 Test and Protect

All staff continue to be encouraged to self-test by Lateral Flow Device (LFD) is on a voluntary basis, and to register their test results. Reporting rates are low with TSH reporting a 6% on average at the time of reporting, compared to a national rate of 10% (reported as a percentage of the expected overall number of tests).

All contractors coming on site continue to undertake LFD testing, and are required to report their test prior to coming on site. The Estates Manager oversees auditing of this process to ensure compliance, and requests evidence that LFD testing has been carried out.

3.7 Clinical Care Guidance for COVID-19 patients

Throughout the pandemic, the Board has received regular reporting on the reviewed contingency planning for the delivery of enhanced care for patients on site for symptoms of Covid-19, in the context of pressures on service delivery in NHS Scotland.

NHS Lanarkshire have continued to have capacity for a model of care delivery wherein any TSH patient who requires acute medical care, will be transferred to a general hospital.

3.8 Personal Protective Equipment

TSH continues to be linked with National Services Scotland (NSS) through procurement. To date, there have been no issues with stock availability on site.

3.9 Patient Flow

TSH links with medium and low security care providers for contingency planning including admission to and transfer between secure mental health services, suspension of detention and preparation for moving into the community. This involves regular transfer review meetings and links with medium secure units, as part of the Forensic Network Capacity Plan. The Board is asked to note the pressure due to a lack of capacity within the medium secure setting in particular presently with at the time of reporting 16 patients ready to transfer and four patients admitted under exceptional circumstances.

The following table outlines the high level position from 1 February 2022 to 31 March 2022.

	MMI	LD	Total
Bed Complement	128	12	140
Staffed Beds	108	12	120
Admissions	7	0	7
Discharges / Transfers	5	0	5
Average Bed Occupancy: Available beds/All beds			94.1% **/** 80.7%

Table 3: Patient flow 1 February 2022 to 31 March 2022

3.10 Virtual and In Person Visiting

In Person Visiting

Following a clinically led review to consider the optimal visiting model, it was agreed to support the continuation of visiting within the Family Centre in the longer term subject to the completion of key structural works required to facilitate this. A short life working group has been stood up to prepare a business case for submission to Scottish Government. The CMT reviewed this at its meeting on 20 April, requesting a detailed update by 18 May, to ensure that progress in this key area is expedited.

The current model of visiting allows most visits to take place in the Family Centre, with a limited number taking place in the ward environment due to the identified need of individual patients. Volunteers continue to support those patients who do not have designated visitors.

TSH will continue to follow national guidance on hospital visiting, to ensure compliance with infection control guidelines. Visitors are encouraged to undertake Lateral Flow Device (LFD) Testing, on a voluntary basis to help support infection control within the hospital.

Virtual Visiting

Virtual visits are taking place through video-conferencing and this is a valued means of keeping in contact for many patients and carers. The eHealth team have established a pilot scheme to help establish the most optimal digital platform for virtual visiting, given positive patient and carer feedback about the availability of this form of contact. The Board will receive dedicated reporting as part of the digital update at today's meeting.

3.11 Workforce

3.11.1 Attendance Management

The Board receives dedicated reporting separately in respect of attendance performance, including Covid-19 related absence.

3.11.2 Planning for Extreme Loss of Staff

TSH has an Extreme Loss of Staff Plan for TSH, developed in response to a significant threat to business continuity.

This has not been required to date, although PMVA Level 2 trained staff have continued to support service delivery through different deployment arrangements.

3.11.3 Staff Recruitment

Human Resources have continued to take forward the recruitment process for all confirmed positions with appointments made across a range of disciplines, with particular focus on the recruitment of registered and non–registered nursing staff.

There are currently 28 posts actively moving through the recruitment process from the following departments: Nursing, eHealth, AHP, Psychology, housekeeping, catering, Forensic Network, Sky Centre, Practice Nurse Development, Corporate Services and Housekeeping.

Since the date of the last Board meeting, recruitment activity has concluded for posts within Ward Based Nursing, eHealth, Sky Centre, Practice Nurse Development, Psychology, Estates, Director/executive level, HR and Catering.

Human Resources have strongly prioritised the on-boarding of new recruits into the organisation, including expediting inductions and training programmes. Nursing recruitment continues to be of particular focus of both registered and non-registered nurses, students and the use of the retire and return policy. This targeted recruitment plan has given considerable success, and the position as at 31 March was as follows, with further recruitment ongoing, and further offers made for registrant nurses.

	Establishment	Actual	Variance
Ward Based Nursing Staff	293	285.4	7.6

Progress is also continuing in respect of a system of supplementary staffing through a Nursing Bank, with applications sought from existing staff, and interviews planned to take place in May. The dedicated short life working group continues to monitor progress to ensure continued viability. The focus will be on supporting the initial cohort of staff into this role, and then taking forward a rolling programme of recruitment.

3.11.4 Staff Wellbeing

The Board will consider the Staff and Volunteer Wellbeing strategy today, with specific reporting in this respect.

By way of further update, the Staff Wellbeing Centre continues to be used as a drop in facility for tea breaks and lunch breaks as well as making use of massage equipment. The Wellbeing Team organise and support a range of activities being offered including yoga, table tennis and crafts. The Healthcare Pastoral Support Worker has joined the hospital and is already engaging with teams to offer advice and support. The Wellbeing Advisors are aligned to this work and are also joining departmental teams meeting to promote the wellbeing agenda for all staff. An introduction to the Wellbeing Team will also be included in the staff induction programme.

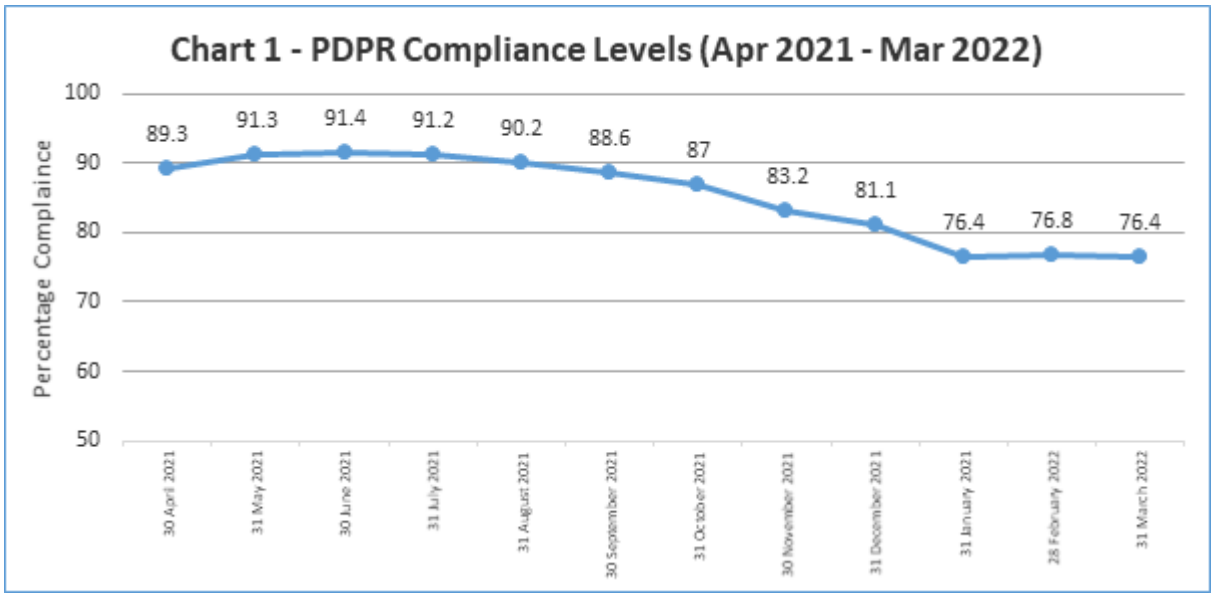
In addition, Mental Health training for Managers commenced in March, supporting managers to integrate a consistent approach to mental health and wellbeing.

3.11.5 Personal Development Planning and Review (PDPR) compliance

As at 31 March 2022:

- The total number of current (i.e. live) reviews was 463 (76.4%).
- A total of 108 staff (17.8%) had an out-of-date PDPR (i.e. the annual review meeting is overdue).
- A further 35 staff (5.8%) had not had a PDPR meeting. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.

Chart 1 shows the trend in organisational PDPR compliance levels for the 12-month period from April 2021 to March 2022.



As highlighted in the previous report, high levels of staff absence and associated staffing resource pressures have continued to impact on current compliances.

3.12. Communication

Staff Bulletins have continued to provide regular communication throughout the organisation, providing high level feedback to staff about national developments, as well as more local updates for TSH. During this period there has been focus on ensuring regular communication to all staff around the outbreaks which have occurred within the hospital; as well as covering the importance of infection control and prevention measures.

3.13 Digital Technology

The Board receives regular updates on the programme of digital transformation for the hospital, and dedicated reporting in this respect is received at every second meeting. This report will be considered by the Board separately at this meeting.

3.14 Remobilisation Planning

TSH continues to provide quarterly updates to Scottish Government on the TSH Remobilisation Plan for the current year, and work is progressing on the operational plan for 2022/23 within the context of three–year forward look as informed by Scottish Government guidance for the development and cohesion of NHS Board Plans. Planning is in place for this to be submitted towards the end of Quarter 1 in 2022.

In the meantime, it is confirmed that a quarter 4 update for 2021/22 will be submitted to Scottish Government by 30th April.

4 RECOMMENDATION

The Board is invited to:

1. Discuss and endorse the position outlined in this report in respect to the ongoing operational management and governance of the organisation in response to the global Covid-19 pandemic.

2. To advise whether any additional reporting is required to be presented.

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MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support operational management and governance structure of the NHS Board during Covid 1-19 emergency response ensuring the NHS Board received detailed reporting across directorate areas.
Workforce Implications	Considered in this report – noting staff wellbeing, staff appraisal arrangements and recruitment.
Financial Implications	Financial implications outlined within a separate dedicated Financial report related to Covid-19 presented at same Board meeting
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board requested for each meeting
Risk Assessment (Outline any significant risks and associated mitigation)	Fully outlined and considered in the report
Assessment of Impact on Stakeholder Experience	Fully outlined and considered in the report: staff patients, carers, volunteers

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.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 April 2022
Agenda Item:	Item No. 7b
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Director of Finance and eHealth
Title of Report:	Financial Governance – Covid-19
Purpose of Report:	Update on Covid financial impact

1 SITUATION

Due to the Covid-19 crisis, additional specific costs are being incurred by the Hospital on an ongoing basis. These costs have been identified since the onset of the crisis in March 2020, as the Hospital operates under new ways of working.

2 BACKGROUND

These specific Covid-related costs have been formally reported on a regular basis, through 2020/21 and 2021/22, to the Scottish Government's Covid-19 Health Finance team within the Health Finance and Infrastructure Directorate. Feedback / discussion followed directly on each of these reports, including a focus on consistency of reporting between boards, and discussions for finalisation of the year-end positions.

In 2020/21 this included late changes made via NSS and their auditors with regard to national 2020/21 PPE funding, as raised and noted at TSH Audit Committee and Board meetings when the year-end accounts were finalised, and the position in this regard is now underway for 2021/22 PPE in order that this is confirmed within the main audit timing.

The 2020/21 position was finalised and agreed with SG, and was fully accounted for and audited within our year-end accounts for 31 March 2021.

For 2021/22, the year-end position is now drafted pre-audit, for final SG agreement and offset against the funding provided in-year.

In April 2022, notification was received that Covid-specific funding would not be provided within the 2022/23 allocation, and such costs for all boards will now be faced as additional in-year pressures – as noted below in section 3.3.

For TSH – per 3.2 and 3.3 – these costs continue to relate principally to staff costs and contingent project costs.

3 ASSESSMENT - FINANCE

3.1 Financial Governance and SG allocation

As previously notified, any specific individual costs in excess of £100k with relation to Covid19 are required to be notified for approval to Scottish Government - agreement being in line with governance arrangements approved in 2020 by Chief Executives and Directors of Finance.

For 2021/22, as with 2020/21, SG provided an additional allocation agreed with individual boards in recognition of Covid costs – which were reported throughout the year and monitored against the allocation. We have had regular meetings with our SG finance team to review this position and to ensure that sufficient clarity has been provided of any cost pressures. Our reporting and forecasting is in line with SG expectations confirming support to cover our Covid-related costs through to March 2022.

Our budget for 2022/23 is now being drafted with an initial assumption that Covid-related costs could continue through at least Q1 and Q2, with the resultant pressures in the absence of SG funding ongoing.

3.2 Covid19 specific costs

Continuing in the main from 2020/21, the principal revenue costs incurred in relation to Covid19 in 2021/22, as submitted in the Board's returns and forecast are as undernoted.

i. Overtime costs £80k – additional overtime incurred each month due principally to the increased levels of staff absence arising from Covid absences (classified as special leave), together with an element of high level clinical demands. (This is principally re Nursing, but includes £10k re Infection control and Security).

ii. Student nursing recruitment £450k – these costs are to be confirmed with SG with regard to the correct allocation of costs of additional student nurses to confirm if as expected these are to be funded directly through the Covid funding as in 2020/21. This is also a key area for consideration for 2022/23.

iii. Additional deep cleaning £14k – being extra cleaning requirements specific to rooms for patients with positive Covid test results.

iv. Telephony, related IT and digital costs £6k – being the costs of teleconferencing and other remote communication costs now being incurred – this is now much reduced due to the wider use of Teams.

v. Estates/facilities costs £50k – including the requirement for additional food containers for the appropriate provision of safe catering.

vi. "Dual running" / Infection Control staff costs – £160k – relating to Covid support posts and other related costs ongoing.

vii. Perimeter project contingent costs - while an element of delay was incurred due to the site access restrictions in lockdown, the final value is under evaluation for final agreement as the actual cost, while relating to this period, will be charged in 2021/22. Should further restrictions be applied in February / March 2022 then this will require additional consideration.

3.3 Covid19 2022/23 costs

While the impact of Covid19 is now recognised as reducing, as noted above the Board received notification in April 2022 that ongoing funding will not be available for 2022/23. A formal planned review took place between the Chief Executive and the Director of Finance and eHealth, on 19 April 2022. Budget Planning meetings will reflect this change to Covid19 funding.

Review of current Covid19 costs, including those arising from new ways of working brought about by Covid19, and looking towards those likely to continue into the new year, highlights the following –

i. Infection control (staffing) – £31k
ii. On-call (security, negotiators, loggists) – £40k
iii. Covid19 internal support team (staff restructure) – £48k
iv. Staff wellbeing (learning, organisational dev't additional hours) – £30k
v. Catering (containers etc. re ongoing changes in provision of patient meals) – £40k

It should be noted that these costs, while they remain in place, will now be addressed through our core funding allocation and – together with any others which may still arise as a consequence of Covid19 activity, will therefore be cost pressures for 2022/23 within individual directorate budgets and will potentially have a consequential impact on the Hospital's required savings target for 2022/23.

3.4 Covid19 costs – vaccinations programme

In addition to the above, there are costs to the Hospital which arose from taking forward the programme of Covid-19 vaccinations for frontline staff. These costs (relating to staffing – vaccinators and backfilling of roles, refrigeration / storage of vaccines etc.) were included in our reporting and, subject to review, any future costs should they arise will require to be highlighted.

4 RECOMMENDATION

The Board is asked to note this report, including the highlighted potential pressures for 2022/23 costs.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of Financial Position and Digital developments
Workforce Implications	No workforce implications – for information only
Financial Implications	No financial implications – for information only
Route to SG/Board/SMT/Partnership Forum Which groups were involved in contributing to the paper and recommendations.	Finance and eHealth Director
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.

Paper No. 22/23

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 April 2022
Agenda Reference:	Item No: 8
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Risk Management Facilitator
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 A.

3.2 Review Dates

All risks are currently in date.

3.3 Proposed Risks for inclusion on Corporate Risk Register

- Following a review of the Security Directorate Corporate Risks – **SD54 Climate change impact on The State Hospital** - is to be reviewed by the Sustainability Group to better align with DL38 - The Climate Emergency and Sustainable Development Policy. The risk assessment will look to focus on our compliance with the policy as well as the potential impact to the wider hospital should this not be implemented. Update will be provided to group at the next meeting.

- **HR1 - The risk that the State Hospital is not complying with the nationally agreed Staff Governance Standards** – is currently being managed on the HR Local Risk Register. Upon review by the Head of HR it was felt that this is not something that can be managed locally. The Director of Workforce is currently reviewing whether this would be better suited to being managed on the Corporate Risk Register. An update will be provided at the next Board meeting.

3.4 Corporate Risk Register Updates

IT Risk Updates

Work is currently underway to update IT Corporate and Local Risk Registers.

Risk	Action
IT4 - Maintenance of System Backups	To be monitored by eHealth on the Local Risk Register. To be confirmed through HMT.
FD91 - IT System Failure	Replacement of FD91 monitored on the Corporate Risk Register by Finance Director and Head of eHealth.
FD98 - Failure to Comply with Data Protection Arrangements	New risk to be monitored on the Corporate Risk Register.

Security Risk Updates

The Risk Management Facilitator and Head of Risk and Resilience met with the Director of Security, Resilience and Estates to review the Corporate Risks under the Security Directorate. The initial findings from the meeting are detailed below:

Risk	Action
SD50 Serious Security Incident	Change to target level (Major x Rare - Medium)
SD51 Physical or electronic security failure	Change to target level (Major x Rare – Medium)
SD52 Resilience arrangements that are not fit for purpose	Change to target level (Moderate x Unlikely – Low)
SD53 Serious Security Breach	No Change to risk, actions detailed to get to target level
SD54 Climate Change	Risk to be updated to better reflect current situation at TSH
SD55 Brexit	To be removed, Brexit no longer poses major risk to TSH
SD56 Water Management	Under review by Head of Estates with a view to reducing to target level – Low (Moderate x Rare)
SD57 Failure to complete adverse review actions timeously	No Change, actions detailed to get to target level

3.5 High and Very High Risk – Monthly Update

The State Hospital currently has six 'High' graded risks, latest updates are below:

- **Chief Executive: CE14 - 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.**

Risk was reviewed by Chief Executive, Senior Nurse for Infection Control and Risk Management Facilitator with assessment taken to CMT. Likelihood was decreased to 'Possible' reducing the overall grading to 'High'. Decision was based on current situation at the hospital and following the stand down of Incident Command, the current position of the Scottish Government and the relaxation of restrictions. Impact remains at 'Major' as we exercise caution as restrictions relax, changes to self-testing rules apply and the potential for increased transmission. The risk will be monitored monthly.

Monthly Update: CMT agreed to reduce likelihood of risk to possible after review by Chief Executive, SNIC and Risk Management Facilitator. Decision based on the current hospital situation and position of Scottish Government on the relaxation of restrictions. Caution is being exercised based on risk of increased transmission and reduction in testing intervals.

- **Director of Workforce: HRD112 – Compliance with mandatory PMVA Level 2 refresher training.**

Likelihood was increased from 'Possible' to 'Almost Certain' increasing the overall grading to 'High'. Compliance level for PMVA Level 2 Refresher Training was down 54.6% (181 staff) . Attendance at PMVA training has been significantly decreased over the last 6-9 months due to the impact of Covid and staff absence. Risk will now be monitored monthly.

Monthly Update: In response to this work, The Director of workforce has implemented a 3-month plan due for completion in May 2022. The plan will continue to monitor progress, prioritising staff who are most out of date. The training plan has capacity to train 200 delegates between now and the end of May. Five courses are planned for April and Eleven for May. Progress to date is as follows:

320 staff (78.6% of staff within the target group) are fully compliant with overall PMVA training requirements. 87 staff (21.4% of staff within the target group) are overdue refresher training.

- **Director of Nursing: ND73 – Lack of SRK Trained Staff**

Likelihood was increased from 'Possible' to 'Likely' increasing the overall grading to 'High' as target levels for SRK trained staff is 279 with only 117 'in date' at that time (86 out of date and 76 not yet completed) equating to a 42% compliance rate.

Monthly Update: Training programme for this is underway alongside PMVA noted above. Compliance rate for SRK trained staff has increased to 75.8% (75 staff still to be trained).

- **Director of Nursing: ND71** - **Failure to assess and manage the risk of aggression and violence effectively.**

Risk is at target level and continues to be managed effectively with existing procedures and training. Violence and aggression incidents monitored by Risk & Resilience Team.

Monthly Update: Level 3 PPE training has been approved and is due to commence in June 2022.

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

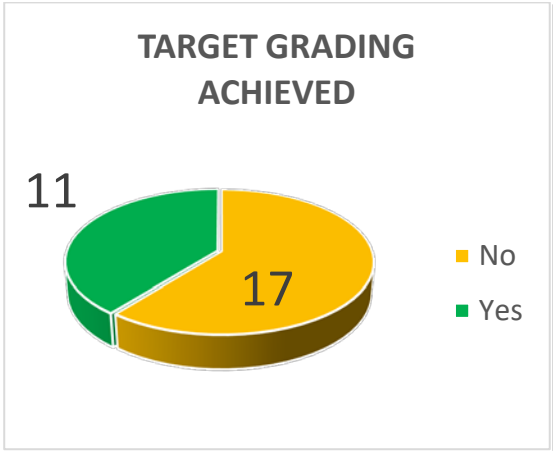
Monthly Update: Overweight and obesity in Mar '22 was 85.8% down from 88% in January. The Supporting Health Choices action plan agreed in Aug 2021 has supported the ongoing action of the 'Counterweight plus' program, update of physical activity target to 150mins/week (matching national target), review of patients shopping bags, audit of patient meal preferences when colour coded for health and the commencement of some clinical pauses to focus on supporting weight management.

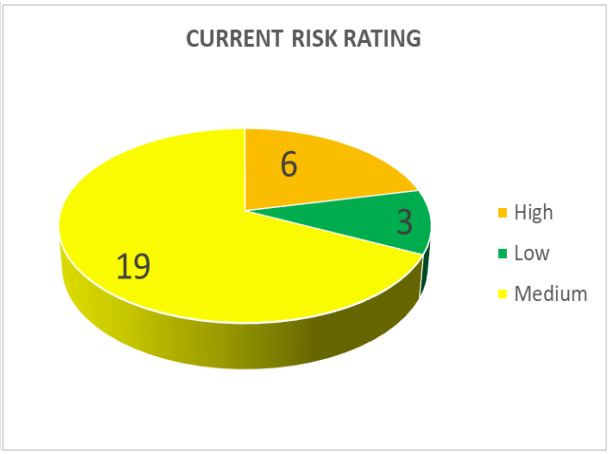
Other SHC items in the planning stages are patients access to full length mirrors, the employment of a part time health psychologist and the development and adopting of admission weight history screening assessment. The appointment of a project manager for the SHC project is awaited.

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

Monthly Update: Staffing issues continue to affect TSH although attendance has improved significantly in the last three weeks. Daily meeting takes place to monitor staff resources in real time managed through the 'Safe to Start' process. Recruitment onboarding is progressing for Band 5, 6 and 7 staff, further details are contained within the HR report of the April Board meeting papers.

3.6 Risk Distribution





Currently 11 Corporate Risks have achieved their target grading, with 17 currently not at target level.

As per the TSH Risk Management Strategy, Low and Medium risks are tolerated within the organisations 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 and is being further monitored through the work plan detailed below.

"The Hospital tolerates **Medium** and **Low** risks as part of the risk appetite mentioned above. **High** and **Very High** risks are treated as unacceptable and will require further action and monitoring from the relevant owner or group"

A work plan is underway to focus on risks not at target level in Q4 2021/22 into Q1 2022/23, this will be taken forward by the Risk Management Facilitator and Head of Risk and Resilience who will liaise with risk owners. The aim is to meet with one directorate each month going forward with updates given to CMT and the Board through this report.

	Negligible	Minor	Moderate	Major	Extreme
Almost Certain			HRD112		
Likely			ND70, ND73	MD30	
Possible			CE12, SD54, SD57, FD91,	ND71, CE14	
Unlikely			MD33, SD52, SD55, FD90, HRD110	MD34, SD56, HR111, SD51, SD50	
Rare			FD97, CE13, FD94	MD32, FD96	CE10, CE11, SD53

Review Periods:

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

4 RECOMMENDATION

The Board are invited to review the current Corporate Risk Register and to confirm agreement that this represents an appropriate assessment of risk for the organisation; and whether the Board requests any adjustments or additions to be made.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The report provides The Board with 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
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

- Blue denotes risk that will be leaving the CRR

Appendix A

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	RA	AP	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	30/06/22	Board	Y/Y	N/A	Quarterly	-
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Chief Executive	30/04/22	Clinical Governance	Y/Y	N/A	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	Risk Management Team Leader	30/04/22	Risk and Resilience Group	Y/Y	N/A	Quarterly	-
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	30/09/22	CMT	Y/Y	N/A	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	Major x Possible	Minor x Possible	Chief Executive	Chief Executive	30/04/22	CMT	Y/Y		Fortnightly	Likelihood ↓
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	01/05/22	Clinical Governance Committee	Y/Y	Y/Y	Monthly	-
Corporate MD 32	Medical	Absconsion of Patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Associate Medical Director	01/06/22	CMT	Y/Y	N/A	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	01/06/22	CMT	Y/Y	N/A	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	01/06/22	CMT	Y/Y	N/A	Quarterly	-

Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Major x Rare	Major x Rare	Security Director	Security Director	01/08/22	CMT	Y/Y	N/A	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	01/08/22	Audit Committee	Y/Y	Y/Y	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	01/08/22	CMT	Y/Y	N/A	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	01/08/22	CMT/Risk and Resilience Committee	Y/Y	Y/Y	Quarterly	-
Corporate SD 54	Service/Business Disruption	Climate change impact on the State Hospital	Minor x Possible	Moderate x Possible	Minor x Possible	Security Director	Head of Estates and Facilities	01/08/22	CMT/Risk and Resilience Committee	Y/Y	N/A	Quarterly	-
Corporate SD 55	Service/Business Disruption	Negative impact of EU exit on the State Hospital	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Chief Executive	Security Director	01/08/22	CMT	Y/Y	N/A	Quarterly	-
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Security Director	Head of Estates and Facilities	01/08/22	Infection Control Committee	Y/Y	N/A	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	01/08/22	CMT	Y/Y	N/A	Quarterly	-
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	01/05/22	CMT	Y/Y	Y/Y	Quarterly	-
Corporate ND 71	Health & Safety	Failure to assess and manage the risk of aggression and violence effectively	Major x Possible	Major x Possible	Major x Possible	Director of Nursing & AHP	Director of Nursing & AHP	01/05/22	CMT	Y/Y	Y/Y	Monthly	-
Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Likely	Moderate x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	01/05/22	PMVA Group and CMT	Y/Y	N/A	Monthly	Likelihood ↑

Corporate FD 90	Financial	Failure to implement a sustainable long term model	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance & Performance Director	Finance & Performance Director	30/05/22	Audit Committee, RF&P Group & CMT	Y/Y	N/A	Quarterly	-
Corporate FD 91	Service/Business Disruption	IT system failure/breach	Moderate x Possible	Moderate x Possible	Minor x Possible	Finance & Performance Director	Head of eHealth	30/05/22	Information Governance Group & CMT	Y/Y	N/A	Quarterly	-
Corporate FD 94	Service/Business Disruption	Inadequate data centre	Moderate x Likely	Moderate x Rare	Moderate x Unlikely	Finance and Performance Director	Head of eHealth	30/07/22	CMT/ Risk and Resilience Committee	Y/Y	N/A	Quarterly	-
Corporate FD 96	Service/Business Disruption	Cyber Security/Data Protection Breach due to computer infection	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth	30/05/22	CMT/Risk and Resilience Committee	Y/Y	N/A	Quarterly	-
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	30/07/22	Information Governance Group & CMT	Y/Y	Y/Y	6 Monthly	-
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Unlikely	Minor x Rare	Interim HR Director	Interim HR Director	01/05/22	CMT	Y/Y	N/A	Quarterly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Unlikely	Moderate x Unlikely	Interim HR Director	Interim HR Director	01/05/22	CMT	Y/Y	Y/N	Quarterly	-
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Moderate x Almost Certain	Major x Rare	Interim HR Director	Training & Professional Development Manager	01/05/22	H&S Committee	Y/Y	N/A	Monthly	Likelihood ↑

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 April 2022
Agenda Reference:	Item No: 10
Sponsoring Director:	Director of Nursing and Operations
Author(s):	Director of Nursing and Operations/ HR Assistant
Title of Report:	Nursing Registration and Revalidation
Purpose of Report:	For Noting

1 SITUATION

This paper outlines the process for monitoring professional registration status of nurses working at The State Hospital (TSH). It also provides assurance to Board members that all registered Nursing staff hold current professional registration.

This report covers the period 31 March 2021 to 1 April 2022.

2 BACKGROUND

In order to maintain registration with the Nursing and Midwifery Council (NMC), nurses need to pay an annual fee to allow them to continue to work as a registered nurse. In addition, every three years, there is a requirement for nurses to renew their registration through revalidation. They do this by meeting the NMC revalidation standards which are:

- Completion of 450 practice hours
- 35 hours of CPD activity
- Submission of five pieces of practice related feedback
- Submission of five reflective practice accounts.

If a nurse does not renew their registration annually and meet the standards for revalidation every three years; this will cause their registration to lapse and they will have to reapply to join the register. Legally, they are unable to work as registered nurse once registration has lapsed, and there are potentially serious legal implications for employers if nurses are found to be working with a lapsed registration.

As an employer, TSH is responsible for ensuring regular checks of the nurses we employ.

3 ASSESSMENT

Whilst registration is the responsibility of individual nurses, internal processes have been put in place within the State Hospital to ensure that:

(i) All affected staff understand the NMC requirements (including individual registrants and their line managers)

(ii) Registered nursing staff are supported in preparing for revalidation

(iii) Robust monitoring systems and checks are in place to ensure compliance with the requirements of registration.

The NMC advise nurses 60 days before the fee expiry date or revalidation application date as a reminder.

Human Resources carry out an initial online check in the middle of each month and notify nursing staff in writing to ascertain the status of their registration if it has not been updated at that time. If a member of staff has not updated their registration, both they and their line manager is notified by a reminder letter. A further check is completed to confirm registration has taken place by the last day of the month and any lapses in registration is escalated immediately to the Director of Nursing and Operations.

In the event that registration has not been renewed, the staff member will not be authorised to practice.

There are currently 201 registered nurses employed by TSH. During the 2021/2022 reporting period, one employee's registration lapsed, citing reason as not receiving communication from NMC. Staff member therefore had to reapply. The staff member was a member of the Nursing Pool Staff, they were temporarily banded as an unregistered member of staff until matter resolved, as per policy.

In response to COVID-19, the NMC had extended the time that nurses have to submit their revalidation evidence by a period of three months. This has now been revised and those revalidating from January 2022 onwards can apply for an 8-week extension if required, which will be considered on a case per case basis.

3 RECOMMENDATION

The Board is asked to **note** the report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support clinical governance and support professional registration of staff
Workforce Implications	Considered in this report
Financial Implications	Considered in report
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested (by workplan)
Risk Assessment (Outline any significant risks and associated mitigation)	Fully outlined and considered in the report
Assessment of Impact on Stakeholder Experience	Fully outlined and considered in the report
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 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:	28 April 2022
Agenda Reference:	Item No: 11
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Business Support
	Head of Clinical Quality
Title of Report:	Quality Assurance and Quality Improvement
Purpose of Report:	For Noting

1 SITUATION

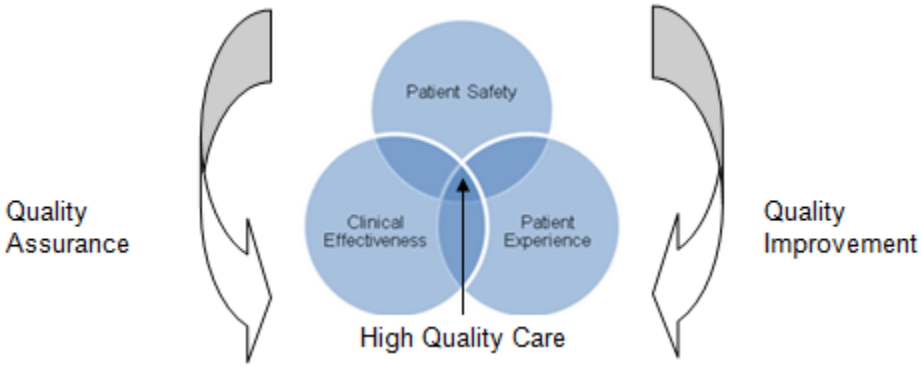
This report provides an update to The State Hospital Board on the progress made towards quality assurance and improvement activities since the last Board meeting in February 2022. The report highlights activities in relation to QA and QI and outlines how these relate to strategic planning and organisational learning and development. It contributes to the strategic intention of The State Hospital to embed quality assurance and improvement as part of how care and services are planned and delivered

2 BACKGROUND

Quality Assurance and Improvement in The State Hospital links to the Clinical Quality Strategy 2017 – 2020. The State Hospital will work towards updating and revising the Clinical Quality Strategy in 2022. The current Clinical Quality Strategy sets out the direction, aims and ambitions for the continuous improvement of clinical care. It outlines the following 7 goals to ensure the organisation remains focussed on delivering our quality vision:

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

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



3 ASSESSMENT

The paper outlines key areas of activity in relation to:

- Quality Assurance through:
  - Clinical audits and variance analysis tools
  - Clinical and Support Services Operating Procedure Indicators Report
- Quality Improvement through the work of the QI Forum
- Capacity Building for Quality Improvement
- Realistic Medicine
- Evidence for quality including analysis of the national and local guidance and standards recently released and pertinent to The State Hospital

4 RECOMMENDATION

The Board are asked to note the content of this paper

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 QI and QA
Workforce Implications	Workforce implications in relation to further training that may be required for staff where policies are not being adhered to.
Financial Implications	Covid monies have been approved to continue with the Daily Indicator Report due to CED staff workload/ weekend working
Route to Board	Route to the Board is via the CMT
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 weekly indicator report will have a positive impact on stakeholder experience as they will be getting more fresh air, physical activity and 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 team work 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.

ASSURANCE OF QUALITY

Clinical Audit

The Clinical Effectiveness Team carry 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 audit reports that have been approved since the last Board Meeting in February 2022 are:

- Diabetes Audit
- T2/T3 audit: Compliance with "Consent to Treatment Form – Adherence to MWC Guidance"

Diabetes audit

Areas of Good Practice

This is the first audit into Diabetes within The State Hospital (TSH) which has been commissioned by the Physical Health Steering Group to ensure that TSH complies with evidenced based practice for treating patients with a diagnosis of Diabetes. These audit findings were overall very positive

- All 12 (100%) patients are in contact with the Health Centre and have reviews commenced for their Diabetes care including patients only recently admitted to TSH.
- All 12 (100%) patients had their HbA1c, Cholesterol and Creatinine levels recorded within the previous 15-month period.
- Of all 12 patients, 11 (92%) patients had their systolic blood pressure reviewed and attended their podiatry review within the 15-month period.
- The 1 patient diagnosed with Type 1 Diabetes had 8 (89%) of the 9 processes completed within the previous 15-month period.
- Of the 5 patients that had Retinopathy Screening completed 4 (80%) were completed within the previous 15-month period.

Areas for improvement:

- A date of diagnosis could not be identified for 7 (58%) of the 12 patients with a Diabetes diagnosis.
- Eleven (92%) of 12 patients are in the Overweight and Obese weight categories with 1 (9%) patient being in the Obese 3 category.
- Seven (58%) of the 12 patients had no Retinopathy Screening competed. This was due to 4 (33%) patients not attending and lack of information recorded within the electronic patient record for a further 3 patients (25%). It should be noted that previous practice was for 2 staff from NHS Lanarkshire to attend in October each year to conduct the Retinopathy Screening. This did not happen in 2020 due to the restrictions imposed by Covid-19 however a service was provided by the visiting optician.

The Physical Health Steering Group will agree an action plan and a re-audit will be carried out in 12 months.

T2/T3 audit: Compliance with "Consent to Treatment Form – Adherence to MWC Guidance"
These audit findings were overall very positive.

Areas of Good Practice

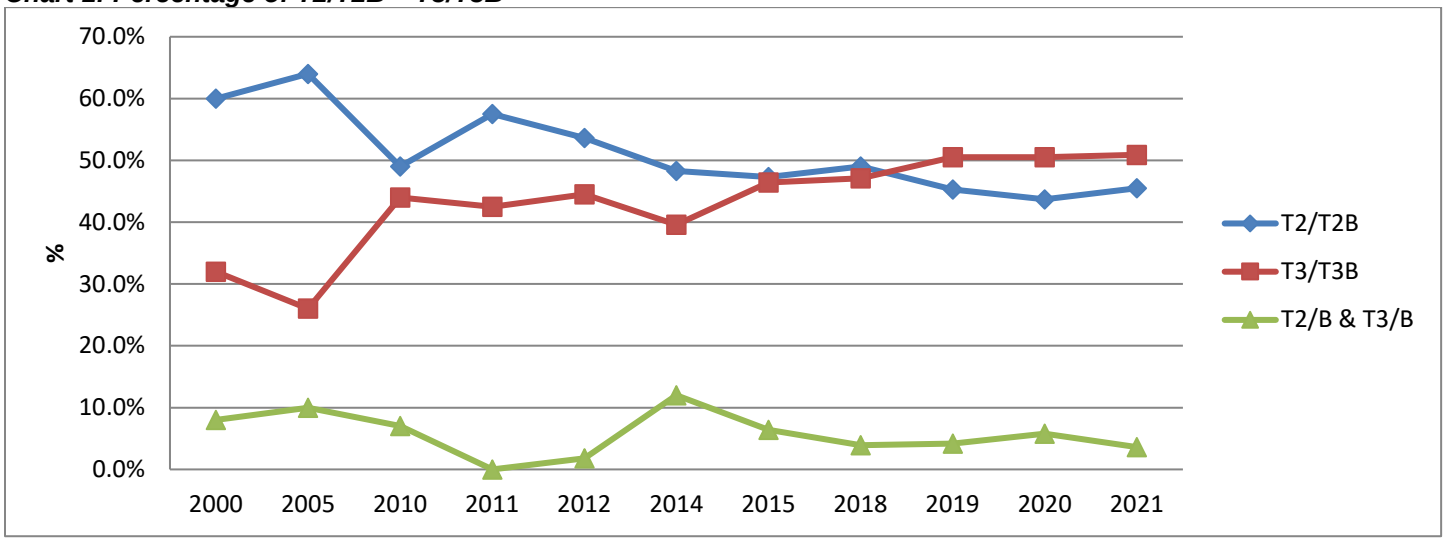
- There were 2 patients on high dose antipsychotic therapy - all had this noted on their T2B. This was the same in 2019 and 2020.
- In all cases the latest version of the T2B was found alongside the prescription sheet.
- In 96.4% of occasions the patient consent form was completed within 7 days – this is a 2.3% increase from 2020.
- Using The British approved name for specific drugs improved from 86% (44) in 2020 to 96% (53) in 2021.
- Noting the administration route has improved from 86% (44) in 2020 to 93% (51) in 2021.
- For the 46 patients whose prescription sheet included oral PRN psychotropic medication all (100%) had this noted on the T2B. This is an increase from 92.72% in 2020.

Areas for improvement

- There is an area within the prescription sheet where it can be noted if the patient is on either a T2B or T3B.For the patients with a T2B on 48 occasions this had been completed, on 7 (13%) occasions there was no clear indication. This is a 7% decrease from 2020
- On 4 occasions there was no expiry date completed in the T2B.
- On 12 (21.8%) occasions the broad class is being used and not the actual medication. This is an improvement from 2020 but not in line with MWC guidance.
- All regular psychotropic medications on prescription sheet being covered on consent to treatment form improved slightly from 90% (46) in 2020 to 91% in 2021. However, on 2 occasions the medication was not covered
- In total 36 (65.5%) patients out of 55 T2Bs had all of 6 areas completed (or, in the case of Clozapine, were not applicable). This means 19 forms did not comply with the guidance for all 6 areas. Although this is a 30.2% improvement from 35.3% in 2020 further improvement required.
- For this first time in since 2019 patients on a T2B have had IM PRN psychotropic medication prescribed. This is not in line with a Mental Welfare Commission recommendation in 2014 where any IM PRN psychotropic medication should be recorded on a T3B.

As can be seen we are seeing more patients with a T3 than a T2 over the last 3 years. The Medicines Committee commissioned an additional piece of analysis to find out if we have more patients that have been admitted from prison sources – the analysis showed that we do have a higher population of patients who have been referred from prison and this may be impacting on the change of the increase in T3/T3B we are seeing in this data.

Chart 1: Percentage of T2/T2B – T3/T3B



There are a number of audits that are being prepared for approval at their commissioning groups. The audits that are being prepared are the Menu Option, PMVA Post Physical Intervention, Observation Level and Record Keeping.

Clinical Governance Committee
At the meeting in February 2022, the following papers were presented with a number of quality assurance and improvement activities contained within them:

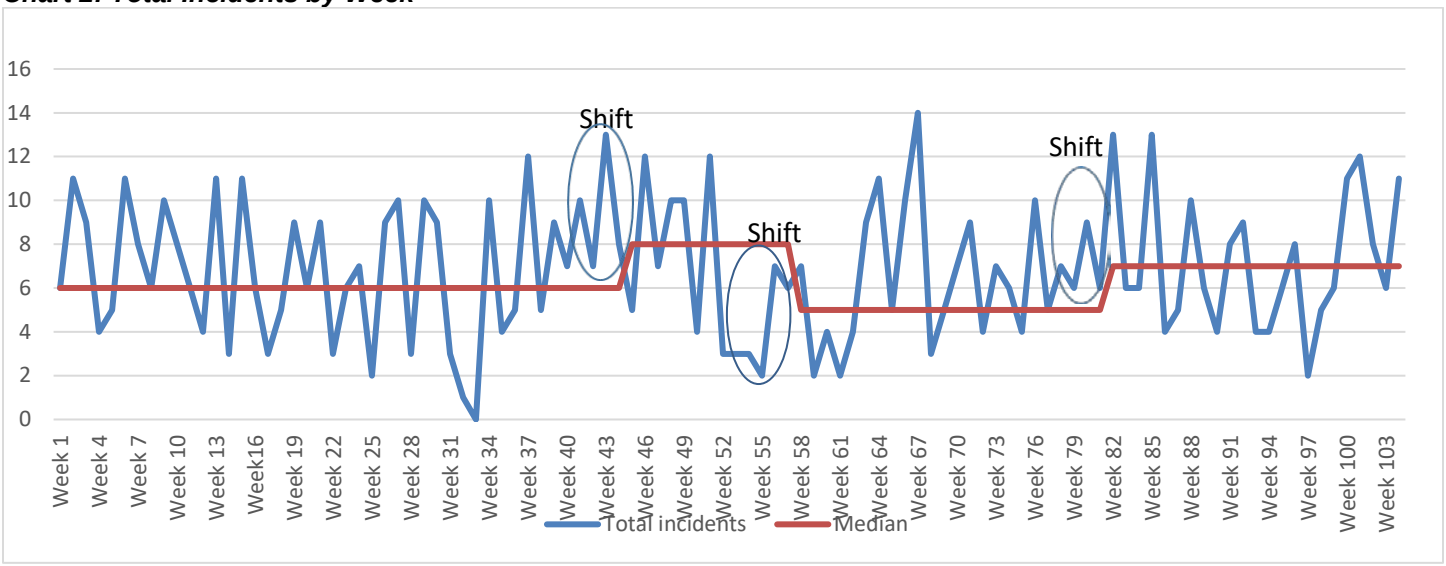
- Covid 19 Update
- Psychological Therapies Service 12 monthly report
- Clinical Governance Group 12 monthly report
- Staffing and Care Report
- Learning from Feedback Quarterly Report
- Learning from Complaints Quarterly Report
- Incident and Patient Restrictions Quarterly Report

Daily and Weekly Indicator Reports
Clinical Quality continue to collate and present the data that gives the Corporate Management Team the assurance that it is safe to continue with the Interim Operational Policy. A sample of the most recent data is below, with week 103 representing data from 18/03/22 – 24/03/22. The full report can be provided on request.

Covid 19 Incidence
Over the reporting period of February and March 2022, TSH experienced a significant increase in both patients and staff testing positive for Covid 19, with 37 positive patients tests and 160 positive staff tests recorded in these months. This contextual information is useful to consider when reviewing the most recent data below.

Datix assaults, attempted assaults and behaviour
Although the median increased from 5 to 7 in week 81, we have seen random variation since then.

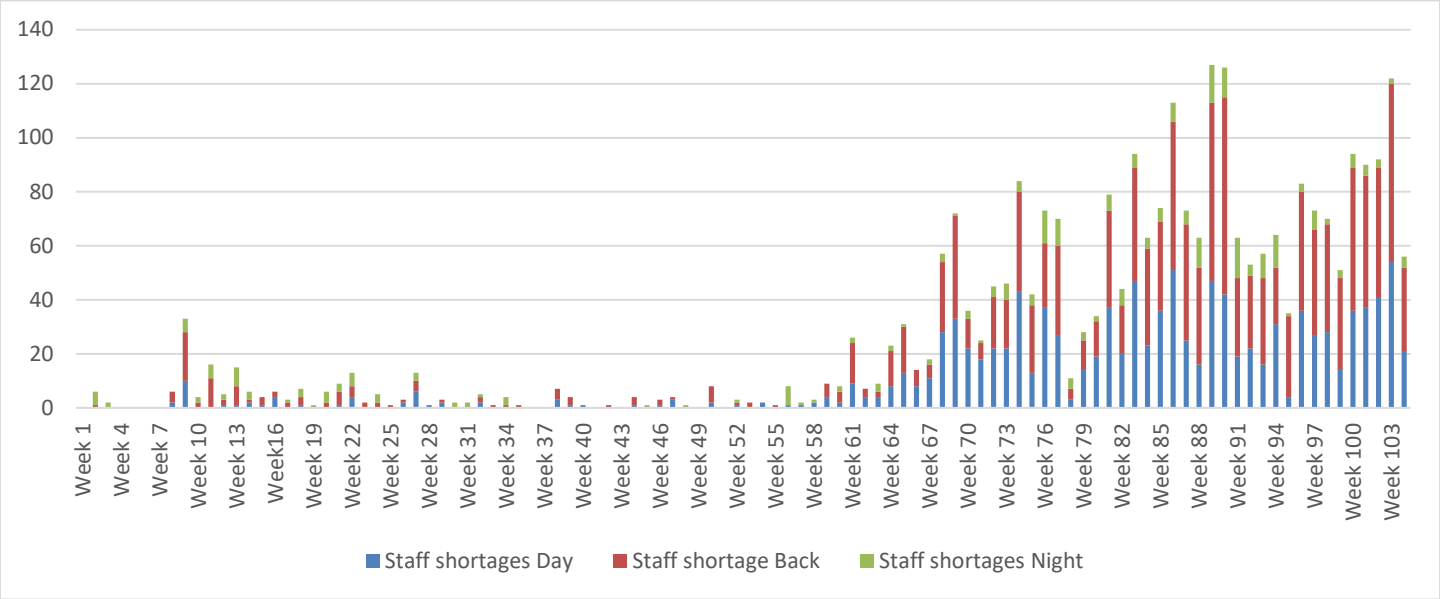
Chart 2: Total Incidents by Week



Ward Staff Shortages

As can be seen below ward staff shortages have continued to be a challenge within the hospital. Skye Centre staff continue to be redeployed to wards, impacting on the activities provided within the Skye Centre.

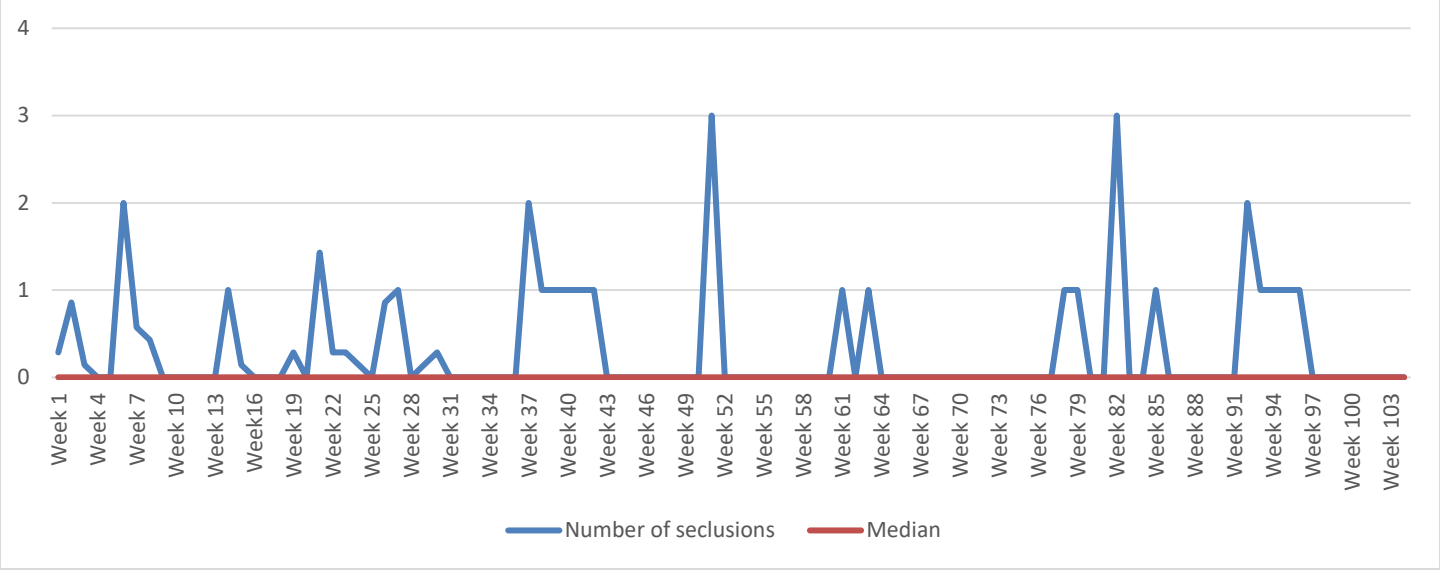
Chart 3: Ward Staff Shortages by Week



Seclusions

Since 1st January 2022, we have seen 4 episodes of seclusion. These pertained to 3 patients as 1 patient has 2 seclusion episodes. The data continues with random variation.

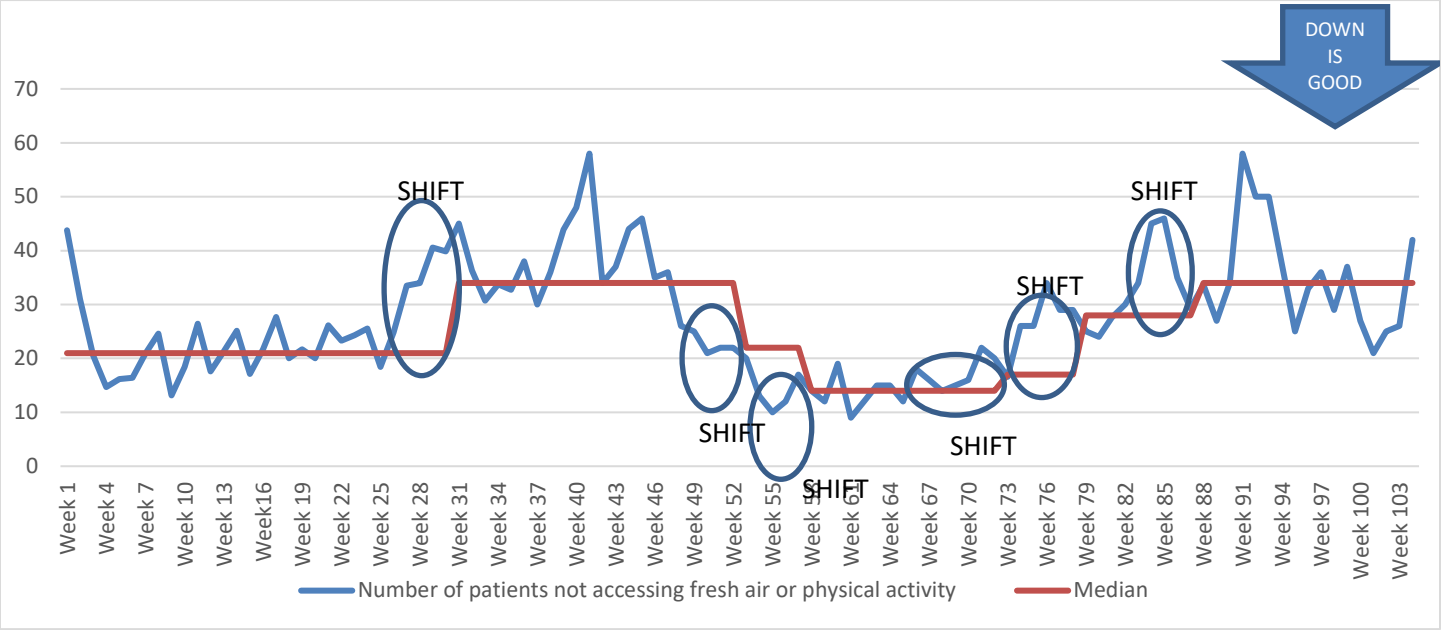
Chart 4: Number of Seclusions by Week



Patients not accessing Fresh air or Physical Activity (this is an average daily figure)
This indicator looks at both the fresh air data from PMTS and timetables and the physical activity data from RiO and highlights the patients that have had no fresh air or physical activity.

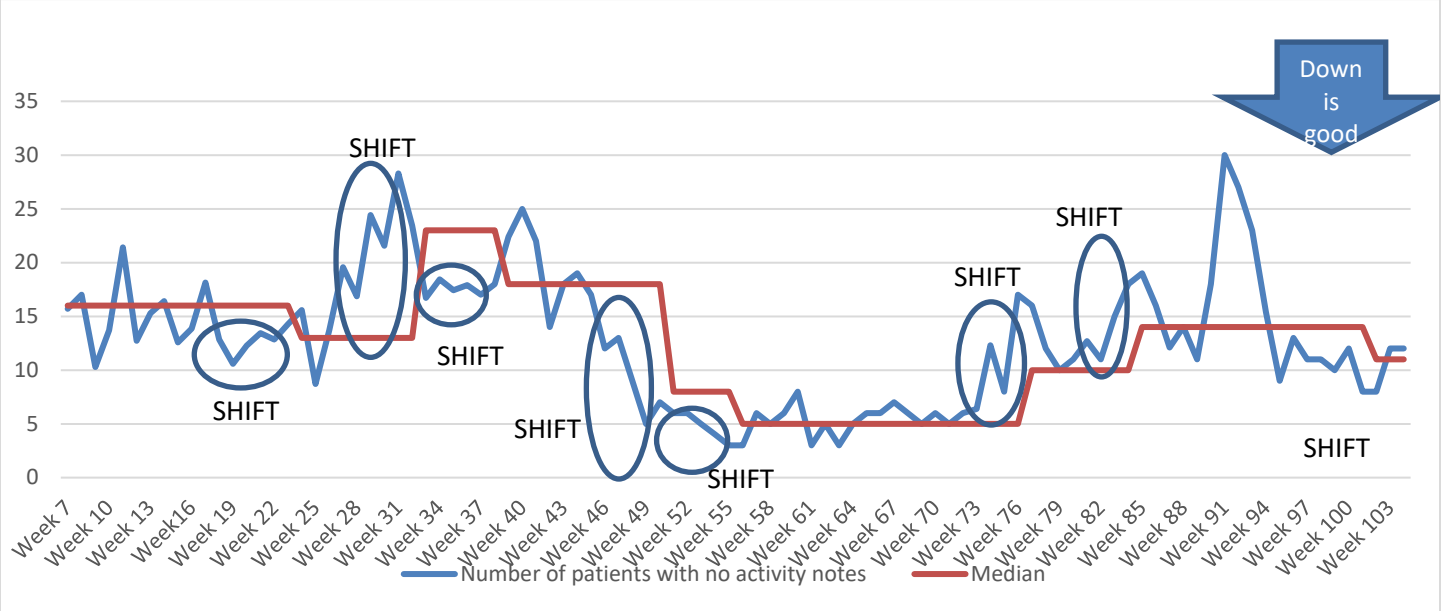
There have been no further shifts seen in this indicator since week 88 when the median moved from 28 to 34. There has been random variation since then.

Chart 5: Average Number of Patients Not Accessing Fresh Air or Physical Activity (figure collected over 7 days then averaged)



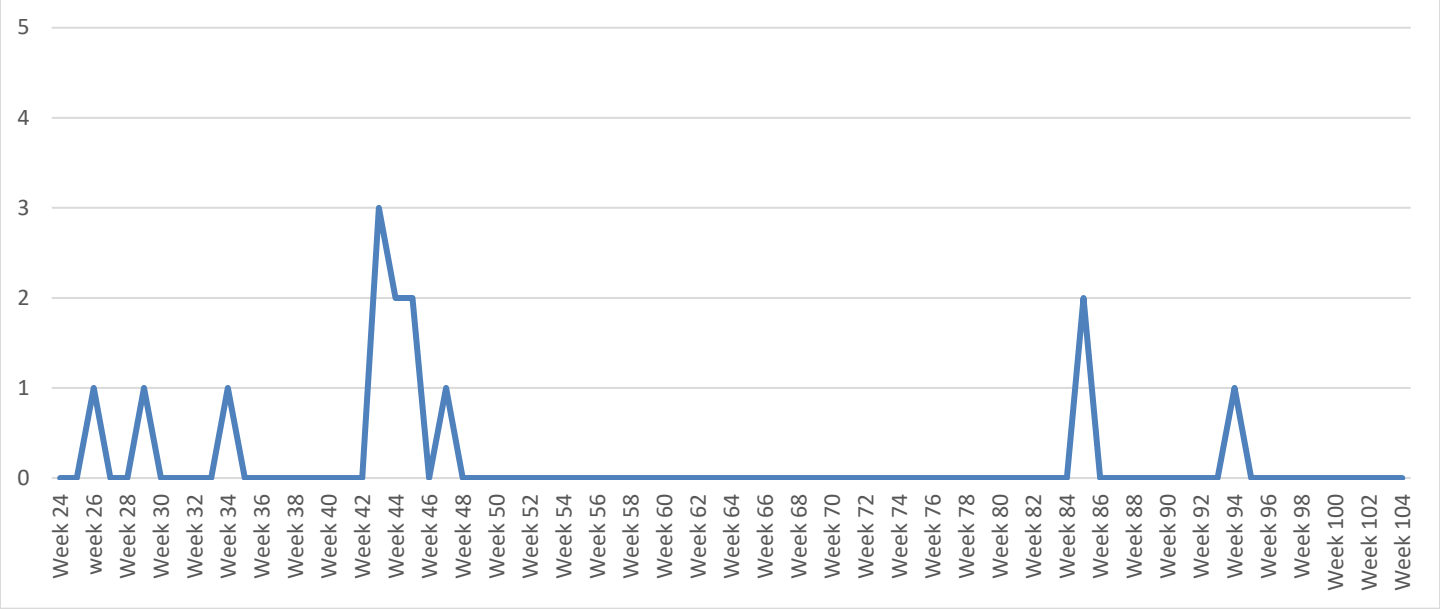
Patients not engaging with fresh air, physical activity or timetable sessions (this is an average daily figure)
One of the main purposes of collecting the daily indicator data was to ensure that there were limited patients that were not engaging with some form of activity i.e. fresh air, physical activity or a timetable session on a daily basis. Since the 1st January 2022, we have seen one positive shift in the data with the median moving from 14 to 11. This is an achievement that should be highlighted due to the number of ward staff shortages the hospital has been experiencing and the number of wards and patients in isolation in the first quarter of the year.

Chart 6: Average Number of Patients Not Accessing Fresh Air, Physical Activity or a Timetable Session (figure collected over 7 days then averaged)



Patient not engaging with fresh air, physical activity or a timetable session at any point in the week
When we look to see how many patients have had either fresh air, physical activity or a timetable session at any point in the week the data shows that the majority of the time, all patients are accessing fresh air, physical activity or a timetable activity at some point in the week. Since 1st January 2022, all patients with the exception of 1 in week 94 have had fresh air, physical activity or a timetable activity at some point in the week.

Chart 7: Patients Not Engaging at Any Point in the Week



The Operating Model Monitoring Group have commissioned 2 further reports in November in response to the data. The first is a weekly report from the Skye Centre to give context to the data and also a report that shows the activities patients have had on the days their wards have been closed – this is to see variation across the site and good practice that can be shared. The table below is taken from the week 104 (31st March 2022) report.

Ward Isolation periods.
Over the reporting period, there were 14 separate instances of wards having to isolate due to Covid 19 outbreak. This together with staff shortages may have impacted on the activity data above that we have seen in recent weeks. Although

Covid 19 is not exclusively a reason for patients not to get access to fresh air or physical activity, this could have contributed.

Planned Timetable Activity
In February 2022, the much anticipated planned timetable went live on RIO. This allows staff to programme in planned activities for our patients, linked to their recovery objectives. A report is issued weekly to show the number of these planned activities that have gone ahead and the reasons when they haven't. An excerpt from the most recent report (31st March 2022) is below:

Table 1: Planned sessions v actual sessions provided

	Week 99	**Week 100**	**Week 101**	**Week 102**	**Week 103**	**Week 104**
Planned sessions that went ahead	252	399	354	371	243	182
Planned sessions that did not go ahead	143	123	132	134	280	330
% planned that went ahead	64%	76%	73%	73%	46%	36%

Monitoring of feedback regarding the reasons for activities not going ahead as planned revealed that departmental closures and Covid 19 were key issues in changes to the delivery of planned activity. The department closures were as a result of Skye Centre staff being deployed to wards to support ward routines and absences within Skye Centre Departments.

QUALITY IMPROVEMENT

QI Forum

The QI Forum meets regularly to champion, support and lead the quality improvement initiatives across the hospital and raise awareness and understanding of QI approaches. The QI Forum continues to support and embed QI approaches to innovation and learning using the model for improvement as a guiding approach.

The QI Forum carried out a review of its purpose and function, this included a development session in November to refresh and build momentum and provide focus and clarity for the future direction over the next 12 – 18 months. The review recognized achievements made in raising the profile of QI, support available and capacity building. It also recognized the constraints of time available for QI on top of other commitments. The QI Forum agreed a range of actions and priorities to guide strategic development and embed QI approaches across TSH.

Realistic Medicine

Realistic Medicine (RM) is the Chief Medical Officer (CMO)'s 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.

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

An updated action plan for this work stream was compiled by the RM Lead and Project Manager whereby progress was noted on many projects, with some now complete and others remaining ongoing. A copy of this updated action plan is within Appendix 1. This plan was presented to Clinical Governance Group and agreement was made that this will be monitored through the Clinical Governance Committee. It has been submitted to Scottish Government for their information in April 2022.

Evidence for Quality

National and local evidence based guidelines and standards
The State Hospital 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 can be reviewed for relevancy by the Clinical Quality Facilitator. During the period 1 February to 31 March 2022, 36 guidance documents have been reviewed. Four were recorded for information and awareness purposes. The remaining 32 documents were considered to be either not relevant to The State Hospital or were overridden by Scottish guidance.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
Mental Welfare Commission	4	4	0
National Institute for Health & Care Excellence (NICE)	32	0	0

As at the date of this report, there are currently 5 additional evaluation matrices which remain outstanding and await review by their allocated Steering Group. The progress of the first 2 evaluations from HIS and the MWC was temporarily paused due to The State Hospital adapting to the COVID-19 pandemic however as per Gold Command, 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. Work is progressing with both. The Osteoporosis guidelines required input from the GP which has proven difficult to access. This evaluation matrix has now been completed and will be reviewed by the new GP once in post in April 2022. Thereafter it will be tabled at the PHSG for final sign off. The review of the Public Health England guideline was unable to be completed within the tight deadline set by the Supporting Healthy Choices group due to poor attendance at the review meeting and delay in members submitting feedback responses. At the date of this report, a date for the next SHC meeting to review the document is still awaited. Although the Clinical Quality Department were approached to in order to complete an evaluation matrix for the remaining Kings Fund document entitled Courage of Compassion, this has now been placed on hold due to the retirement of the lead for this. This will be revisited once the new person is in post.

Table 3: Gap Analysis Summary

Body	Title	Allocated Steering Group	Current Situation	Publication Date
HIS	From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care	MHPSG (via Patient Safety)	Evaluation matrix completed with 28 outstanding recommendations Patient Safety meeting took place mid-September. Evaluation matrix to be revisited upon creation of updated draft Clinical Engagement Policy.	January 2019
MWC	The use of seclusion	MHPSG (via Patient Safety)	Work ongoing. Release of updated Seclusion Policy currently on hold due to ongoing work with Clinical Engagement Policy currently being drafted with seclusion tier 1 and 2 being incorporated. Both to be launched together.	October 2019
SIGN	UPDATED: Management of Osteoporosis and the prevention of fragility fractures	PHSG	Evaluation matrix completed Jan 2022. Some content to be reviewed by new GP once in post (Apr 2022) and will be reviewed by PHSG at that time	June 2020
PH England	Managing a healthy weight in adult secure services - Practice guidance	SHC	Unable to be completed within the tight deadline set by the Supporting Healthy Choices group due to poor attendance at the review meeting and delay in members submitting feedback responses. Awaiting next SHC meeting in order to take document forward.	February 2021
The Kings Fund	Courage of compassion – Supporting nurses and midwives to deliver high quality care	HR and Wellbeing Group	CQ were asked to assist in review of document in October 2021. Now on hold due to change in lead role (Dec 2021). Awaiting guidance once new post holder is in place.	September 2020

Appendix 1:

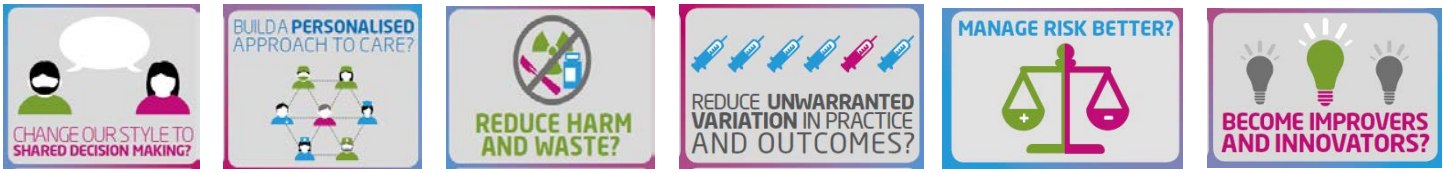
THE STATE HOSPITAL
REALISTIC MEDICINE ACTION PLAN
2022-23

"By 2025, everyone who provides healthcare in Scotland will demonstrate their professionalism through the approaches, behaviours and attitudes of Realistic Medicine" Chief Medical Officer, 2017

Introduction
Realistic Medicine (RM) is the Chief Medical Officer's (CMOs) strategy for sustaining and improving the NHS in Scotland. Originally published in 2016 as the CMOs annual report, RM quickly became a much broader multidisciplinary brand and social movement. In 2017 the Chief Medical Officer stated her vision that:

"By 2025, everyone who provides healthcare in Scotland will demonstrate their professionalism through the approaches, behaviours and attitudes of Realistic Medicine."

So, what is Realistic Medicine?
RM puts the person receiving health and social care at the centre of decisions made about their care. It encourages health and care workers to find out what matters most to patients so that their care fits their individual preferences, needs and situation. RM recognises that "a one size fits all" approach to health and social care is not the most effective path for the patient or the NHS. The original six principles of RM set out in 2016 are still in place today. These are:



RM is not just about doctors. 'Medicine' includes all professionals who use their skills and knowledge to help people maintain health and to prevent and treat illness. This includes professions such as nursing, pharmacy, psychology, AHPs and social work.

The renewal of this RM action plan for The State Hospital (TSH) for 2022-23 both demonstrates the commitment of the organisation to incorporating an RM approach into all appropriate areas of practice, and provides the mechanism through which progress towards this aim is measured and monitored.

Aims and Objectives
The aims and objectives of this action plan are directly linked to the CMOs vision that **"By 2025, everyone who provides healthcare in Scotland will demonstrate their professionalism through the approaches, behaviours and attitudes of Realistic Medicine."** The objective of the action plan is to provide the mechanism through which the implementation of the principles of Realistic Medicine will be monitored within the organisation.

Realistic Medicine in Forensic Mental Health Services (FMHS)
It is important to understand the context of TSH and FMHS generally in relation to the implementation of the principles of RM. For example, while the hospital strives to ensure that at every possible opportunity patients are actively involved in a shared decision making (SDM) process, given the nature of our patient population, this is not always easy. All TSH patients are detained under mental health legislation. TSH also employs a different understanding of the term 'risk' in relation to patient care, than that intended within the principles of RM. Our focus is on risk of harm to others and a major part of our work is on developing individual violence risk assessment and management plans. All other forms of medical risk such self-harm or iatrogenic complications are also relevant to our patients. So, while it is important to note these differences, TSH are clear in our view that these differences should not be considered insurmountable barriers to as full an implementation

of the principles of RM as is possible, and accept that in some cases a more innovative approach may be needed to affect positive change within a secure environment. TSH does not work in isolation but is part of a larger network of secure mental health facilities across Scotland. In 2021, a national review of FMHS on Scotland was completed. The review made a number of recommendations which could potentially change the way FMHS are structured and run in Scotland. A short life working group convened by Scottish Government is currently considering how to take forward the recommendations of the review. Irrespective of the outcome of the review, both TSH and the wider Forensic Managed Care Network will continue to endeavour to embed RM within FMHS in Scotland.

Delivery and governance of RM in TSH

The RM Team in TSH currently consists of the RM Clinical Lead (1 day per week, 2PAs) and the RM Project Manager (1 day per week Band 6). The RM Team is responsible for the development and renewal of the RM Action Plan and some specific areas of work within the plan. The RM Team also communicates regularly with Scottish Government and the other RM Clinical Leads and Project Mangers across other Board areas. The RM Team reports 6 monthly to the Clinical Governance Group in TSH and annually to the Clinical Governance Committee within TSH and the RM Team at Scottish Government.

Aligning RM Projects and Principles

As noted above, the principles of RM need careful consideration within the context of high-secure forensic mental health service. The table below sets out the range of projects that TSH is engaged in and which RM principle(s) they are relevant to. Some projects relate to more than one principle but we have listed next to the principle deemed most relevant to each project. Each individual project also has specific outcomes to be measured and monitored and these are included in the action plan below (page 6).

RM Principle	Project
Shared Decision Making	Advance Statements Citizen's Jury Recommendations SDM online module
Personalised approach to care	Pre-Admission Specific Needs Form CPA Review Personalised approach to patient activity Improving Observation Practice WMTY initiatives
Reduce Harm and Waste	Skye Centre activity redesign Reduce restrictive practice: grounds access Reduction in ad-hoc medication orders Learning into Practice System Quality and Safety Visits Digital transformation Staff wellbeing centre
Reduce unwarranted variation	Clinical model consultation Clinical Pause Clinical outcomes monitoring process CQIF Forensic Network professional groups
Manage Risk better	Safety Survey HEPMA Patient and staff debriefs Carers Clinic Forensic Network Carer Coordinators Group
Become Improvers and Innovators	TSH3030/365 QI Training SoFM short course training opportunities PAS initiatives

Review of TSH RM Communications Plan 2021-22

The communication plan aims to raise awareness, promote understanding and ensure staff are up to date with how we are embedding RM in TSH.

Month	Communication action	Person Responsible	Target Audience	Update
January 2021	Use general staff bulletin to circulate short article on Realistic Medicine, plans to recruit RM Programme Manager, and aspects of ongoing RM work.	RM Lead	All TSH staff	Completed. Special RM staff Bulletins published 8/18 and 3/21. RM Project Manager in post from 31/8/21.
January 2021	Existing Forensic Network communication processes will be used to promote a Realistic Medicine approach across the Forensic Managed Care Network	FN Manager	All FN sites will be included with a request to cascade the communication across all FN staff.	Ongoing. The Network continue to encourage professional groups to consider RM principles throughout the work that they do.
From RM Programme Manager appointment	RM Programme Manager to commence programme of meetings with professional groups, clinical teams, and other appropriate groups to promote RM activity and training.	RM Programme Manager	All staff but targeted approach to specific groups	Ongoing. RM Clinical Lead and Project Manager have held sessions with all Hub Leadership teams and a range of other professional groups.
March 2021	Use specific RM focused staff bulletin or 'Vision' article to introduce RM programme manager and their role, provide more detail on RM activity within TSH, the planned activity as outlined in the action plan, and the training opportunities available to support staff in using an RM approach.	RM Programme Manager	All TSH staff	Variation. RM Project Manager introduced in other fora. Other aspects of this action completed via series of meetings held with staff.
From June 2021	Provide a regular quarterly RM update to all staff through bulletin.	RM Programme Manager	All TSH staff	Incomplete. Plan to update staff via Bulletin to launch refreshed action plan in April 2022.
All RM related communication	The RM Team will ensure the use of Case studies within the RM related communication to staff. This will provide a link between the principles of RM, and	RM Programme Manager	All TSH staff	Ongoing. Will include case studies in future communications

	practical examples of work ongoing within the hospital.			where appropriate.

TSH RM Communications Plan 2022-23

Communication Actions 22/23	Frequency	Person Responsible	Target Audience
Attend meetings of Programme / Project Managers across all other NHS Boards and relay any pertinent information surrounding Realistic Medicine.	Monthly	RM Project Manager	All TSH staff if applicable.
Attend symposiums and network meetings to share learning and information across the NHS.	Quarterly	RM Lead / RM Project Manager	Feedback to be provided to all TSH staff if applicable.
Advertise the Shared Decision Making Module on Learnpro regularly to ensure the training opportunities for staff in this area are achieved.	Quarterly	RM Lead / RM Project Manager	All TSH staff.
Existing Forensic Network communication processes will be used to promote a Realistic Medicine approach across the Forensic Managed Care Network	Quarterly	FN Manager	All FN sites will be included with a request to cascade the communication across all FN staff.
Provide a bulletin to update staff on RM progress against the action plan.	Quarterly	RM Project Manager	All TSH staff.
Chair meetings with professional groups, clinical teams, and other appropriate groups to promote RM activity and training. This could be facilitated through our internal Seminar Series and Learning into Practice (LiP) meetings.	6-monthly	RM Lead / RM Project Manager	All TSH staff

Case Study: Pre-Admission Specific Needs Form
Background

The Pre-Admission Specific Needs Information Form was introduced to ensure that any specific requirements patients had regarding hearing, mobility, health, nutrition and hydration, spiritual and pastoral care, communication and smoking would be addressed prior to admission to TSH to ensure the provision of high quality, patient centred, individualised care. Medical staff complete the form whilst assessing the patient for admission to TSH. Once this information is entered into the TSH electronic records system, automatic emails are generated to Heads of Service to highlight any specific issues identified.

An audit was carried out in 2020 to check the Pre-Admission Specific Needs Assessment form was being completed for all patients admitted to TSH. During the audit period (2019) there were 33 admissions to TSH and the Pre-Admission Specific Needs Assessment form was only completed on 12 (36%) occasions. The Mental Health Practice Steering Group (MHPSG) have responsibility for the efficacy of the Pre-Admission Specific Needs Assessment form and due to the poor audit results suggested a Quality Improvement project to address the issue.

The MHPSG had also received feedback from patients and carers that there could be very long delays getting a patient telephone PIN approved after admission. This could delay (sometimes for weeks) a patient being able to have phone contact with family and friends. Discussion at the group led to the suggestion of adding a contacts section to the existing Pre-Admission Specific Needs Assessment form to speed up this process.

<u>QI Project:</u>

The project started on 1 February 2021 – it's aims were to:

- Improve the completion of the Pre-Admission Specific Needs Assessment Form to 80% by June 21
- To have patient contact details prior to admission to ensure that the patient has a hospital telephone PIN when they arrive at the State Hospital

The first stage of the project was to put a formal process and tools in place to ensure completion of the assessment. In order to create this process, discussions were held with the Person Centered Improvement Lead, RMO's and Medical Secretaries, Health Records and Estates.

After a number of PDSA cycles the percentage of forms completed increased to 82% (18 out of 22). This was a significant improvement (46%) and exceeded the 80% target set at the start of the project. The 4 occasions where the form was not completed were fed back to the 3 relevant RMO's.

Looking at baseline data on phone activation in the 2 months prior to the project starting (Dec 20 and Jan 21) the average time between admission and the patient's phone line being activated was 25 days– ranging between 2 and 78 days with a median of 8. After the QI project (Feb-Jul 21) the average time between admission and the patient's phone line being activated was 4 days after admission - ranging from 4 days prior to admission to 35 days after admission – with a median of 0. This is an excellent improvement. Initially it was thought that improvement to this could be achieved by adding a contacts section to the form but was, in fact, achieved by introducing the practice of Health Records notifying Estates of the date of all new admissions

Clinical Model Redesign				
Initiative	**Summary of Action**	**Measurable Outcomes**	**Person Responsible**	**Timeframe**
Clinical Model consultation	Planning progressed with mapping exercises in June and October. These exercises provided evidence that the model of 2 admission wards, 4 treatment and recovery wards, 2 transition wards and 2 ID wards continue to be appropriate. However, the patient population for Major Mental Illness (MMI) patients continues to exceed the beds available for this group in the Clinical Model. A range of options for addressing this issue were considered and an agreement has been reached that some MMI may need to board in the ID wards if this situation continues when implementation takes place.	Once the new model is in place it will be crucial that an ongoing engagement, monitoring and feedback process is in place to support staff engagement in the shared decision-making aspects of the ongoing continuous improvement approach.	Medical Director	This is dependent on the timeframe for the implementation of the new clinical model which will in turn be impacted upon by the status of the pandemic.
Safety Survey	The staff safety survey was conducted in the Hospital in response to a period with high levels of inpatient violent incidents. The survey was aimed at engaging staff in conversation over factors seen to support a high level of violent incident and identify mitigations or changes that could be introduced to make the environment safer for staff and patients, with a view to informing the discussions over any change to the hospital's clinical model. The survey was prefaced by analysis of incident data to identify any patterns. The analysis revealed that the majority of incidents involved a small number of patients, and the introduction of Complex Case Reviews supported a reduction in assaultive behaviour. This survey should be repeated once clinical model changes have been introduced.	Monitor the impact of Complex Case Reviews on behaviour of specific patients.	Medical Director	Revisit safety survey once new Clinical Model is in place and staff have had time to assess the impact of the change.
More personalised	The various Impacts of the covid-19 pandemic have	It is important that any positive benefits of the	Head of Corporate	The TSH Remobilisation Plan

approach to patient activity	affected patient care in a number of ways. However, one of the positive outcomes has been the necessity for more of a focus on a personalised approach to care due to the suspension of group work and the household model reducing any mixing between wards.	ongoing restrictions are maintained once the impact of the pandemic has ceased (or at least reduced). The TSH Remobilisation plan will include focus not only on reducing waste and unwanted variation, but also on maintaining some of the innovative aspects of good practice that have been introduced.	Planning and Business Support	was updated in September 2021 to V4 and a further Delivery Plan update has been provided to Scottish Government in January 2022 to update on key areas of delivery and new developments.
Improving Observation Policy (IOP)	The Improving Observation Practice (IOP) work was initially focused on the identification of practice, provision of a consistent approach, investigating what could be considered a restrictive practice for patients, and looking into the staffing requirements with specific focus on level 3 observations. That initial work resulted in the development of a new Observation policy. The IOP team are now taking a QI approach to implementing the new Observation policy within the hospital.	Patient Days on Level 3 Observation. Staff days working on Observation. Days between episodes of Level 3 Observation.	Nursing Practice Development IOP Lead	Autumn 2022 This work stream also aligns with the HIS Collaborative timeline whereby staff are asked to attend learning sessions and workshops from 1 April 2022 – 31 March 2023.
Skye Centre Activity redesign	This project is taking a QI approach to developing the processes used within the hospital to support patient access to opportunities for activity within the hospitals Skye Centre, wards and Hubs. The project will be live for 90 days and will utilise a review of literature, process mapping, and expert interviews to initially develop a project driver diagram. The project will then develop prototypes and pilot to inform the development of a Skye Centre Activity Implementation plan.	Development of implementation plan.	Head of Corporate Planning and Business Support	This project completed stage 1 of the 90-day process with analysis of evidence on best practice for activity design and consultation with key experts through Focus Group Discussions. Process mapping was carried out and presented to CMT. Key areas for development form this have been identified to be included in planning for new clinical model.
CPA process review	The hospital's Mental Health Practice Steering group have been asked to conduct a wide ranging review into the patient's annual and interim	The aim of the review is to support a more co-productive approach to all aspects of CPA care planning.	MHPSG	2022 in line with the clinical model implementation.

	CPA (Care Programme Approach) review process. MHPSG Group agreed that the CPA work should be fed into the 4 new clinical model work streams with the learning over the last 2 years being provided. Recommendations as follows: • Review and revision of CPA paperwork to join New Clinical Model work stream to ensure meeting meets needs of 4 patient ward types. • Clinical teams to be empowered to make changes at hub level to CPA meetings to improve patient and carer engagement whilst using existing paperwork. Any learning to be reported back to MHPSG and shared to other hubs for consideration, e.g. use of structured discussion pre CPA to ensure patient views/questions are brought and addressed at meeting – approved and should feed into the LiP processes • Continue to work with Clinical Quality colleagues to ensure any changes to CPA process continue to meet legal requirements and are auditable. Once RiO 21 is in place priority will be given to storing the CPA information on RiO in real time.	The project will need to consider the changes that may be brought about by the planned revision of the hospital Clinical Model, and the opportunity for the level of patient involvement and shared decision making to be dependent on the stage at which the patient is in their journey through high secure forensic care.		

Quality Improvement: Being Innovators and Improvers				
Initiative	**Summary of Action**	**Measurable Outcomes**	**Person Responsible**	**Timeframe**
TSH3030/TSH365	See TSH3030 Case Study as above.	Monitor the number of QI initiatives in place under a TSH365 model when compared to success of TSH3030.	QI Forum	QI Forum continued to meet and QI projects within hospital are supported.
Clinical Pause	The use of the Clinical Pause is now embedded across all four Hubs and	Identify any variation in Clinical pause across the site. Use identified	RM Lead	Clinical Pauses continue as an integral part of risk

	is being used regularly as a care planning/risk management process. The next steps are to complete the data entry into RiO and to conduct an in depth audit of all the Clinical Pause meetings to identify any variation across the site and potential areas for improvement. The IOP project is also building the Clinical Pause into the new Continuous Intervention policy to support decision making and least restrictive practices.	variation to support quality improvement approach to clinical pause use. Monitor the use of the clinical pause as part of the IOP Continuous Intervention.		management systems in TSH. An audit function has been established in RiO. Staff have been identified to complete data entry for the audit and analyse results by August 2022.
Pre admission specific needs form	The ongoing development of the Pre admission specific needs form and associated process is aimed at ensuring a person centred approach to care, and anticipating any communication difficulties which may impact on the shared decision making aspect of care prior to a patient being admitted to the hospital.	The process should ensure clinical teams have an early understanding of the specific needs of all newly admitted patients to support the early implementation of a personalised approach to care. This process is intended to be embedded into practice to ensure with the MHPSG reviewing its progress.	MHPSG	Monthly monitoring from April 2022
Reduce Restrictive Practice: Grounds access	The level of patients with Grounds Access is monitored monthly by TSH and is in control as at Feb 22 at on average just under 60%. The work to move the Grounds Access permission process onto an electronic system is complete. However, this will not be rolled out until the Grounds Access policy is reviewed and updated.	Timescale from the point of submitting an application for grounds access to the approval of grounds access will be reduced.	MHPSG	June 2022
Hospitals Electronic Prescribing and Medicines administration system (HEPMA)	The State Hospital is engaged with the national programme to implement HEPMA systems across all NHS Scotland Boards. TSH is working in	Full implementation of HEPMA system into practice. HEPMA benefits realisation monitoring will also be in place.	HEPMA Project Manager	HEPMA go-live is currently scheduled for a 4-week period commencing on Monday the 25th of April with go-live

	regional collaboration with NHS Lothian to introduce the system with the aim of reducing harm, and better managing clinical risk.			taking place one hub at a time over the 4-week period. The go-live commencement date may be affected by a slight delay in work required to develop an interface between the HEPMA system and RiO EPR, but go live will commence asap.
Clinical Outcomes Monitoring process	The outcomes process has been in place for some time, providing a high level summary of TSH patient outcomes across a range of outcomes areas specific to FMH care. Engaging staff in the use of this data for improvement has been difficult and work is now focused on identifying ways in which frontline staff can be more effectively engaged in the use of data for improvement.	More effective engagement of frontline clinical staff in utilising the wide range of available data to inform and support clinical decision making.	R&D Manager	Work on a revised Clinical Outcomes monitoring process has continued within MHPSG. The revised process will be Tableau based and will also be directly linked to the provision of data to staff to support the new amended CPA process once defined.
Continuous Quality Improvement Framework Reviews (CQIF)	The Forensic Network supports independent quality peer reviews across the forensic estate and into the community. The third round of the Continuous Quality Improvement Framework Reviews is due to commence in 2022.	The CQIF Reviews provide the opportunity for consistent benchmarking and auditing across the forensic mental health estate. Production of standards within the review process which incorporate the principles of realistic medicine where appropriate.	Forensic Network Manager	2022 – 2025
Patient Advocacy Service (PAS) Initiatives	The Patients' Advocacy Service is managed independently from the rest of the Hospital and provides a free, confidential service to all patients. The PAS provides individual support to help patients share their thoughts and opinions about care and	Better access to PAS whilst in seclusion / on level 3's. The PAS ward drop-in model and how this could be amended to better serve the patients and the clinical model. PAS input for patients transferred to general hospitals and the	PAS Manager	Aligned to policy changes for Improving Observation Practice / Seclusion – Autumn 2022. Taken forward in line with clinical model redesign – 2022.

	treatments as well as other issues which affect their life.	process this might follow. PAS support for Court (this might be a future development however has been identified as a potential requirement for patients).		

Staff and Patient Engagement				
Initiative	**Summary of Action**	**Measurable Outcomes**	**Person Responsible**	**Timeframe**
Advance Statements	The Advance Statement is a process by which Mental Health patients can make a statement about their wishes regarding their future care. The MHPSG has continued to work with through Clinical Teams and Advocacy to ensure that all patients are offered the opportunity to produce an Advance Statement. A recent audit showed that the Advance Statement was not always stored alongside the patient's kardex. A piece of work has been carried out to rectify this and a process has been put in place whereby Health Records will forward a copy of any new Advance Statement to the ward for filing in the kardex. This will be re-audited in 3 months.	The Advance Statement is a key aspect of supporting a personalised approach to care within Mental Health. The main outcome of the review will be that all Advance Statements in place will have been developed in a co-productive way to ensure they are actionable within the context of high secure care but provide clear advance information on a patient's wishes should their illness affect their capacity to consent to treatment. Monitoring of the proportion of patients who do not have an advance statement will continue with feedback sought from those patients who have made the decision that they do not want an advance statement. This feedback can be used to inform development of the Advance statement process and ascertain how this can be improved.	MHPSG	June 2022
Patient and Staff Debriefs	A project to ensure that following certain incidents within the hospital that the staff and patients have a meaningful debrief. This	Number of debriefs that take place following incidents – patient and staff	Practice Development	Autumn 2022 Currently undergoing a scoping exercise

	will help us to meet the requirement of NICE 10: Violence and Aggression: short term management in mental health, health & community settings	Feedback from patients as to the benefit of a patient debrief		with other services to allow benchmarking.
Carers Clinic	A small project to improve the contact with relatives and carers by conducting a regular carer led carers clinic. This is starting within Mull hub on a pilot basis.	Number of carers attending. Feedback from Carers as to benefit of the clinic.	Mull Hub Project Lead	August 2022. Pilot clinic completed Feb 22. Positive feedback from carers involved. Plan to continue to test quarterly VC clinic for carers for one RMO and spread from there.
Citizens Jury Recommendations event	The RM lead had planned a Forensic Network event to discuss the recommendations of the Citizen's Jury on SDM for April 2020. Unfortunately, due to the pandemic the event had to be cancelled but a further event will be arranged for early 2021.	The objective of the FN event will be to review the Jury's recommendations and to develop an action plan to address the issue of SDM within the FN.	RM Lead / RM Programme Manager	Autumn 2022, This initiative has not progressed. Communication was sent out across the FN to gauge interest in collaborating re RM work Several services were interested. We hope to pick this up in the coming months.
'What Matters To You?' (WMTY) initiative, Equality Outcomes, Volunteer Impact, Carer support, Visitor Experience.	The Hospital Board is committed to engaging meaningfully with patients, carers and volunteers to support a collaborative approach to service improvement. The annual WMTY process is inextricably linked to a range of other initiatives including, however not limited to, Realistic Medicine, Excellence in Care and the Hospital's Equality Outcomes. The indicators supporting this area reflect a co-productive SDM focus, and highlight opportunities to enhance processes to support the embedding of a collaborative approach across all areas of service delivery. Quarterly 'Learning from Feedback'	Tangible outcomes are measured through a wide range of processes including the WMTY Outcome Action Plans, Triangle of Care assessment, Equality Outcome Action Plans, Volunteering Impact Assessment and Visitor Experience feedback processes.	Person Centred Improvement Lead	Ongoing.

	Reports continue to monitor improvements to service delivery directly attributable to stakeholder feedback.			
Forensic Network Carer Co-ordinator Group	The Carer Co-ordinator Group is a professional group facilitated by the Forensic Network which aims to bring together carer co-ordinators from across all NHS Health Boards. The group aims to address the needs of forensic carers, share initiatives from all health board areas and be a platform for information sharing and good practice. The Person Centred Improvement Lead for TSH is a member of this group.	Formalised links between services and processes for sharing information when patients move on. Consideration of how to engage carers in a meaningful way. Collaborative work to avoid duplication and provide a joined up service to better meet the needs of carers and patients within forensic services.	Forensic Network Manager	2022/23
To reduce the number of ad-hoc medications orders being placed by pharmacy	A number of change ideas have been implemented that have seen a reduction in the number of ad-hoc medications being ordered. These changes were made at both The State Hospital and St Johns. A full report will be made available in due course	Reduction in INP containers Reduction in INP orders	Lead Pharmacist	March 2022 but will remain an ongoing priority.
Learning into Practice (LiP) Meetings	The LiP system provides multidisciplinary staff with a process to identify, share, reflect and discuss experiences and generate learning and change ideas from their practice. All staff (clinical and non-clinical) are invited to participate.	Organisational learning resource from recordings and flash reports.	Project Lead	Ongoing through 2022
Quality and Safety Visits	The visit programme supports a small team of staff led by an Executive Director / Senior Lead to physically visit a pre-agreed clinical area. The visit process includes meeting on site, moving together to the visit area, having discussions with staff on duty, relaying the	Increased engagement with senior managers and frontline staff. Reduction in number of quality or safety issues at frontline level.	SPSP Project Manager	Monthly programme planned for 2022

	initial findings to the Nurse in Charge of the clinical area, as well as documenting the visit on the appropriate templates.			

Staff Training				
Initiative	**Summary of Action**	**Measurable Outcomes**	**Person Responsible**	**Timeframe**
QI Training	The State Hospital is committed to utilising available national QI training as is evidenced through our continuing link to the ScLIP and ScIL programmes. However, the hospital has also developed and provided its own 'Essentials of QI' training programme for staff. The programme is based on the SIFS course and provided by members of the QI forum. The hospital intranet also includes the 'QI Zone', a QI dedicated area that includes links to a wide range of QI information and training resources. RM will be included as a clear component of the wider QI training initiative. The hospital will also encourage all appropriate staff to undertake the VBH training modules provided through Scottish Government.	Number of staff with completed ScIL and ScLIP training will increase. Number of staff on Essentials of QI training and plans for online delivery in 2022. Number of 'hits' on QI Zone. Number of staff to complete VBH training modules.	QI Forum	QI training provided by NES has been completed; final ScIL modules to be delivered by April 2022. Internal QI Essential training in development with plan to deliver to a staff team in 2022
Shared Decision Making online module	Shared Decision making online module to be added to the TSH Learnpro platform as a module available for all staff.	Number of staff who have completed the SDM module.	Learning and Development Dept.	Ongoing initiative. As of 18 March 2022, 45 staff have completed the Learnpro Module.
Forensic Network Professional Groups	The Forensic Network supports a number of professional groups across the estate to allow colleagues to consider discipline specific issues (e.g. AHP Leads, Forensic Clinical Psychology, Social Work, Pharmacy). The groups offer the opportunity for the RM team to engage	Number of staff engaging with RM opportunities through Professional groups.	RM Lead / FN Manager	2022/23

	with staff to promote RM activity and training across all disciplines in the forensic estate.			
SoFMH short course training opportunities	The School of Forensic Mental Health (SoFMH) offer a varied range of short courses to forensic practitioners from across Scotland and Northern Ireland. The course list currently includes a QI Training course, but the SoFMH course list offers an opportunity to provide Rm focused training to staff from across the FN.	Use Training Needs analysis data and links to Professional Group leads to ascertain desire for RM focused course. Development of courses or training materials to support RM awareness across Forensic estate.	FN Manager / RM Lead	2022/23

Impact of Covid and Remobilisation plans				
Initiative	**Summary of Action**	**Measurable Outcomes**	**Person Responsible**	**Timeframe**
Staff wellbeing centre	The hospital has put in place a staff wellbeing centre to support staff throughout the pandemic period. This has been an invaluable resource and given the high stress nature of forensic mental healthcare the staff wellbeing centre will be maintained beyond the end of the pandemic period to provide support and advice to staff on ways to support and improve their own mental health and wellbeing.	Number of staff attending Wellbeing Centre See an improvement in Staff wellbeing through the results of the Staff wellbeing survey. Compare WEMWBS scale mean scores across each run of the wellbeing survey.	Staff Wellbeing Group	In place and monitoring will remain an ongoing task.

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THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL FORUM **CF(M) 21/06**

Draft Minutes of the Clinical Forum held at 10.00am on Tuesday 23 November 2021 via Microsoft Teams

Chair:

Dr Sheila Howitt	*Consultant Forensic Psychiatrist*

Present:

Dr Jana De Villiers	*Consultant Psychiatrist*
Dr Kerry Jo Smith	*Clinical Psychologist*
Carolin Walker	*Professional Nurse Advisor*

Apologies:

Dr Aileen Burnett	*Consultant Clinical Psychologist*
Marcus Topping	*Practice Nurse*

In Attendance:

Sandie Dickson	*Person Centred Improvement Lead*
Carly Doolan	*Allied Health Professional*
Ben Green	*Clinical Liaison Security Manager*
David Hamilton	*Social Work Team Leader*
Monica Merson	*Head of Planning & Business (Item 7)*
Brian Moore	*Board Chair (Item 8)*
Sheila Smith	*Head of Clinical Quality*
Julie Warren	*Personal Assistant*
Fiona Warrington	*Clinical Pharmacist*

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

The Forum Chair, Dr Sheila Howitt, welcomed everyone to the meeting. Apologies were noted as detailed above.

NOTED.

2 CONFLICT(S) OF INTEREST

There were no conflicts of interest declared.

NOTED.

3 APPROVAL OF PREVIOUS MINUTES

Discussion took place in terms of recorded details of which members of the group were recorded as 'present' and 'in attendance.' Ms Warren provided advice to the Forum by referencing the approved Terms of Reference to give clarity. This related to the Clinical Forum's link directly to The State Hospitals Board for Scotland to ensure support for the provision of multi-professional advice of clinicians and professional advisory forums. In doing so, the Clinical Forum represents the views of the advisory structures for Medicine, Allied Health Professions and Psychology, with representation from the Health Centre. The Forum also captures the views of Pharmacy, Security, Social Work and Person Centred Improvement Team in attendance.

Further discussion took place, around the table. Ms Dickson queried whether there should be reconsideration of her role. Mr Green advised on behalf of Security that he was content to continue to sit within the Forum in an advisory capacity. The Chair noted that it would be good practice for the Clinical Forum review its terms of reference regularly and that this would take place in early course in 2022. Ms Warren would check that this was included on the workplan.

Action: Julie Warren

AGREED.

The minutes of the previous meeting held on 28 September 2021 **were approved** as an accurate record.

APPROVED.

4 URGENT MATTERS ARISING

There were no urgent matters which have arisen over the preceding seven days.

NOTED.

5 REVIEW OF ROLLING ACTIONS LIST

The Rolling Actions List was reviewed, and would be updated following today's meeting.

NOTED.

6 UPDATES FROM EACH ADVISORY COMMITTEE ON SALIENT BUSINESS POINTS / APPROVED MINUTES TO NOTE

(a) Nursing and Allied Health Professions Advisory Committee

Mrs Walker advised that the next meeting was scheduled to take place on 8 December 2021. Two key topics for discussion and on the agenda were gender mix balance within the organisation and Skye Centre skill mix.

NOTED.

(b) Medical Advisory Committee

Members received and noted the approved Minutes of the Medical Advisory Committee held on 11 October 2021. It was recognised that the Intellectual Disability Taskforce proposed amendments to grounds access policy was on today's agenda for discussion.

NOTED.

(c) Psychology Professional Practice Meeting

By way of a verbal update, Ms (Kerry Jo) Smith advised that mental base therapy groups had now resumed.

NOTED.

Discussion took place around the nursing staffing shortages experienced across the organisation recently, which has resulted in high intensity psychological therapy group work being cancelled.

There was concern expressed about how this impacted the ability to plan and accommodate other

workload priorities which impacted on service delivery as described above. Thought was given to ensuring the correct representation from departments across the site were in attendance at the daily staffing contingency meetings.

Dr de Villiers underlined the role for Clinical Leads who would link in through Hub Leadership Teams to discuss the way forward given the importance of high intensity mental based therapy sessions and wider Skye Centre activities for patient care. Members recognised patient specific needs were individual and acknowledged that patients' wellbeing and therapeutic work required to be balanced with ensuring the safety of both patients and staff within a high secure forensic service. Ms (Sheila) Smith advised that work was progressing on the collation of data on scheduled patient activity compared to actual activity carried out.

The Clinical Forum also noted that the Mental Welfare Commission would be visiting The State Hospital on the following day, and would have the opportunity for review.

On behalf of the Clinical Forum, Mrs Walker agreed to highlight the concerns expressed in this discussion with the Director of Nursing, AHP's and Operations.

Action: Carolin Walker

AGREED.

(d) Update Report from Dentist, General Practitioner and Optometric

Members received and noted the written update from Mr Topping, Practice Nurse dated 17 November 2021. No concerns were raised.

NOTED.

7 DATA PERFORMANCE WORKBOOK

Ms Merson, Head of Corporate Planning and Business Support, joined the meeting and delivered a presentation to the group on the data performance workbook which continues to be a focus of led through the Strategic and Planning Performance meetings. Ms Merson provided members with an update and covered the key areas on organisational commitments and objectives being monitored, reviewed and reported within the hospital for the period 2021 – 2022.

Members were provided with an overview of the performance workbook and structure and development of this workstream.

The Clinical Forum acknowledged this extensive piece of work. The improvement with data performance and management across the organisation was highlighted as crucial and the progress through data reporting using tableau dashboard was particularly positive.

Members expressed their thanks to Ms Merson for providing a very detailed overview and the excellent work in this area.

NOTED.

8 CHAIR UPDATE

Mr Moore, Board Chair, joined the meeting and provided members with an update on key topics of discussion at the Board meeting on 28 October 2021 and other areas of focus. Key topics of discussion had been an update on the Clinical Model and progress of same, progress of digital transformation and priorities, the Risk and Resilience Annual Report, and the security project.

Mr Moore also noted that in October 2021 the Scottish Government published a response to the

Independent Review of Forensic Mental Health Services. Mr Moore advised that a Short Life Working Group had been established with relevant stakeholders, Scottish Government and involvement and participation from Mr Gary Jenkins, CEO. Engagement sessions were scheduled for January and February with a final recommendation expected in April 2022.

He also noted that the Staff Excellence Awards were scheduled to take place on 30 November 2021 via the Microsoft Teams platform, which were a high priority in terms of staff recognition.

Mr Moore finalised his update and advised that the Ministerial Annual Review would take place in January 2022, virtually as had been the case in 2021 due to Covid-19. He would ask that Ms Smith Board Secretary, provide an update on the role for the Clinical Forum in the review.

Action: Ms (Margaret) Smith

NOTED.

9 UPDATE FROM CHAIR OF CLINICAL GOVERNANCE COMMITTEE

Ms Fallon, Chair of the Clinical Governance Committee was scheduled to be in attendance at today's meeting however unfortunately was required to submit her apologies. Ms Fallon would be invited to attend the Forum's next meeting in January 2022.

Action: Julie Warren / Sheila Howitt

NOTED.

10 DISCUSSION ON DRAFT AMENDMENTS TO GROUNDS ACCESS POLICY

Members received and noted the proposed amendments to the Unescorted Grounds Access Policy from the Intellectual Disability Taskforce, which Dr de Villiers provided a brief overview of. Dr de Villiers advised that the Medical Advisory Committee had previously reviewed and endorsed these changes and therefore, this was being brought to the Clinical Forum for further discussion and review. The paper detailed the benefits of viewing grounds access as a therapeutic space for the intellectual disability patient cohort in particular as well as the wider patient population.

Mr Green suggested reviewing a comparison between the State Hospital and Rampton Hospital who have an ID service whereby further detail would be sought in terms of their process for unsupervised and unescorted grounds access. Mr Green agreed to forward Director contact details to Dr de Villers to progress with same.

In principal, members agreed to endorse the proposed plan, subject to assurance that further inclusive and proactive stakeholder approach would be taken and that the process would be tailored to patient individual specific risks and needs. Members noted that a short life working group had been stood up, and wished to establish a link for the Clinical Forum. Members agreed it would be beneficial for an invite to be extended to the Clinical Liaison Security Manager who was leading on the policy review, at the next meeting in January in order that further discussion could take place.

Action: Sheila Howitt / Julie Warren

AGREED.

11 UPDATE FROM AREA CLINICAL FORUM CHAIR'S GROUP FOR SCOTLAND

The Chair advised that the next Area Clinical Forum Chair's Group was scheduled to take place on 1 December 2021. Dr Howitt advised she would update members on content of meeting by way of electronic means after the meeting on key topics of interest discussed.

Action: Sheila Howitt

NOTED.

12 REVIEW OF 2021

The Forum reflected over the course of 2021 and the following views were offered. Members agreed;

- the Clinical Forum benefited from formal governance arrangements in place and had developed more of an identity within the organisation,
- The agenda and direction of the group was more structured and sufficiently differentiated from management group meetings across the hospital,
- The Forum was more imbedded within the Board structure with clear communication from Executive and Non-Executive Members,
- Ongoing review of development linked to the Forums Terms of Reference would be helpful,
- The Forum remains actively involved in a number of workstreams and innovations across the Hospital including the new Clinical Model.
- Overall, positive progress was made over the past twelve-month period.

NOTED.

13 REVIEW OF 2021 CLINICAL FORUM WORKPLAN AND AGREEMENT OF WORK TO TAKE FORWARD IN 2022

Members received and noted the Forums 2021 workplan and agreed the following business for January 2022 meeting;

- Review of Terms of Reference
- Update from Chief Executive Officer
- Clinical Model update
- Extend invitation to Ms Cathy Fallon, Chair of the Clinical Governance Committee
- Extend an invitation to Clinical Liaison Security Manager in respect of an update on Grounds Access Policy

AGREED.

The Chair, alongside secretariat support agreed to review the full draft workplan for 2022 which would be presented at the meeting in January 2022 for comment and agreement.

Action: Sheila Howitt / Julie Warren

NOTED.

14 AOCB

The Chair advised that Carolin Walker would be retiring early in the New Year and a new Vice Chair would require to be elected.

The Chair asked that members put thought to willingness of this position from members of the professional committees and put themselves forward as potential candidates for this position. In line with the Terms of Reference, a Vice Chair would be chosen by members of the Forum among their numbers. Election of the Vice Chair would be based on a majority of votes cast.

Action: Members of Professional Committees

Kerry Jo Smith also advised of her expected departure from the organisation in February 2022 and agreed to confirm her replacement within the Forum in due course.

Action: Kerry Jo Smith

In order for the Clinical Forum to conduct its business effectively, the Chair advised she would review future planning attendance in line with two members of staff from each professional committee i.e. Nursing / Allied Health Professions, Medical Advisory Committee and Psychology Professional Practice Meeting.

Action: Sheila Howitt

NOTED.

15 DATE AND TIME OF NEXT MEETING

The next meeting of the Clinical Forum would take place at 10am on Tuesday 24 January 2022 via Microsoft Teams.

Meeting concluded at 1155 hours

Paper No. 22/26

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 April 2022
Agenda Reference:	Item No: 13
Sponsoring Director:	Director of Workforce
Author(s):	Organisational Development Manager
Title of Report:	Staff and Volunteer Wellbeing Strategy 2022-2024
Purpose of Report:	For Decision

1 SITUATION

When Covid-19 hit the nation early in 2020, there was a widespread acceptance that people's wellbeing would be key to maintaining morale and a patient-focused service. In March 2020, the Minister for Mental Health, Ms Clare Haughey, wrote to all NHS Scotland boards emphasising the importance of supporting the positive mental health and wellbeing of staff. Healthy Working Lives (HWL) already played a key role in delivering a number of wellbeing interventions. However, in due course, it became clear that a wider wellbeing strategy would be required to provide a comprehensive direction to any wellbeing work in the future and to encompass the growing wellbeing agenda.

This strategy has been developed in consultation with a number of key groups including HWL, HR & Wellbeing Group, Staff, Volunteers and the Chaplaincy team. This paper is the final draft of the Staff and Volunteer Wellbeing Strategy 2022-24 approved for presentation to the Board, through the Corporate Management Team.

2 BACKGROUND

In April 2020, DL (2020)8 - Staff Wellbeing and Support: Employers' Duty of Care During Covid-19 Pandemic. (https://www.sehd.scot.nhs.uk/dl/DL(2020)08.pdf) set out the wellbeing support arrangements required within each health board. A network of staff wellbeing champions was set up across Scotland and The State Hospital (TSH) developed a Wellbeing Centre (the Centre) in Harris. The approach taken was a tiered support model based on the principles of Psychological First Aid.

The Centre currently has a dedicated resource (1.2 WTE) – this is fixed term and consists of the support of three people: two Wellbeing Advisors, and a Staff Care Specialist (previously title of pastoral support) post. These posts will support the activities, initiatives and support offered to our staff and volunteers from the Wellbeing Centre. There is also support available via the National Wellbeing Hub https://wellbeinghub.scot.

3 ASSESSMENT

This strategy applies to all staff, volunteers and any colleagues who work for us but are not employed under NHS Terms and Conditions e.g. our Chaplaincy Team. It seeks to be inclusive and welcoming to all

The Strategy focuses its efforts in eight areas: mental health, environmental, financial, personal growth & development, physical health, social, spiritual and occupational. It encompasses the work of HWL as well as any wellbeing work across the organisation.

Over the course of the next three years, implementation will involve ensuring support at the following levels:

- Self-help, providing resources and signposting staff;
- Peer, offering advice and opportunities for staff to access one-to-one or group support;
- Line management, ensuring appropriate training opportunities are available for our managers;
- Organisational, making the links with the relevant organisational and national groups to ensure our approach is inclusive, comprehensive and encompassing.

The strategy will be supported by an annual action plan (Appendix 1) It is important to highlight that the eight dimensions of the strategy are supported by existing pieces of work across the organisation e.g. HWL action plan (Appendix 2), corporate training plan, occupational health service etc. The HWL action plan itself already incorporates many elements of the dimensions and is being updated for 2022-23.

The Strategy and Action Plan will undergo scrutiny through evaluation using local data, set KPI's and feedback from stakeholders.

Recommendations

Board Members are invited to consider and discuss the draft Staff & Volunteer Wellbeing Strategy, in terms of whether it fully describes the way forward for leading and supporting wellbeing, as well as the framework for governance and assurance reporting as set out through the Board and its committees and the organisational governance framework.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Links to the Wellbeing Agenda and iMatter.
Workforce Implications	Considered in this report
Financial Implications	Finance will need to be considered moving forward with non-recurring funding currently used from Scottish Government and TSH.
Route To Board Which groups were involved in contributing to the paper and recommendations.	HR & Wellbeing Group, HWL and CMT
Risk Assessment (Outline any significant risks and associated mitigation)	Key risk is termination of future resources which are currently non-recurring.
Assessment of Impact on Stakeholder Experience	It is well evidenced that good workforce morale is directly linked to a more positive patient and staff experience
Equality Impact Assessment	Screened and no implications identified 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).	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.

APPENDIX 3

HEALTHY WORKING LIVES

Maintaining Gold Award and Action Plan 2021-2022

Bronze maintenance	Silver maintenance	Gold Maintenance
3 x Health, safety and wellbeing information campaigns	1 x Information campaign to raise awareness of the alcohol and drugs policy	HWL three-year strategy and action plan
1 x Activity based on the topic of mental health	1 x Information campaign on healthy eating	HWL organisational profile
2 x Health, safety and wellbeing activities	1 x Information campaign on physical activity	Employee consultation
1 x information campaign raise awareness of the smoking policy	4 x Opportunities in healthy eating	Benchmarking
	2 x Opportunities in physical activity	Health inequalities
		Optional criteria
		Review of HWL three-year strategy and action plan
		Policy reviews: smoking, alcohol and drugs
		HWL checklist

Key:

HWL – Healthy Working Lives

SWC – Staff Wellbeing Centre

MSK – Musculoskeletal

HSW – Health, Safety and Wellbeing

MH – Mental Health

PH – Physical Health

HE – Healthy Eating

Appendix 1

Healthy, Safety and Wellbeing Strategy Plan 2019-2022

Action Plan:

Organisational Priority	**Desired Outcome**	**Actions**		**Timescale**	**Group Lead**
HWL Gold Award	HWL Core Criterion 1	Strategy & Action Plan (Three year plan with annual review)		3 Yearly/ Annual	JB/GS
	HWL Core Criterion 2	Benchmarking		Annual	JB/GS
	HWL Core Criterion 3	Health Inequalities		Annual	JB/GS
	HWL Optional Criterion 4c	Lifestyle Checks		Annual	JB/GS
	HWL Optional Criterion 4d	Recycling Staff garden		TBC	JB/GS
Organisational Priority	**Desired Outcome**	**Action**	**HWL Criteria**	**Timescale**	**Group Lead**
Health, Safety and Wellbeing	Provide staff access to wellbeing initiatives and activities as well as helping to reduce stress and anxiety	Stress Awareness Month Promotion	HSW Information Campaign	1 – 30 April 2021	GS
		Mental Health Awareness Week Promotion	HSW Information Campaign	10 – 16 May 2021	GS
		Men's Health Week Promotion	HSW Information Campaign	14 – 20 June 2021	KW
		Women's Health Week Promotion	HSW Information Campaign	TBC	KW/CC
		World Mental Health Day Promotion	HSW Information Campaign	10 October 2021	KW
		National Work Life Week Promotion	HSW Information Campaign	11 – 15 October 2021	GS

		Alcohol Awareness Week Promotion	HSW Information Campaign	16 – 22 November 2021	KW
		World Aids Day Promotion	HSW Information Campaign	1 December 2021	GS
		16 Days of Action Against Domestic Violence Promotion	HSW Information Campaign	25 November – 10 December 2021	GS
		Dry January Promotion	HSW Information Campaign	January 2022	GS
		Time to Talk Day Promotion	HSW Information Campaign	February 2022	GS
		Sleep Awareness Week Promotion	HSW Information Campaign	March 2022	KW
		Stop Smoking Campaign Promotion	HSW Information Campaign	March 2022	GS
		Promote NHS core values & behaviours	HSW Information Campaign	Ongoing	GS/CW
		Wellbeing Peer Support Programme	MH/HSW Activity	TBC	CW/GS
		Staff Coffee Morning	HSW Activity	24 September 2021	HWL Group
		Completion of Suicide Awareness and Prevention learnPro module	MH/HSW Activity	On-going	All TSH Staff
		Wellbeing Webinars /masterclass	MH/HSW Activity	TBC	CW/GS
		Massage Therapy Provision (in SWC and at Health Event)	HSW Activity	Ongoing	HWL Group
		Financial Health Awareness and Advice Event	HSW Activity	TBC	HWL Group
		Pre-Retirement Information Sessions	HSW Activity	10 June 2021 4 November 2021	GS/LC
		Excellence Awards	HSW Activity	November 2021	GS/JB
		Long Service Awards	HSW Activity	November 2021	GS/JB

		Go with Flo Quit Smoking Workplace Programme	HSW Activity	January – March 2022	GS/KW
		Flu Vaccination Programme	HSW Activity	November 2021	KB
		Craft Workshops in SWC	HSW Activity	TBC	CW/GS
		Yoga	HSW Activity	TBC	GS
		Reading Group	HSW Activity	Ongoing	RH
		Mindfulness sessions in SWC	HSW Activity	Ongoing	MI
		Health and wellbeing library books	HSW Activity	Ongoing	RH
		Support local foodbanks and charity organisations	HSW Activity	December 2021	GS
		Men's Health Information Day	HSW Activity	TBC	HWL Group
		Women's Health Information Day	HSW Activity	TBC	HWL Group
		Information Day	HSW Activity	TBC	HWL Group
Organisational Priority	**Desired Outcome**	**Action**	**HWL Criteria**	**Timescale**	**Group Lead**
Musculoskeletal & Physical Health	Promote back care awareness and provide opportunities to engage in physical activity	Homeworking and desk exercises information and access to video links	PH Information Campaign	June 21	LMcC/NC
		Raise awareness of common gym injuries and how to avoid them through poster campaign/leaflets	PH Information Campaign	Information on intranet	LMcC/NC

		Promote MSK health through Bulletin	PH Information Campaign	TBC	LMcC/NC
		Promote #Active CommuteClub via bulletin and MS Teams	PH Information Campaign	March 2021	GS
		Daily Mile	PH Information Campaign/ PH Activity	Ongoing	CMcC
		Back care awareness session/workshop via MS Teams	PH Activity	4-8 October 2021	LMcC
		Yoga sessions online or face to face	PH Activity	TBC	GS
		Access to staff gym and sports sessions (badminton, table tennis)	PH Activity	TBC	HWL Group
		Provide staff with discounted membership to local authority leisure centres	PH Activity	TBC	GS
		Walking Challenge	PH Activity	TBC	JB/LMcC
		Drop in Physio sessions in the SWC	PH Activity	TBC	CC
Organisational Priority	**Desired Outcome**	**Action**	**HWL Criteria**	**Timescale**	**Group Lead**
Healthy Eating	Promote healthy eating awareness and provide opportunities to choose healthy food options	Healthy Eating and myth busting awareness campaign in bulletin or leaflet/poster	HE Information Campaign	TBC	FB
		Dieticians Week	HE Information Campaign	TBC	FB

		Weigh 2 Go Programme	HE Activity/ Opportunity	TBC	FB
		Healthy Living Plus Award	HE Activity/ Opportunity	Annual	GL
		Themed healthy option days in staff dining room	HE Activity/ Opportunity	TBC	GL/JW
		Cooking workshop at staff health event	HE Activity/ Opportunity	TBC	HWL Group

WELLBEING ACTION PLAN 2022-23

AIM OF WELLBEING STRATEGY
To have a happy, healthy, engaged and thriving workforce and volunteer team.

KEY AREA	**ACTIONS**	**TIMESCALE**	**HOW WE WILL MONITOR**	**LEAD**
KPI's	1. Agree a set of KPIs and system to allow a full analysis of the health and wellbeing across The State Hospital	May 2022	Agree and monitor these via HR and Wellbeing Group	Director of Workforce
Wellbeing Centre	2. Ensure appropriate resources are provided which are relevant to supporting health and wellbeing. 3. Ensure ease of access to the Centre and its resources 4. Establish the role of the Wellbeing Advisors and the Staff Care Specialist, reviewing engagement and interactions.	Ongoing	Use set KPI's which will align to the Centre and its used / support requests received.	Wellbeing Advisors / Staff Care Specialist
Healthy Working Lives / HR and Wellbeing Group	Discuss with both Groups a more joined up approach to dealing with the health and wellbeing agendas moving forward so that there is no duplication of effort or resources. Review and update TOR moving forward.	August 2022	Consideration / review of how this is working across TSH	Director of Workforce

Support roles and function.	5. Continue to review 3 fixed terms posts to ascertain future support needs health and wellbeing and also for the Wellbeing Centre.	August 2022	HR & Wellbeing Group	Director of Workforce
Wellbeing Dimensions	6. Provide range of opportunities and interventions with support of Healthy Working Lives to address needs under 8 dimensions: 1. Personal growth & development: - Provision of corporate L&D programme/Leadership programme - Coaching programme rollout	Ongoing	Reporting on individual areas as noted through appropriate channels	Training & Professional Dev Manager
	2. Physical health: - HWL Action Plan roll out - Occupational Health Review			Wellbeing Advisors / Director of Workforce
	3. Mental health: - HWL action plan roll out - Occupational Health Review - Whistleblowing policy Review			Wellbeing Advisors / Director of Workforce
	4. Occupational: - Ongoing Review of HR policies and procedures			Director of Workforce / Employee Director
	5. Social - Wellbeing Centre Development - Annual Excellence awards - Annual Long Service Awards - HWL interventions Review			Wellbeing Advisors / Director of Workforce
	6. Environmental - Security measures* - DSE procedures**			*Security Director **Health, Safety & Welfare C'tee

	- Review and Development of a Staff garden*** - Develop further Recycling and climate-preserving measures			***Wellbeing Advisors
	7. Financial - Pension scheme updates as and when required - Pension advice from a neutral source - Development of NHS benefits and discounts			Wellbeing Advisors / Director of Workforce
	8. Spiritual - Review ongoing Pastoral/Peer support via Staff Care Specialist			Wellbeing Advisors and Staff Care Specialist
iMatter	Continue to communicate the benefits of completing iMatter Recognise the achievements of the organisation/directorates as illustrated by iMatter reports and encourage/support teams to publish their stories for shared learning Share any outputs from other Health Boards in their learning.	End of each iMatter cycle	Number of stories shared Feedback from staff of impact of sharing	Wellbeing Advisors / Director of Workforce
	Annual monitoring performance in the Staff Governance Standards, seeking to address any barriers to improvement	Annual	iMatter results Proxy data e.g. attendance, number of grievances etc	Director of Workforce

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 April 2022
Agenda Reference:	Item No: 14
Sponsoring Director:	Director of Workforce
Author(s):	HR Advisor
Title of Report:	Attendance Performance Summary
Purpose of Report:	For Noting

1 SITUATION

This report provides the Board with an update on overall attendance performance from January 2022 for the period up to 31 March 2022.

Detailed information and analysis is provided quarterly to the Staff Governance Committee. Monthly reviews occur by the Corporate Management Team and HR & Wellbeing Group.

2 BACKGROUND

The State Hospital has a target sickness absence rate of no higher than 5%.

Work has continued to support staff with their attendance. However, across the last two years of the pandemic, figures have fluctuated for both sickness absence and COVID related absence. Specific peaks in absence have occurred at the onset of the associated 'waves' of the pandemic.

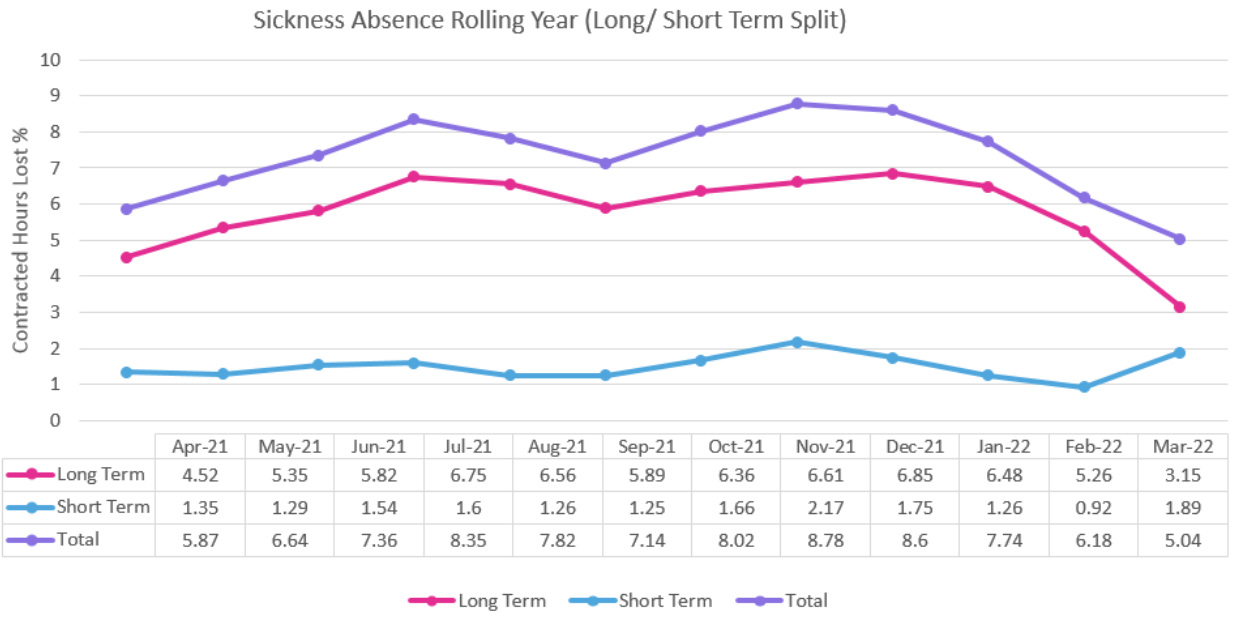
The data extract used comes from the SSTS (Scottish Standard Time System) which is a live data set and therefore more accurate. There is also an extract from SWISS (which is a national repository) and provides an overview of all Health Boards in Scotland for comparison.

3 ASSESSMENT

As detailed in Table 1, March 2022 has seen overall sickness absence reduce to 5.04%. This is the lowest level of absence for the current 12-month rolling period (to 31st March 2022).

Long term absence is also at its lowest for this period too at 3.15%, however short term absence levels have slightly increased to 1.89%. The overall picture for the month of March is extremely positive and work will continue to build and support staff attendance.

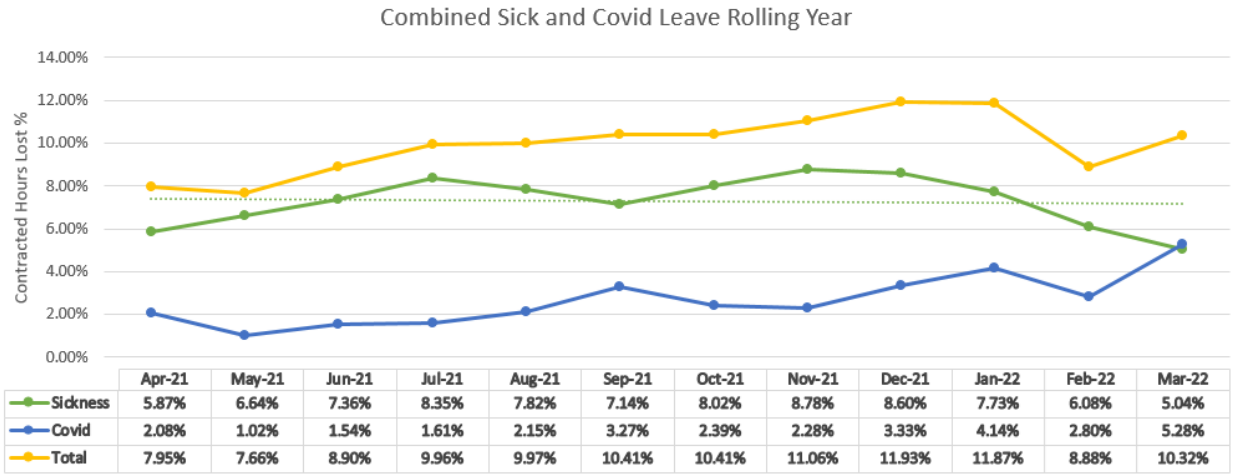
Table 1 - Sickness Absence – Rolling Year 1 April 2021 to 31 March 2022 (SSTS)



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Long Term	4.52	5.35	5.82	6.75	6.56	5.89	6.36	6.61	6.85	6.48	5.26	3.15
Short Term	1.35	1.29	1.54	1.6	1.26	1.25	1.66	2.17	1.75	1.26	0.92	1.89
Total	5.87	6.64	7.36	8.35	7.82	7.14	8.02	8.78	8.6	7.74	6.18	5.04

Table 2 details the current sickness absence rates / COVID absence and the overall absence in total.

Table 2 – COVID Special Leave/ Sickness Combined - Rolling Year 1 April 2021 to 31 March 2022 (SSTS)



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Sickness	5.87%	6.64%	7.36%	8.35%	7.82%	7.14%	8.02%	8.78%	8.60%	7.73%	6.08%	5.04%
Covid	2.08%	1.02%	1.54%	1.61%	2.15%	3.27%	2.39%	2.28%	3.33%	4.14%	2.80%	5.28%
Total	7.95%	7.66%	8.90%	9.96%	9.97%	10.41%	10.41%	11.06%	11.93%	11.87%	8.88%	10.32%

HR Advisors each have designated departments to support within the Hospital. They work closely with line managers to support the management of long term sickness absence cases. Regular activities include HR support meetings with line managers to discuss absence cases, running regular SSTS absence reports and liaising with line managers to discuss absence levels and analysis.

HR Advisors also check the appropriate paperwork has been received including timely fit notes, Occupational Health referrals, and actions per the Attendance Management Policy. HR have an internal audit in place to ensure all paperwork has been received in HR.

A new Attendance Management Training Programme has been developed and is currently being implemented to all line managers. To date, 18 Line Managers have attended the training sessions in March 2022 and work will continue with this over the coming months.

Table 3 details the national SWISS data alongside the comparison with other Health Boards throughout NHS Scotland. It should be noted that data varies slightly from SSTS for all Health Boards but it does give helpful comparator information.

Table 3 - National Comparison Data - Rolling Year 1 March 2021 to 28 February 2022 (SWISS)

	Absence Rate			Instances			Absence Reason	
	Total	Long Term [1]	Short Term [2]	Total	Long Term [1]	Short Term [2]	Yes	No [3]
Scotland	**5.60**	**3.79**	**1.81**	**255,271**	**36,383**	**218,888**	**210,363**	**44,908**
NHS Ayrshire & Arran	5.21	3.65	1.56	13,223	2,155	11,068	11,590	1,633
NHS Borders	5.18	3.38	1.80	4,714	644	4,070	3,612	1,102
NHS National Services Scotland [4]	4.43	3.05	1.37	4,231	531	3,700	3,696	535
NHS 24	8.43	5.62	2.82	4,543	617	3,926	4,140	403
NHS Education For Scotland	1.59	1.09	0.49	962	109	853	507	455
Healthcare Improvement Scotland	3.14	2.05	1.08	469	47	422	415	54
NHS Health Scotland [4, 5]	-	-	-	-	-	-	-	-
Public Health Scotland [4, 6]	2.66	1.62	1.05	1,282	108	1,174	996	286
Scottish Ambulance Service	7.90	5.73	2.17	9,500	1,728	7,772	8,248	1,252
The State Hospital	6.53	5.06	1.47	715	189	526	626	89
National Waiting Times Centre	5.70	3.69	2.01	3,129	476	2,653	2,593	536
NHS Fife	5.62	3.92	1.71	12,362	2,063	10,299	10,543	1,819
NHS Greater Glasgow & Clyde	6.20	4.39	1.81	59,743	10,153	49,590	52,242	7,501
NHS Highland	5.16	3.43	1.73	14,789	1,758	13,031	9,529	5,260
NHS Lanarkshire	6.47	4.73	1.74	17,733	3,378	14,355	14,273	3,460
NHS Grampian	4.49	2.59	1.90	26,814	2,424	24,390	19,491	7,323
NHS Orkney	4.76	3.22	1.54	916	119	797	774	142
NHS Lothian	5.15	3.16	1.99	41,960	4,509	37,451	34,684	7,276
NHS Tayside	5.53	3.61	1.92	20,020	2,649	17,371	16,159	3,861
NHS Forth Valley	6.09	4.29	1.80	8,942	1,557	7,385	7,980	962
NHS Western Isles	5.44	3.55	1.89	1,584	194	1,390	1,246	338
NHS Dumfries & Galloway	5.40	3.55	1.85	6,422	872	5,550	5,933	489
NHS Shetland	4.18	2.64	1.55	1,218	103	1,115	1,086	132

4 RECOMMENDATION

Board members are invited to note:

- the improvement in March for overall Sickness Absence
- the increase in COVID absence
- the ongoing collaborative work between HR and line managers to support staff back to workplace

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Links to the Attendance Management Policy and aids monitoring of 5% attendance target set by the Scottish Government
Workforce Implications	Failure to achieve 5% target will impact ability to efficiently resource organisation.
Financial Implications	Failure to achieve 5% target results in additional spend to ensure continued safe staffing levels
Route To Board Which groups were involved in contributing to the paper and recommendations.	Staff Governance Committee Partnership Forum, HR and WB Group
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	Failure to achieve the 5% target will impact on stakeholder experience
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 **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:	28 April 2022
Agenda Reference:	Item No: 15
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Whistleblowing Update
Purpose of Report:	For Noting

1 SITUATION

As part of the Whistleblowing Standard, a quarterly update is being provided to the Board on the current situation with any outstanding Whistleblowing Investigations.

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 form a 'Once for Scotland' approach to Whistleblowing.

3 ASSESSMENT

The State Hospital fully launched the Whistleblowing Standards and the National Policy. A key requirement of the revised standards is notification of case incidence to the Board and Staff Governance Committee. This is final quarterly update and also provides an end of year summary. During the year 1 April 2021 to 31st March 2022, two Whistleblowing cases were raised and subsequently investigated.

Case 1 – this was fully investigated and is now concluded. Detailed feedback has been given to the individual by the Investigating Lead. The next stage open to this individual is for them to make contact direct to the INWO and ask them to investigate the process. At this point in time, no notification has been confirmed that such a request has been made.

Case 2 – this was fully investigated and is now concluded. Detailed feedback has been given to the complainant by the Investigating Lead. As with the first case, the next stage for the complainant will be to make contact with the INWO and ask them to investigate the process. The Outcome Report includes recommendations from the Investigation Team on possible opportunities for improvement in relation to the timescales for dealing with Whistleblowing concerns and communication to staff on the processes available to them. These will be considered and taken forward to form an Action Plan for improvement of the Policy and processes.

The Board has invited the INWO to attend a board seminar in September 2022, as part of a development session.

4 RECOMMENDATION

Board members are invited to note the information and confirmation of compliance with the National Policy.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Links to the National Guidance for Whistleblowing set by the Scottish Government
Workforce Implications	Positive measure in support of Staff Governance Standards.
Financial Implications	N/A
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board requested
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
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.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 April 2022
Agenda Reference:	Item No: 16
Sponsoring Director:	Finance & eHealth Director
Author(s):	Finance & eHealth Director
Title of Report:	Annual Review of Standing Documentation
Purpose of Report:	For review and approval

1 SITUATION

This report provides an update on proposed changes to Standing Documentation covering updated changes to Procurement Legislation related to tendering and contracting and bringing TSH in-line with other public bodies.

2 BACKGROUND

The Board is required, on an annual basis, to review and adopt any changes to Standing Documentation i.e. Standing Financial Instructions, Scheme of Delegation and Standing Orders. The Audit Committee reviewed the documents at their meeting on 17 March 2022 and their recommendation was then noted for the Board's adoption.

3 ASSESSMENT

3.1 Standing Financial Instructions

There are amendments noted as follows –

- Sections 10.2.7, 10.3.2 – removing EU reference, update re new Procurement Regulations
- Sections 10.3.4,5 – updated tender thresholds to comply with Procurement Act 2014, updated tender waiver from £5k to £10k (last update 2016)
- Section 10.3.10 – updated re new TSH Procurement Policy
- Section 10.4.1 – updated re new legislation

3.2 Scheme of Delegation

There are minor amendments noted to update tender levels to comply with current legislation, and amendment to procurement department job titles (ss 14.7, 14.9).

3.3 Standing Orders

These were fully updated in 2020 in line with NHS national guidance and prescribed formatting, and there are no further amendments proposed.

4 RECOMMENDATION

The Board is asked to approve the annual review of Standing Documentation.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Ensures that the Board's standing documentation is up to date in respect of Scottish Government guidance and possible changes to Senior staff's portfolios.
Workforce Implications	None
Financial Implications	None
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Finance & eHealth Director, Head of Procurement, Board Secretary.
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).	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.

STANDING ORDERS FOR THE PROCEEDINGS AND BUSINESS OF THE STATE HOSPITALS BOARD FOR SCOTLAND

1 General

1.1 These Standing Orders for regulation of the conduct and proceedings of **The State Hospitals Board for Scotland,** for the Board and its Committees, are made under the terms of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (2001 No. 302), as amended up to and including The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2016 (2016 No. 3).

The NHS Scotland Blueprint for Good Governance (issued through DL 2019) 02) has informed these Standing Orders. The Blueprint describes the functions of the Board as:

- Setting the direction, clarifying priorities and defining expectations.
- Holding the executive to account and seeking assurance that the organisation is being effectively managed.
- Managing risks to the quality, delivery and sustainability of services.
- Engaging with stakeholders.
- Influencing the Board's and the organisation's culture.

Further information on the role of the Board, Board members, the Chair, Vice-Chair, and the Chief Executive is available on the NHS Scotland Board Development website (https://learn.nes.nhs.scot/17367/board-development)

1.2 The Scottish Ministers shall appoint the members of the Board. The Scottish Ministers shall also attend to any issues relating to the resignation and removal, suspension and disqualification of members in line with the above regulations. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances.

1.3 Any statutory provision, regulation or direction by Scottish Ministers, shall have precedence if they are in conflict with these Standing Orders.

1.4 Any one or more of these Standing Orders may be varied or revoked at a meeting of the Board by a majority of members present and voting, provided the notice for the meeting at which the proposal is to be considered clearly states the extent of the proposed repeal, addition or amendment. The Board will annually review its Standing Orders.

1.5 Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances. The Scottish Ministers may by determination suspend a member

from taking part in the business (including meetings) of the Board. Paragraph 5.4 sets out when the person presiding at a Board meeting may suspend a Board member for the remainder of a specific Board meeting. The Standards Commission for Scotland can apply sanctions if a Board member is found to have breached the Board Members' Code of Conduct, and those include suspension and disqualification. The regulations (see paragraph 1.1) also set out grounds for why a person may be disqualified from being a member of the Board.

Board Members – Ethical Conduct

1.6 Members have a personal responsibility to comply with the Code of Conduct for Members of The State Hospitals Board for Scotland. The Commissioner for Public Standards can investigate complaints about members who are alleged to have breached their Code of Conduct. The Board will have appointed a Standards Officer. This individual is responsible for carrying out the duties of that role, however he or she may delegate the carrying out of associated tasks to other members of staff. The Board's appointed Standards Officer shall ensure that the Board's Register of Interests is maintained. When a member needs to update or amend his or her entry in the Register, he or she must notify the Board's appointed Standards Officer of the need to change the entry within one month after the date the matter required to be registered.

1.7 The Board's appointed Standards Officer shall ensure the Register is available for public inspection at the principal offices of the Board at all reasonable times and will be included on the Board's website.

1.8 Members must always consider the relevance of any interests they may have to any business presented to the Board or one of its committees. Members must observe paragraphs 5.6 - 5.10 of these Standing Orders, and have regard to Section 5 of the Code of Conduct (Declaration of Interests).

1.9 In case of doubt as to whether any interest or matter should be declared, in the interests of transparency, members are advised to make a declaration.

1.10 Members shall make a declaration of any gifts or hospitality received in their capacity as a Board member. Such declarations shall be made to the Board's appointed Standards Officer who shall make them available for public inspection at all reasonable times at the principal offices of the Board and on the Board's website. The Register of Interests includes a section on gifts and hospitality. The Register may include the information on any such declarations, or cross-refer to where the information is published.

1.11 The Board's Board Secretary shall provide a copy of these Standing Orders to all members of the Board on appointment. A copy shall also be held on the Board's website.

2 Chair

2.1 The Scottish Ministers shall appoint the Chair of the Board.

3 Vice-Chair

3.1 The Chair shall nominate a candidate or candidates for vice-chair to the Cabinet Secretary. The candidate(s) must be a non-executive member of the Board. A member who is an employee of a Board is disqualified from being Vice-Chair. The Cabinet Secretary will in turn determine who to appoint based on evidence of effective performance and evidence that the member has the skills, knowledge and experience needed for the position. Following the decision, the Board shall appoint the member as Vice-Chair. Any person so appointed shall, so long as he or she remains a member of the Board, continue in office for such a period as the Board may decide.

3.2 The Vice-Chair may at any time resign from that office by giving notice in writing to the Chair. The process to appoint a replacement Vice-Chair is the process described at paragraph 3.1.

3.3 Where the Chair has died, ceased to hold office, or is unable for a sustained period of time to perform his or her duties due to illness, absence from Scotland or for any other reason, then the Board's Board Secretary should refer this to the Scottish Government. The Cabinet Secretary will confirm which member may assume the role of interim chair in the period until the appointment of a new chair, or the return of the appointed chair. Where the Chair is absent for a short period due to leave (for whatever reason). the Vice-Chair shall assume the role of the Chair in the conduct of the business of the Board. In either of these circumstances references to the Chair shall, so long as there is no Chair able to perform the duties, be taken to include references to either the Interim Chair or the Vice-Chair. If the Vice-Chair has been appointed as the Interim Chair, then the process described at paragraph 3.1 will apply to replace the Vice-Chair.

4 Calling and Notice of Board Meetings

4.1 The Chair may call a meeting of the Board at any time and shall call a meeting when required to do so by the Board. The Board shall meet at least six times in the year and will annually approve a forward schedule of meeting dates.

4.2 The Chair will determine the final agenda for all Board meetings. The agenda may include an item for any other business, however this can only be for business which the Board is being informed of for awareness, rather than being asked to make a decision. No business shall be transacted at any meeting of the Board other than that specified in the notice of the meeting except on grounds of urgency.

4.3 Any member may propose an item of business to be included in the agenda of a future Board meeting by submitting a request to the Chair. If the Chair elects to agree to the request, then the Chair may decide whether the item is to be considered at the Board meeting which immediately follows the receipt of the request, or a future Board meeting. The Chair will inform the member which meeting the item will be discussed. If any member has a specific legal duty or responsibility to discharge which requires that member to present a report to the Board, then that report will be included in the agenda.

4.4 In the event that the Chair decides not to include the item of business on the agenda of a Board meeting, then the Chair will inform the member in writing as to the reasons why.

4.5 A Board meeting may be called if one third of the whole number of members signs a requisition for that purpose. The requisition must specify the business proposed to be transacted. The Chair is required to call a meeting within 7 days of receiving the requisition. If the Chair does not do so, or simply refuses to call a meeting, those members who presented the requisition may call a meeting by signing an instruction to approve the notice calling the meeting provided that no business shall be transacted at the meeting other than that specified in the requisition.

4.6 Before each meeting of the Board, a notice of the meeting (in the form of an agenda), specifying the time, place and business proposed to be transacted at it and approved by the Chair, or by a member authorised by the Chair to approve on that person's behalf, shall be circulated to every member so as to be available to them at least three clear days before the meeting. The notice shall be distributed along with any papers for the meeting that are available at that point.

4.7 With regard to calculating clear days for the purpose of notice under 4.6 and 4.9, the period of notice excludes the day the notice is sent out and the day of the meeting itself. Additionally only working days (Monday to Friday) are to be used when calculating clear days; weekend days and public holidays should be excluded.

Example: If a Board is meeting on a Wednesday, the notice and papers for the meeting should be distributed to members no later than the preceding Thursday. The three clear days would be Friday, Monday and Tuesday. If the Monday was a public holiday, then the notice and papers should be distributed no later than the preceding Wednesday.

4.8 Lack of service of the notice on any member shall not affect the validity of a meeting.

4.9 Board meetings shall be held in public. A public notice of the time and place of the meeting shall be provided at least three clear days before the meeting is held.

The notice and the meeting papers shall also be placed on the Board's website. The meeting papers will include the minutes of committee meetings which the relevant committee has approved. The exception is that the meeting papers will not include the minutes of the Remuneration Committee. The Board may determine its own approach for committees to inform it of business which has been discussed in committee meetings for which the final minutes are not yet available. For items of business which the Board will consider in private session (see paragraph 5.22), only the Board members will normally receive the meeting papers for those items, unless the person presiding agrees that others may receive them.

4.10 Any individual or group or organisation which wishes to make a deputation to the Board must make an application to the Chair's Office at least 21 working days before the date of the meeting at which the deputation wish to be received. The application will state the subject and the proposed action to be taken. Any member may put any relevant question to the deputation, but will not express any opinion on the subject matter until the deputation has withdrawn. If the subject matter relates to an item of business on the agenda, no debate or discussion will take place until the item is considered in the order of business.

Any individual or group or organisation which wishes to submit a petition to the Board will deliver the petition to the Chair's Office at least 21 working days before the meeting at which the subject matter may be considered. The Chair will decide whether or not the petition will be discussed at the meeting.

5 Conduct of Meetings

Authority of the Person Presiding at a Board Meeting

5.1 The Chair shall preside at every meeting of the Board. The Vice-Chair shall preside if the Chair is absent. If both the Chair and Vice Chair are absent, the members present at the meeting shall choose a Board member who is not an employee of a Board to preside.

5.2 The duty of the person presiding at a meeting of the Board or one of its committees is to ensure that the Standing Orders or the committee's terms of reference are observed, to preserve order, to ensure fairness between members, and to determine all questions of order and competence. The ruling of the person presiding shall be final and shall not be open to question or discussion.

5.3 The person presiding may direct that the meeting can be conducted in any way that allows members to participate, regardless of where they are physically located, e.g. video-conferencing, teleconferencing. For the avoidance of doubt, those members using such facilities will be regarded as present at the meeting.

5.4 In the event that any member who disregards the authority of the person presiding, obstructs the meeting, or conducts himself/herself inappropriately the person presiding may suspend the member for the remainder of the meeting. If a person so suspended refuses to leave when required by the person presiding to do so, the person presiding will adjourn the meeting in line with paragraph 5.12. For paragraphs 5.5 to 5.20, reference to 'Chair' means the person who is presiding the meeting, as determined by paragraph 5.1.

Quorum

5.5 The Board will be deemed to meet only when there are present, and entitled to vote, a quorum of at least one third of the whole number of members, including at least two members who are not employees of a Board. The quorum for committees will be set out in their terms of reference, however it can never be less than two Board members.

5.6 In determining whether or not a quorum is present the Chair must consider the effect of any declared interests.

5.7 If a member, or an associate of the member, has any pecuniary or other interest, direct or indirect, in any contract, proposed contract or other matter under consideration by the Board or a committee, the member should declare that interest at the start of the meeting. This applies whether or not that interest is already recorded in the Board Members' Register of Interests. Following such a declaration, the member shall be excluded from the Board or committee meeting when the item is under consideration, and should not be counted as participating in that meeting for quorum or voting purposes.

5.8 Paragraph 5.7 will not apply where a member's, or an associate of their's, interest in any company, body or person is so remote or insignificant that it cannot reasonably be regarded as likely to affect any influence in the consideration or discussion of any question with respect to that contract or matter. In March 2015, the Standards Commission granted a dispensation to NHS Board members who are also voting members of integration joint boards. The effect is that those members do not need to declare as an interest that they are a member of an integration joint board when taking part in discussions of general health & social care issues. However members still have to declare other interests as required by Section 5 of the Board Members' Code of Conduct.

5.9 If a question arises at a Board meeting as to the right of a member to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting be referred to the Chair. The Chair's ruling in relation to any member other than the Chair is to be final and conclusive. If a question arises with regard to the participation of the Chair in the meeting (or part of the meeting) for voting or quorum purposes, the question is to

be decided by the members at that meeting. For this latter purpose, the Chair is not to be counted for quorum or voting purposes.

5.10 Paragraphs 5.6-5.9 shall equally apply to members of any Board committees, whether or not they are also members of the Board, e.g. stakeholder representatives.

5.11 When a quorum is not present, the only actions that can be taken are to either adjourn to another time or abandon the meeting altogether and call another one. The quorum should be monitored throughout the conduct of the meeting in the event that a member leaves during a meeting, with no intention of returning. The Chair may set a time limit to permit the quorum to be achieved before electing to adjourn, abandon or bring a meeting that has started to a close.

Adjournment

5.12 If it is necessary or expedient to do so for any reason (including disorderly conduct or other misbehaviour at a meeting), a meeting may be adjourned to another day, time and place. A meeting of the Board, or of a committee of the Board, may be adjourned by the Chair until such day, time and place as the Chair may specify.

Business of the Meeting

The Agenda

5.13 If a member wishes to add an item of business which is not in the notice of the meeting, he or she must make a request to the Chair ideally in advance of the day of the meeting and certainly before the start of the meeting. The Chair will determine whether the matter is urgent and accordingly whether it may be discussed at the meeting.

5.14 The Chair may change the running order of items for discussion on the agenda at the meeting. Please also refer to paragraph 4.2. For Board meetings only, the Chair may propose within the notice of the meeting “items for approval” and “items for discussion”. The items for approval are not discussed at the meeting, but rather the members agree that the content and recommendations of the papers for such items are accepted, and that the minutes of the meeting should reflect this. The Board must approve the proposal as to which items should be in the “items for approval” section of the agenda. Any member (for any reason) may request that any item or items be removed from the “items for approval” section. If such a request is received, the Chair shall either move the item to the “items for discussion” section, or remove it from the agenda altogether.

Decision-Making

5.15 The Chair may invite the lead for any item to introduce the item before inviting contributions from members. Members should indicate to the Chair if they wish to contribute, and the Chair will invite all who do so to contribute in turn. Members are expected to question and challenge proposals constructively and carefully to reach and articulate a considered view on the suitability of proposals.

5.16 The Chair will consider the discussion, and whether or not a consensus has been reached. Where the Chair concludes that consensus has been reached, then the Chair will normally end the discussion of an item by inviting agreement to the outcomes from the discussion and the resulting decisions of the Board.

5.17 As part of the process of stating the resulting decisions of the Board, the Chair may propose an adaptation of what may have been recommended to the Board in the accompanying report, to reflect the outcome of the discussion.

5.18 The Board may reach consensus on an item of business without taking a formal vote, and this will be normally what happens where consensus has been reached.

5.19 Where the Chair concludes that there is not a consensus on the Board's position on the item and/ or what it wishes to do, then the Chair will put the decision to a vote. If at least two Board members ask for a decision to be put to a vote, then the Chair will do so. Before putting any decision to vote, the Chair will summarise the outcome of the discussion and the proposal(s) for the members to vote on.

5.20 Where a vote is taken, the decision shall be determined by a majority of votes of the members present and voting on the question. In the case of an equality of votes, the Chair shall have a second or casting vote. The Chair may determine the method for taking the vote, which may be by a show of hands, or by ballot, or any other method the Chair determines.

5.21 While the meeting is in public the Board may not exclude members of the public and the press (for the purpose of reporting the proceedings) from attending the meeting.

Board Meeting in Private Session

5.22 The Board may agree to meet in private in order to consider certain items of business. The Board may decide to meet in private on the following grounds:

- The Board is still in the process of developing proposals or its position on certain matters, and needs time for private deliberation.

- The business relates to the commercial interests of any person and confidentiality is required, e.g. when there is an ongoing tendering process or contract negotiation.
- The business necessarily involves reference to personal information, and requires to be discussed in private in order to uphold the Data Protection Principles.
- The Board is otherwise legally obliged to respect the confidentiality of the information being discussed.

5.23 The minutes of the meeting will reflect when the Board has resolved to meet in private.

Minutes

5.24 The names of members present at a meeting of the Board, or of a committee of the Board, shall be recorded in the minute of the meeting. The names of other persons in attendance shall also be recorded.

5.25 The Board's Board Secretary (or his/her authorised nominee) shall prepare the minutes of meetings of the Board and its committees. The Board or the committee shall review the draft minutes at the following meeting. The person presiding at that meeting shall sign the approved minute.

6 Matters Reserved for the Board

Introduction

6.1 The Scottish Government retains the authority to approve certain items of business. There are other items of the business which can only be approved at an NHS Board meeting, due to either Scottish Government directions or a Board decision in the interests of good governance practice.

6.2 This section summarises the matters reserved to the Board:

a) Standing Orders
b) The establishment and terms of reference of all its committees, and appointment of committee members
c) Organisational Values
d) The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.
e) The Annual Operational Plan for submission to the Scottish Government for its approval. (Note: The Board should consider the draft for submission in private session. Once the Scottish Government has approved the Annual Operational Plan, the Board should receive it at a public Board meeting.)

f) Corporate objectives or corporate plans which have been created to implement its agreed strategies.
g) Risk Management Policy.
h) Financial plan for the forthcoming year, and the opening revenue and capital budgets.
i) Standing Financial Instructions and a Scheme of Delegation.
j) Annual accounts and report. (Note: Note: This must be considered when the Board meets in private session. In order to respect Parliamentary Privilege, the Board cannot publish the annual accounts or any information drawn from it before the accounts are laid before the Scottish Parliament. Similarly the Board cannot publish the report of the external auditors of their annual accounts in this period.)
k) Any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval. The Board shall comply with the Scottish Capital Investment Manual.
l) The Board shall approve the content, format, and frequency of performance reporting to the Board.
m) The appointment of the Board's chief internal auditor. (Note: This applies either when the proposed chief internal auditor will be an employee of the Board, or when the chief internal auditor is engaged through a contract with an external provider. The audit committee should advise the Board on the appointment, and the Board may delegate to the audit committee oversight of the process which leads to a recommendation for appointment.)

6.3 The Board may be required by law or Scottish Government direction to approve certain items of business, e.g. the integration schemes for a local authority area.

6.4 The Board itself may resolve that other items of business be presented to it for approval.

7 Delegation of Authority by the Board

7.1 Except for the Matters Reserved for the Board, the Board may delegate authority to act on its behalf to committees, individual Board members, or other Board employees. In practice this is achieved primarily through the Board's approval of the Standing Financial Instructions http://intranet.tsh.scot.nhs.uk/Policies/Policy%20Docs/Forms/Category%20View.aspx and the Scheme of Delegation http://intranet.tsh.scot.nhs.uk/Policies/Policy%20Docs/Forms/Category%20View.aspx

7.2 The Board may delegate responsibility for certain matters to the Chair for action. In such circumstances, the Chair should inform the Board of any decision or action subsequently taken on these matters.

7.3 The Board and its officers must comply with the NHS Scotland Property Transactions Handbook, and this is cross-referenced in the Scheme of Delegation.

7.4 The Board may, from time to time, request reports on any matter or may decide to reserve any particular decision for itself. The Board may withdraw any previous act of delegation to allow this.

8 Execution of Documents

8.1 Where a document requires to be authenticated under legislation or rule of law relating to the authentication of documents under the Law of Scotland, or where a document is otherwise required to be authenticated on behalf of the Board, it shall be signed by an executive member of the Board or any person duly authorised to sign under the Scheme of Delegation in accordance with the Requirements of Writing (Scotland) Act 1995. Before authenticating any document the person authenticating the document shall satisfy themselves that all necessary approvals in terms of the Board's procedures have been satisfied. A document executed by the Board in accordance with this paragraph shall be self-proving for the purposes of the Requirements of Writing (Scotland) Act 1995.

8.2 Scottish Ministers shall direct which officers of the Board can sign on their behalf in relation to the acquisition, management and disposal of land.

8.3 Any authorisation to sign documents granted to an officer of the Board shall terminate upon that person ceasing (for whatever reason) from being an employee of the Board, without further intimation or action by the Board.

9 Committees

9.1 Subject to any direction issued by Scottish Ministers, the Board shall appoint such committees (and sub-committees) as it thinks fit. NHS Scotland Board Development website will identify the committees which the Board must establish. (https://learn.nes.nhs.scot/17367/board-development)

9.2 The Board shall appoint the chairs of all committees. The Board shall approve the terms of reference and membership of the committees. The Board shall review these as and when required, and shall review the terms within 2 years of their approval if there has not been a review.

9.3 The Board shall appoint committee members to fill any vacancy in the membership as and when required. If a committee is required by regulation to be constituted with a particular membership, then the regulation must be followed

9.4 Provided there is no Scottish Government instruction to the contrary, any non-executive Board member may replace a Committee member who is also a non-

executive Board member, if such a replacement is necessary to achieve the quorum of the committee.

9.5 The Board's Standing Orders relating to the calling and notice of Board meetings, conduct of meetings, and conduct of Board members shall also be applied to committee meetings where the committee's membership consist of or include all the Board members. Where the committee's members includes some of the Board's members, the committee's meetings shall not be held in public and the associated committee papers shall not be placed on the Board's website, unless the Board specifically elects otherwise.. Generally Board members who are not members of a committee may attend a committee meeting and have access to the meeting papers. However if the committee elects to consider certain items as restricted business, then the meeting papers for those items will normally only be provided to members of that committee. The person presiding the committee meeting may agree to share the meeting papers for restricted business papers with others.

9.6 The Board shall approve a calendar of meeting dates for its committees. The committee chair may call a meeting any time, and shall call a meeting when requested to do so by the Board.

9.7 The Board may authorise committees to co-opt members for a period up to one year, subject to the approval of both the Board and the Accountable Officer. A committee may decide this is necessary to enhance the knowledge, skills and experience within its membership to address a particular element of the committee's business. A co-opted member is one who is not a member of The State Hospitals Board for Scotland and is not to be counted when determining the committee's quorum.

THE STATE HOSPITALS BOARD FOR SCOTLAND

SCHEME OF DELEGATION

VERSION 1~~6~~5

Version Control Log		
Version	**Date**	**Description**
1	July 2005	Approved By Board
2	May 2006	Annual Review presented to Audit Committee.
2.1	5 June 2006	Approved by the Board on 22 June 06.
3.0	11 June 2007	Approved by the Board on 21 June 2007.
3.1	24 April 2008	Approved by the Board on 19 June 2008.
4.0	30 April 2009	Presented to Audit Committee on 30 April 2009. Detailed Scheme – No change Financial limits • 13.6 – Constraint text "subject to appointment of bankers by Board" removed • 14.3 (d) – "Annually" added to Virement of Budget "per event over £25,000 and up to £100,000" Several instances referring to SEHD updated to SGHD.
4.1	16 July 2009	Approved by the Board 18 June 2009
4.2	24 September 2009	Changed to reflect portfolio changes. Approved by Audit Committee 24 September 2009.
4.3	April 11	Changes proposed to board
	June 11	Changes approved by the board
4.4	April 12	Changes approved by the board
5	April 13	Changes to SFI references to agree to SFI's Approved by Audit Committee on 25 April 2013
5.1	April 13	Approved by Board 2 May 2013
6	April 14	Changes to SO references to agree to SO's. Changes to responsibilities to reflect portfolio changes and changes in staff. Financial limits amended to reflect limits in Pecos system • 14.8 a) Capital value changed from £1.800 to £2,400 • 14.8 b) eHealth capital value added - value up to £4,000 and value up to £24,000 Approved by Audit Committee 24 April 2014. Approved by Board 26 June 2014.

7	April 15	Amended PFPI to Equality & Involvement Added Achievement of savings to 14.3 Management of Budgets Changes to 16.1.3 re change in responsibility of patients property. Approved by Audit Committee 2 April 2015 after changes to reflect that Remuneration Committee is no longer a sub committee.
8	March 16	Changes to responsibilities to reflect portfolio changes re L&D PO approval 14.7 – added in Procurement Team Leader Asset disposals 14.10 – removed Security Director limit up to £10k and replaced with Finance Director. Added authorised deputy.
8.1	June 16	Financial limit for waiver of tenders 14.9 increased from £3k to £5k. Approved by Audit Committee and Board 23 June 2016.
9	March 17	Changed Nursing Director to Director of Nursing & AHP and removed reference to General Manager. Approved by Audit Committee 23 March 2017 Approved by Board 4 May 2017
10	March 18	Section 3 & 13.5 – change financial monitoring forms to Financial Performance Returns. Clinical Effectiveness Strategy 6.2 replaced with Quality Assurance and Improvement Strategy. IM&T Security11.8 – change title of authorised deputy to Information Governance and Data Security Officer. Approved by Audit Committee 5 April 2018
11	June 18	Section 14.7 –-Pay Revenue Expenditure – Requisitioning / Ordering of Goods and Services 14.7c – change to >£15k - <£20k 14.7d – change to >£10k - <£15k 14.7e – change to >£5k - <£10k 14.7f – change to >£1k - <£5k Approved by Audit Committee 28 June 2018
12	March, May 2019	Sections 3.1, 7.2 – changed title from Involvement and Equality Lead to Person Centred Improvement Lead Section 8.1 – corrected delegated authority from Director of Nursing and AHPs to Medical Director Approved by Audit Committee 28 March 2019 Approved by Board 20 June 2019
13	March 2020	Amended for updated job titles. 14.8 d) inclusion of Programme Director approval levels for contract variations. Approved by Audit Committee 26 March 2020 Approved by Board 18 June 2020
14	December 2020	Amended approvals for clarity re batch processing and BACS
15	March 2021	Amended for updated job titles. Amended terminology re Remobilisation Plan (formerly Annual Operating Plan) Allocation of Risk responsibility to Security Directorate (section 5.2) ~~Issue to~~Approved by Audit Committee 25 March 2021 Approved by Board 17 June 2021
16	March 2022	Amended sections 14.7, 14.9 for changes to procurement job titles and updated tender levels to comply with current legislation in line with SG Procurement Journey Process. For Audit Committee approval 17 March 2022

1. DELEGATION OF POWERS

1.1 Delegation to Committees

1.1.1 Under Standing Order (SO) B20, the Board may determine that certain of its powers shall be exercised by committees. Under SO D27 each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board) as the Board shall decide. In accordance with SO D28d committees may not delegate executive powers to sub-committees unless expressly authorised by the Board.

1.1.2 Under the SO D27c the committees established by the Board are:

Clinical Governance Committee
Staff Governance Committee
Audit (Finance) Committee
Remuneration Committee

2. SCHEME OF DELEGATION TO OFFICERS

2.1 Role of the Chief Executive

2.1.1 All powers to the Board which have not been retained as reserved by the Board or delegated to a committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions he/she shall perform personally and which functions have been delegated to other Directors and Officers. This scheme will be reviewed annually in March of each year.

2.1.2 The Chief Executive is accountable to the Board and as Accountable Officer is also accountable to the Principal Accountable Officer of the NHS in Scotland and the Scottish Parliament for ensuring that the Board meets its obligation to perform its functions within available financial resources.

2.1.3 The Chief Executive shall have overall executive responsibility for the Hospital's activities and shall be responsible to the Board for ensuring that its financial obligations and targets are met and shall have overall responsibility for the Board's system of internal financial control.

2.1.4 All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. As Accountable Officer the Chief Executive is accountable to the Principal Accountable Officer of the Scottish Government Health and Social Care Directorate (SGHSCD) for the funds entrusted to the Board.

2.2 Caution over the Use of Delegated Powers

2.2.1 Powers are delegated to Directors and Officers on the understanding that they would not exercise delegated powers in a manner that in their judgement was likely to be a cause for public concern.

2.3 Directors' Ability to Delegate their own Delegated Powers

2.3.1 The Scheme of Delegation shows the "top level" of delegation within the Board. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Board.

2.4 Absence of Directors and Officers to Whom Powers have been Delegated

2.4.1 In the absence of a Director or Officer to whom powers have been delegated those powers shall be exercised by that Director or Officer's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent powers delegated to him/her shall be exercised in accordance with the Accountable Officer Memorandum.

2.4.2 Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive ("CE"), the Finance and EHealth Director ("FD" / "Finance Director") and other Directors. These responsibilities are summarised below.

2.4.3 Certain matters need to be covered in the Scheme of Delegation that are not covered by SFIs or SOs as they do not specify the responsible Officer.

2.4.4 This Scheme of Delegation covers only matters delegated by the Board to Directors and certain other specific matters referred to in SFIs. Each Director is responsible for the delegation within their sphere of responsibility. They should produce a Scheme of Delegation covering their area of responsibility and in particular the Scheme of Delegation should include how their budget responsibility and procedures for approval of expenditure are delegated.

3. SCHEME OF DELEGATION ARISING FROM STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

	SO Reference	Delegated to	Duties Delegated
	1.6	CE	Maintenance of Register of Board Members Interests

	SFI Reference	Delegated to	Duties Delegated
	1.1.5	FD	Approval of all financial procedures.
	1.3.9	CE	To ensure all employees and directors, present and future, are notified of and understand Standing Financial Instructions.
	1.3.10	FD	Responsible for implementing the Board's financial policies and co-ordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented.
	1.3.10	FD	Maintaining an effective system of internal financial control
	1.3.10	FD	Ensuring that sufficient records are maintained to show and explain the Board's transactions
	1.3.14	ALL DIRECTORS AND EMPLOYEES	Ensuring that the form in which financial records are kept and the manner in which directors and employees discharge their duties is to the satisfaction of the Finance Director.
	3.1.1	CE	Submit to the Board an annual strategic plan (currently "Remobilisation Plan"- formerly "Annual Operational Plan" to 2020) covering 3 year period.
	3.1.2 & 3.1.3	FD	Submit budgets to Board and monitor performance against budget and strategic plan.
	3.2	CE	Delegate management of budgets to budget holders.
	3.3	FD	Devise and maintain systems of budgetary control.
	3.3	FD	Deliver adequate training on an ongoing basis to budget holders to enable them to manage effectively.
	3.4	CE	Identifying and implementing cost improvements and income generation initiatives.
	3.6	CE	Ensuring that the required financial performance returns are submitted to the SGHSCD.
	4	FD	Prepare annual accounts, financial returns and supporting papers
	5.1	FD	Managing the Board's banking arrangements
	6.1	FD	Designing, maintaining and ensuring compliance with income systems.
	7.1	CE	Capital programme investment process, and scheme of delegation for capital investment management.
	7.1.4	FD	Procedures for the regular reporting of expenditure and commitment, including reporting to the Board.

	SFI Reference	Delegated to	Duties Delegated
	7.1.9	FD	Procedures for financial management of capital investment.
	7.2	CE	Maintenance of asset registers.
	7.2.4	FD	Procedures for reconciling balances on ledgers to fixed asset registers.
	7.3	CE	Overall responsibility for fixed assets.
	7.3.2	FD	Asset control procedures.
	8	CE	Agreeing service agreements for provision of patient services.
	9.1	HR Director	Application of pay and expenses rates within arrangements approved by Remuneration Committee and Scottish Government circulars and guidance.
	9.2	CE	Variation of funded establishment from annual budget.
	9.3	CE	Delegation of authority to engage, re-engage, regrade employees, hire agency staff, or agree changes in remuneration.
	9.4	HR Director	Contracts of employment.
	9.5	HR Director	Pay and Payroll documentation.
	9.6	FD	Processing of payroll.
	9.7	HR Director / FD	Early retirement and redundancy policy and procedures.
	9.8	HR Director	Removal expenses policy and procedures.
	10.1.1	CE	Determine, and set out, level of delegation of non-pay expenditure to budget managers.
	10.1.2 & 10.1.3	FD	Identify managers who are authorised to place requisitions including maximum levels and set out procedures on the seeking of professional advice
	10.2	FD	Procedures for seeking advice on supply of goods and services.
	10.2.3	FD	Prompt payment of accounts.
	10.2.4	FD	Advise the Board regarding setting thresholds for quotations or tenders.
	10.2.4	FD	Designing a system of verification for all non pay amounts payable.
	10.2.6	CE	Authorise who may use and be issued with official orders.
	10.3.5	CE / FD	Dispensing with need for competitive tendering or quotations.
	10.5	FD	Procedures for payment of grants to local authorities and voluntary organisations.
	10.6	CE	Best value achieved for all services provided under contract or in-house.
	11.1.1	CE	Identify person with overall responsibility for control for stores.
	11.1.3	FD	Procedures and systems to regulate the stores.
	11.1.7 & 11.1.8	FD	Stocktaking arrangements.
	12.1.1	CE	Risk management programme including Health and Safety.

	SFI Reference	Delegated to	Duties Delegated
	12.1.4	FD	Insurance arrangements.
	13.1.1	FD	Responsible for accuracy and security of computerised financial data.
	13.1.2	FD	Development of new financial systems and amendments to existing systems.
	13.1.4 & 13.1.5	FD	Contracts for computer services for financial applications
	13.1.6	Associate MD	Procedures to comply with the Data Protection Act.
	13.1.7	FD	Procedures to comply with the Freedom of Information Act.
	14.2.1	FD	Developing and implementing Fraud, Theft and Irregularity Policy.
	14.2.1	FD	Investigate fraud or other irregularity in consultation with Chief Internal Auditor and Counter Fraud Services.
	14.3	FD	Arrangements to report on effectiveness of internal control.
	14.3	FD	Arrangements for internal audit.
	14.3	Chief Internal Auditor (CIA)	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
	15.1	FD	Procedures for disposal of assets including condemnations.
	15.1.4	Security Director	Procedures for disposal of land including compliance with Property Transactions Handbook.
	15.2	FD	Maintain procedures for recording and accounting for losses and special payments; maintaining a register.
	15.2.8	CE & FD	Approval of losses and authorisation of special payments within limits set by SGHSCD.
	15.3	FD	Preparing a “Fraud Response Plan”
	15.3.4	CE	Designating a Fraud Liaison Officer.
	15.3	Fraud Liaison Officer	Notifying police, Counter Fraud Service, appropriate Director, appointed Auditor and Internal Audit in respect of theft.
	15.3	Counter Fraud Services	Investigating instances of *prima facie* grounds for believing a criminal offence has been committed.
	16.1.2	CE	Ensure patients or guardians informed of extent of Board’s liability or responsibility for patients property brought into Health Service property.
	16.1.3	Security Director	Provide detailed written instructions on collection, custody, investment, recording, safekeeping and disposal of patients' property.
	16.1.5	FD	Approval of payment towards costs of funeral expenses.
	16.1.6	HR Director	Advise staff on appointment of their responsibilities and duties in respect of the administration of patients’ property.

	SFI Reference	Delegated to	Duties Delegated
	16.1.8	FD	Preparing an abstract of receipts and payments for patients' funds, for presentation to the Audit Committee annually; with independent audit.
	17.1.1	CE	Retention of document procedures.
	18.1	CE	Standards of Business Conduct policy.
	18.2	FD	Maintain a Register of Gifts and Hospitality.
	18.4	CE	Maintain Register of Board members interests
	18.4	FD	Maintain a Register of staff members interests

THE STATE HOSPITALS BOARD FOR SCOTLAND
SCHEME OF DELEGATION

1. Organisational Scope / Profile

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
1.1 Preparation and Maintenance of Service Directory	Chief Executive	Director of Nursing & AHP	N/A	CG & RM Standards

2. Corporate Governance

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
2.1 Maintenance of Register of Board Member Interests	Chief Executive	N/A	N/A	Standing Orders A4
2.2 Scheme of Delegation Responsibility for preparation and update of Scheme	Chief Executive	Finance & EHealth Director ("Finance Director")	N/A	CG & RM standards, SG standards, Governance Statement
2.3 Sealing of Documents	Chief Executive	N/A	N/A	Standing Orders E28

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
2.4 Distribution of all relevant new legislation, regulations, good practice and case law	Chief Executive	N/A	N/A	CG & RM standards
3. Communications				
3.1 Preparation of Communications Strategy				
Overall communications framework	Chief Executive	Head of Communications	N/A	
Internal (staff)	Chief Executive	Head of Communications	N/A	SG Standards
External	Chief Executive	Head of Communications	N/A	CG & RM Standards
Patients and Carers	Director of Nursing & AHP	Person Centred Improvement Lead	N/A	CG & RM Standards

4. Planning and Performance

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
4.1 Preparation and Implementation of the Delivery Plan	Chief Executive	Finance Director	as per supporting Financial Plan	SGHSCD letter CG & RM standards
4.2 Preparation of Corporate Objectives, Targets, Measures	Chief Executive	Finance Director	as above	SGHSCD letter CG & RM standards
4.3 Performance management systems	Finance Director	Head of Corporate Planning & Business Support	N/A	CG & RM standards
4.4 Service Level Agreements with other Health Boards	Chief Executive	Finance Director	all	CG & RM standards
4.5 Partnership Agreements	Chief Executive	N/A	all	

5. Risk Management

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
5.1 Preparation of Risk Management Strategy	Chief Executive	Security Director	N/A	CG & RM standards Statement of Internal Control
5.2 Policies and Procedures				
Risk Management	Security Director	Risk Manager	N/A	CG & RM standards
Child Protection	Director of Nursing & AHP	N/A	N/A	
Prescribing	Associate Medical Director	N/A	N/A	HDL(2007)12 Safer management of controlled drugs - Accountable Officer status delegated to Associate Medical Director
Health and Safety	Chief Executive	Security Director	N/A	HSG 65 (Health & Safety Executive) and associated regulations
5.3 Emergency and Continuity Planning	Security Director	N/A	N/A	CG & RM standards
5.4 Insurance Arrangements	Finance Director	Procurement Manager	N/A	SFI 12

6. Clinical Governance

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
6.1 Clinical Governance Strategy	Medical Director	N/A	within existing resources	CG & RM standards
6.2 Quality Assurance and Improvement Strategy	Medical Director	N/A	within existing resources	CG & RM standards
6.3 Research Governance Compliance with research governance standards	Associate Medical Director	N/A	N/A	CG & RM Standards Research Governance Standards
Approval of Research and Development Studies including associated clinical trials and indemnity agreements for commercial studies	Associate Medical Director	N/A	N/A	Research Governance Standards
6.4 Legal Claims				
Clinical negligence (negotiated settlements)	Finance Director	Chief Executive	< £25k	
Personal injury claims involving negligence where legal advice has been obtained and guidance applied	Finance Director	Chief Executive	< £25k	
All other claims	Chief Executive	Finance Director	> £25k	Scottish Government approval is required for all claims in excess of £100,000

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
6.5 Complaints				
Responding to complaints	Chief Executive	Deputy Chief Executive	N/A	Complaints guidance
Maintenance of complaints procedures and reporting	Finance Director	Head of Corporate Planning & Business Support	N/A	Complaints guidance
6.6 Knowledge Services	Director of Nursing & AHP	N/A	within existing resources	CG &HIS standards

7. Equality & Involvement

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
7.1 Designated Director for Equality & Involvement	Director of Nursing & AHP	N/A	N/A	CG & RM standards Equality & Involvement Self Assessment
7.2 Policies and Procedures				CG & RM standards Equality & Involvement Self Assessment
Equality/Diversity (Human Rights, Race, Disability, Gender, etc)	Director of Nursing & AHP	N/A	N/A	
Advocacy	Director of Nursing & AHP	N/A	N/A	
Carers	Director of Nursing & AHP	Person Centred Improvement Lead	N/A	
Volunteering	Director of Nursing & AHP	Person Centred Improvement Lead	N/A	
Spiritual and Pastoral Care	Director of Nursing & AHP	Person Centred Improvement Lead	N/A	
Patient and Carer Information and Communications	Director of Nursing & AHP	Person Centred Improvement Lead	N/A	

8. Access, transfer, referral, discharge

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
8.1 Monitoring of Waiting Times				
- Psychological Therapies	Medical Director	N/A	N/A	Delivery Plan
- Patient Activity and Recreational Services	Director of Nursing & AHP	N/A	N/A	Delivery Plan
8.2 Public Information on access to services	Director of Nursing & AHP	N/A	N/A	CG & RM Standards
8.3 Access Policy	Medical Director	N/A	N/A	CG & RM Standards
8.4 Discharge Strategy and Policy	Medical Director	Associate Medical Director	N/A	CG & RM Standards
8.5 Clinical Supervision Policy	Medical Director & Director of Nursing & AHP	N/A	N/A	CG & RM Standards
8.6 Consent Policy	Medical Director	N/A	N/A	CG & RM Standards

9. Healthcare Associated Infection

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
9.1 Compliance and adherence to national standards in healthcare acquired infection	Director of Nursing & AHP	N/A	Within available resources	Infection Control Standards SGHSCD guidance
9.2 Compliance and adherence to national standards in				
decontamination	Security Director	N/A	Within available resources	SGHSCD guidance
cleaning	Security Director	N/A	Within available resources	SGHSCD guidance

10. Health Promotion and Education

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
10.1 Health Education and Health Promotion Activities	Director of Nursing & AHP	N/A	as per financial plan	CG & RM Standards
10.2 Public Health Information dissemination	Director of Nursing & AHP	N/A	N/A	CG & RM Standards

11. Information Management

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
11.1 Information Management Systems & Strategy	Finance Director	Head of eHealth	within programme plan	CG & RM Standards National eHealth Strategy
11.2 Clinical Responsibility for eHealth Strategy	Medical Director	Associate Medical Director	N/A	CG & RM Standards
11.3 Information Governance Framework	Finance Director	Head of eHealth	N/A	CG & RM Standards Information Governance Standards
11.4 Data Protection Act **- patient related data** **- staff related data**	Caldicott Guardian HR Director	Head of eHealth Head of eHealth	N/A	CG & RM Standards Information Governance Standards
11.5 Freedom of Information Act	Finance Director	Head of eHealth	N/A	CG & RM Standards Information Governance Standards
11.6 Caldicott Guardian	Medical Director	Associate Medical Director	N/A	CG & RM Standards Information Governance Standards

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
11.7 Records Management				
- clinical records	Caldicott Guardian	Health Records Manager	N/A	CG & RM Standards
- non clinical records	Finance Director	Health Records Manager	N/A	Information Governance Standards
11.8 Information Management & Technology Security	Finance Director	eHealth Security Officer	N/A	CG & RM Standards Information Governance Standards
11.9 Data Quality	Finance Director	Health Records Manager	N/A	CG & RM Standards Information Governance Standards

12. Staff Governance

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
12.1 Staff Governance Standards Implementation of Staff Governance Standards action plan	HR Director	N/A	N/A	Staff Governance Standards
HR policies and procedures	HR Director	N/A	Within existing resources	PIN guidelines

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
12.2 Pay Modernisation Benefits Realisation Plans	HR Director	N/A	N/A	SGHSCD guidance
12.3 Workforce Planning	HR Director	N/A	N/A	SGHSCD guidance
12.4 Contracts of employment	HR Director	N/A	N/A	Staff Governance Standards PIN guidelines
12.5 Systems for Professional registration and CPD	Medical Director & Director of Nursing & AHP	N/A	N/A	CG & RM Standards
12.6 Learning and Development Plans	HR Director	N/A	N/A	Staff Governance Standards Development Plan
12.7 Whistleblowing Policy	HR Director	N/A	N/A	PIN guidelines Counter Fraud Service Partnership Agreement

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
12.8 Disciplinary Action and Appeal				
a) Decision to dismiss	Any Director in consultation with HR Director	N/A	N/A	
b) Appeal against disciplinary action short of dismissal	Manager of Disciplinary decision maker	N/A	N/A	Subject to no involvement in disciplinary action
c) Appeal against disciplinary action short of dismissal (action taken by Director)	Chief Executive	N/A	N/A	
d) Appeal against disciplinary action short of dismissal (action taken by Chief Executive)	Staff Governance Committee	N/A	N/A	
e) Appeal against dismissal	Chief Executive	N/A	N/A	
f) Appeal against disciplinary action in respect of Directors	Remuneration Committee	N/A	N/A	
g) Appeal against disciplinary action in respect of the Chief Executive	Full Board or special Committee with delegated authority	N/A	N/A	Subject to members not having been involved in disciplinary action
12.9 Senior Employees Remuneration				
Remuneration and performance of Directors and Senior Managers	Remuneration Committee	N/A	N/A	SGHSCD guidance

13. Financial controls (subject to compliance with Standing Orders and Standing Financial Instructions)

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
Financial/Organisational Governance 13.1 System for funding decisions and business planning	Finance Director	N/A	N/A	
13.2 Preparation of Financial Plans	Finance Director	Deputy Director of Finance	Allocation Letter	
13.3 Preparation of budgets	Finance Director	Deputy Director of Finance	Per Financial Plan	
13.4 Financial Systems and Operating Procedures	Finance Director	Deputy Director of Finance	N/A	
13.5 Financial Performance Reporting System	Finance Director	Deputy Director of Finance	N/A	
13.6 Maintenance / Operation of Bank Accounts	Finance Director	Deputy Director of Finance	N/A	
13.7 Annual Accounts signatories	Chairperson Chief Executive Finance Director	N/A	N/A	In accordance with Scottish Accounts Manual

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
13.8 Audit Certificate	Appointed Auditors	N/A	N/A	In accordance with Scottish Accounts Manual
13.9 Systems for administration of patients funds	Finance Director	Deputy Director of Finance	N/A	
13.10 Fraud, Theft and Irregularity Policy	Finance Director	Fraud Liaison Officer	N/A	

14. Financial limits (subject to compliance with Standing Orders and Standing Financial Instructions)

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.1 Authority to commit expenditure for which no provision has been made in approved plans/ budgets	Chief Executive Finance Director	Finance Director N/A	£100k £25k	
14.2 Virement of Budget within approved Resource Limit for items where no provision has been made in approved plans/ budgets	Chief Executive	Finance Director	£100k	
14.3 Management of Budgets Responsibility for keeping expenditure within budgets				
a) at individual budget level (pay and non-pay)	Nominated budget-holders	Named Deputies	Budget notified	
b) at service level	Directors	Named Deputies	Budget notified	
c) for reserves and contingencies	Finance Director	Deputy Director of Finance		
d) achievement of savings	Directors Chief Executive	Named Deputies	Savings notified	

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
e) Virement of Budget between Directors				Subject to maximum virement limit of Chief Executive
- per event up to £25,000	Directors	Named Deputies	< £25k	
- per event over £25,000 and up to £100,000 annually	Chief Executive	Finance Director	> £25k < £100k	
f) Virement of Budget between Directors				
- non recurring	Finance Director	N/A	< £100k	
-recurring	Chief Executive	N/A	< £100k	
14.4 Engagement of staff not on establishment				
All staff (ie bank/agency/locums)				
a) where aggregate commitment in any one year is less than £5,000	Directors	Finance Director	< £5k	
b) where aggregate commitment in any one year is more than £5,000 but less than £25,000	Finance Director	Chief Executive	> £5k < £25k	
c) where aggregate commitment in any one year is more than £25,000	Chief Executive	N/A	> £25k	
14.5 Setting of Fees and Charges	Finance Director	N/A	N/A	
14.6 Agreement/ Licences				
a) Granting and termination of leases with annual rent less than £25,000	Finance Director	N/A	< £25k	
b) Granting and termination of leases with annual rent more than £25,000	CE and FD jointly	N/A	> £25k	
c) Preparation & signature of all tenancy licences for all staff subject to Board policy on accommodation	Finance Director	N/A	N/A	

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
d) Extensions to existing leases	Chief Executive and Finance Director jointly	N/A	N/A	
e) Letting of premises to outside organisations	Chief Executive	N/A	N/A	
f) Approval of rent based on professional assessment	Finance Director	N/A	N/A	
14.7 Non-Pay Revenue Expenditure - Requisitioning/				
Ordering of Goods and Services				
a) Value over £100,000	Board	N/A	>£100k	
b) Annual Value over £20,000 and up to £100,000	Chief Executive	Finance Director, Deputy Chief Exec	>£20k < £100k	Subject to containment within overall Board resources
	~~Procurement Manager~~ Head of Procurement (PO only)	Procurement Team Leader, Deputy Director of Finance, Finance Director (PO only)		
c) Annual Value over £15,000 and up to £20,000	Finance Director	Chief Exec, Deputy Chief Exec	>£15k < £20k	Subject to containment within overall Board resources
	~~Procurement Manager~~ Head of Procurement (PO only)	Procurement Team Leader, Deputy Director of Finance, Finance Director (PO only)		

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
d) Annual Value over £10,000 and up to £15,000	Budget Director	Finance Director, Chief Exec, Deputy Chief Exec	>£10k < £15k	Subject to containment within overall delegated funds for Directorate
	~~Procurement Manager~~ Head of Procurement (PO only)	Procurement Team Leader, Deputy Director of Finance, Finance Director (PO only)		
e) Annual Value over £5,000 and up to £10,000	Budget Manager	Budget Director	>£5k < £10k	Subject to containment within overall delegated funds for budget manager
	~~Procurement Manager~~ Head of Procurement (PO only)	Procurement Team Leader, Deputy Director of Finance (PO only)		
f) Annual Value over £1,000 and up to £5,000	Budget holder	Budget Manager	>£1k < £5	Subject to containment within overall delegated funds for budget holder
	~~Procurement Manager~~ Head of Procurement (PO only)	Procurement Team Leader (PO only)		
		Deputy Director of Finance (PO only)		
g) Annual Value up to £1,000	Budget holder	Budget Manager	< £1k	Subject to containment within overall delegated funds for budget holder
	~~Procurement Manager~~ Head of Procurement (PO only)	Procurement Team Leader (PO only)		
		Deputy Director of Finance (PO only)		
h) Orders exceeding a 12 month period over £50,000 and up to £100,000	Chief Executive	Deputy Chief Exec, Finance Director	> £50k < £100k	Subject to containment within overall Board resources

i) Orders exceeding a 12 month period and up to £50,000	Finance Director	Chief Executive	< £50k	Subject to containment within overall Board resources

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
j) Subsequent variations to contract	Finance Director	Chief Executive	N/A	Subject to containment within delegated limits and within budget
k) Specific exceptions to above limits – Utilities – up to £25,000	Estates Manager	Estates Co-ordinator, Security Director	< £25k	Subject to containment within budget
- Laundry - up to £5,000	Estates Manager	Estates Co-ordinator		
- Decontamination – up to £3,000	Estates Manager	Estates Co-ordinator		
- Shop Trading Account – up to £5,000	Designated budget holders	N/A	< £5k	Countersigned by Procurement Manager (PO only)
l) Consolidated orders up to £10,000	Head of Procurement ~~Procurement Manager~~	Procurement Team Leader	< £10k	Subject to individual items authorised as above
m) Invoice matching queries	Head of Procurement ~~Procurement Manager~~ / Deputy Director of Finance	Senior Management Accountant	<£100 or 10% whichever is lower	Above this level re-authorisation by the budget holder is required
n) Approval of removal expenses packages	Chief Executive	Deputy Chief Executive	<£8k	Taxable Threshold. In exceptional circumstances a higher level may be considered, reasons to be documented
DELEGATION TO INDIVIDUAL OFFICERS TO BE APPROVED BY FINANCE DIRECTOR				

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.8 Capital schemes a) Non IM&T capital schemes - approval and authorisation to proceed				
-value over £ 2,000,000	Board and SGHSCD jointly	N/A	> £2.0m	HDL (2005) 16
- value between £ 500,000 and £ 2,000,000	Chief Executive and Board jointly	N/A	> £0.5m < £2.0m	Internal business case required for £ 1.0m
- value up to £ 500,000	Chief Executive	Deputy Chief Executive	< £0.5m	
- value up to £ 10,000	Finance Director	N/A	<£0.01m	
b) eHealth capital schemes - approval and authorisation to proceed				
-value over £ 1,000,000	Board and SGHSCD jointly	N/A	> £1.0m	HDL (2005) 16
- value between £100,000 and £ 1,000,000	Chief Executive and Board jointly	N/A	> £0.1m < £1.0m	Internal business case required for £ 0.5m
- value up to £100,000	Chief Executive	Deputy Chief Executive	< £0.1m	
- value up to £20,000	Finance Director	N/A		
- value up to £5,000	Head of eHealth	N/A		
c) Selection of professional advisors	Chief Executive	N/A	N/A	subject to containment within approved budget
d) Approval of variations to contract				
-value up to £ 100,000	Chief Executive	Deputy Chief Executive	> £25k < £100k	
- value up to £ 25,000 or 10% of approved expenditure of any scheme whichever is the lower	Security Director or Finance Director	N/A	< £25k	
- value up to £ 5,000 on up to 5 occasions between contract Project Board meetings	Programme Director	N/A	< £5k	or 10% of approved spend whichever is lower
- value up to £ 1,000 on up to 5 occasions between contract Project Board meetings	Deputy Programme Director	N/A	< £1k	

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
- value up to £ 5,000 on up to 5 occasions between contract Project Board meetings				
14.9 Quotation, Tendering and Contract Procedures				
a) Quotations Three minimum quotations for goods/services for spend over £5,000 and up to ~~£10,000~~ £50,000	~~Procurement Manager~~ Head of Procurement	N/A	>£5k < ~~£10k~~ £50k	~~refer to tendering procedures~~Refer to Route 1 SG Procurement Journey Process
b) Tenders ~~Three minimum quotations for goods/services for spend~~ Regulated tender process ~~over~~ £~~10,000~~ £50,000 and up to £100,000	Finance Director	N/A	>~~£10k~~ £50k < £100k	~~refer to tendering procedures~~ Refer to Route 2 SG Procurement Journey Process
~~Three minimum quotations for goods/services for spend~~ Regulated tender process ~~over~~ £100,000	Chief Executive	N/A	>£100k	~~subject to EU regulations~~ Refer to Route 3 SG Procurement Journey Process if value over £138,760 (incl. Vat)
c) Waiving of quotations & tenders ~~subject to SOs~~ over £10,000	Chief Executive & Finance Director	N/A	N/A	
d) Arrangements for opening tenders	~~Procurement Manager~~Head of Procurement	N/A	N/A	All Tenders are now electronic uploaded to PCS or PCS-T
e) Procurement Strategy Approval for Regulated Tenders				
Contract value up to £250,000	Director of Finance	N/A	N/A	Approval to proceed with tender process
Contract value over £250,00	Chief Executive	N/A	N/A	Approval to proceed with tender process

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Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.10 Condemning & Disposal of Assets (excluding heritable property) Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively				
- with current /estimated purchase price up to £50,000	Finance Director	Deputy Director of Finance	< £50k	
- with current/estimated purchase price over £50,000	Chief Executive	N/A	> £50k	
14.11 Condemnations, Losses and Special Payments				
a) Compensation Payments made under legal obligation - ex gratia				
- over £100,000	Board	N/A	> £100k	requires SGHSCD approval
- between £25,000 and £100,000	Chief Executive	Deputy Chief Executive	>£25k < £100k	
- up to £25,000	Finance Director	N/A	< £25k	
b) Other ex-gratia payments - other payments				
- over £5,000	Board	N/A	> £ 5k	requires SGHSCD approval
- up to £5,000	Chief Executive	N/A	< £5k	

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
c) Stores/stock losses due to - theft, fraud, arson ; incidents of the service; or disclosed at check				
- over £20,000	Board	N/A	> £20k	requires SGHSCD approval
- up to £20,000	Finance Director & Chief Executive	N/A	< £20k	
d) Routine stores write on / write off disclosed at check - up to £100	Deputy Director of Finance	N/A	< £100	
- over £100	Finance Director	N/A	> £100	
e) Losses of cash due to theft, fraud, overpayment and others				
- over £5,000	Board	N/A	> £5k	requires SGHSCD approval
- up to £5,000	Finance Director & Chief Executive	N/A	< £5k	
f) Abandoned Claims				
- over £5,000	Board	N/A	> £5k	requires SGHSCD approval
- up to £5,000	Finance Director & Chief Executive	N/A	< £5k	
g) Damage to buildings				
- over £20,000	Board	N/A	> £20k	requires SGHSCD approval
- up to £20,000	Finance Director & Chief Executive	N/A	< £20k	

THE STATE HOSPITALS BOARD FOR SCOTLAND

STANDING FINANCIAL INSTRUCTIONS

VERSION 1~~8~~6

Version Control Log		
Version	Date	Description
1		Approved by Board
2	11 May 06	Approved by Audit Committee on May 2006
2.1	5 June 06	Approved by the Board on June 2006
3.1	21 June 07	Above changes approved by Board June 2007
4.0	24 April 08	Approved by the Board June 2008
5.0	30 April 09	Annual review of SFIs
5.1	16 July 09	Approved by the Board June 2009
5.2	24 Sep 09	Changed to reflect portfolio changes. Approved by Audit Committee September 2009.
6	15 Apr 10	Approved by Board 17 June 2010
7	Apr 11	Approved by audit committee 7/4/11
8	19 Apr 12	Update all references with regard to circulars issued in year Update for SGHD name change to SGHSCD Update for revised CFS partnership agreement Update for key procurement principles Updated for staff title changes Update of SIC to Governance Statement
9	4 April 13	Approved by Audit Committee 25 April 2013 after removal of reference to Vice Chair
9.1	29 April 13	Approved by Board 2 May 2013
10	April 14	Annual review of SFI's – no changes made. Approved by Audit Committee 24 April 2014. Approved by Board 26 June 2014
11	April 15	Updated section 4.1.4 to include additional report. Updated section 16.1.3 from Finance Director to Security Director. Updated section 9.5.3 re authorisation of payroll change forms. Approved by Audit Committee 2 April 2015 after changes to reflect that Remuneration Committee is no longer a sub committee and changed section 14.3.1 & 14.3.5 to Public Sector Internal Audit Standards.
11.1	May 15	Added section 15.7 as per SG guidance re CFS
12	March 16	Updated section 2.6.2 from Nursing Director to Finance Director. Updated Section 4.1.4© to reflect changes in Annual Accounts reports. Updated section 9.7 to reflect updated guidance from SG. Approved by Audit Committee 24 March 2016.
12.1	June 16	Amended section 10.3 re tender waiver limit from £3k to £5k. Approved by Audit Committee & Board 23 June 2016.
13	March 17	Approved by Audit Committee 23 March 2017 subject to inclusion of statement re secondment of HR Director – see section 1.3.15 Approved by Board 4 May 2017

14	March 18	Updated section 2.6.2 to reflect depute Accountable Officer as being Nursing & AHP Director and not Finance Director. Updated section 3.6 to change Monitoring Returns to Financial Performance Returns. Updated section 5 in relation to Project Bank Accounts. Updated section 9.6 to reflect that payments to employees would be by bank credit only. Updated section 13.1.1 to include reference to General Data Protection Regulations. Updated section 16.1.10 to include new rules imposed in October 2017 around patient gambling. Approved by Audit Committee 5 April 2018. Approved by Board 28 June 2018
15	March, May 2019	Updated references to Local Delivery Plan – amended to Annual Operational Plan Updated section 5.3.2 – reflect requirement of two directors' signed authorisation to open any bank account in the name of the Hospital Removed section 17 – Funds held in Trust – no longer applicable to the Hospital with no endowment funds in place Approved by Audit Committee 28 March 2019. Approved by Board 20 June 2019
16	March 2020	Amended wording re secondment of HR Director (1.3.15) Approved by Audit Committee 26 March 2020 Approved by Board 18 June 2020
17	March 2021	Updated references to Annual Operational Plan – amended to Remobilisation Plan Updated job titles Approved by ~~To~~ Audit Committee 25 March 2021 Approved by Board 17 June 2021
18	March 2022	Updated sections 10.2.7, 10.3.2 – removing EU reference, update re new Procurement Regulations Updated section 10.3.4,5 – update tender thresholds to comply with Procurement Act 2014, tender waiver from £5k to £10k (last update 2016) Updated section 10.3.10 – re new TSH Procurement Policy Updated section 10.4.1 – re new legislation For approval by Audit Committee 17 March 2022

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1 INTRODUCTION

1.1 General

1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Financial Directions issued by the Scottish Ministers under the provisions of the National Health Service (Scotland) Act 1978, the National Health Service (Financial Provisions) (Scotland) Regulations 1974, Section 4, together with the subsequent guidance and requirements contained in The Health Act 1999, NHS Circular No 1974 (GEN) 88 and Annex, and NHS MEL 1994 (80) for the regulation of the conduct of the Board, its members and officers, in relation to financial matters they shall have effect as if incorporated in the Standing Orders (SOs) of the Board.

1.1.2 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Board. They are designed to ensure that its financial transactions are carried out in accordance with the law and Scottish Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Reservation of Powers to the Board (Standing Orders Section 20 a)) and the Scheme of Delegation adopted by the Board.

1.1.3 These SFIs identify the financial responsibilities that apply to everyone working for the Board. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial operating procedures.

1.1.4 Statutory Instrument (1974) No 468 requires NHSScotland Finance Directors to design, implement and supervise systems of financial control and NHS Circular 1974 (Gen) 88 requires the Hospital's Finance and EHealth Director ("Finance Director") to:

- approve the financial systems;
- approve the duties of officers operating these systems; and
- maintain a written description of such approved financial systems, including a list of specific duties

1.1.5 As a result, the Finance Director must approve all financial procedures. Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Finance Director must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Board's SOs.

1.1.6 Failure to comply with SFIs and SOs is a disciplinary matter that could result in dismissal.

1.2 Interpretation

1.2.1 Any expression to which a meaning is given in Health Service legislation, or in the Financial Directions made under the legislation, shall have the same meaning in these instructions.

1.2.2 Wherever the title Chief Executive, Finance Director, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.2.3 Wherever the term "employee" is used, and where the context permits, it shall be deemed to include employees of third parties contracted to the Board when acting on behalf of the Board.

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1.3 Responsibilities and Delegation

1.3.1 The Board exercises financial supervision and control by:

a) Formulating the financial strategy with due regard to Remobilisation Plans
b) Monitoring performance against plans and budgets by regular reports at Board meetings
c) Requiring the submission and approval of budgets within resource limits
d) Defining and approving essential features in respect of procedures and financial systems
e) Defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document.

1.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the "Reservation of Powers to the Board" (Standing Orders Section 20 a)).

1.3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Board.

1.3.4 The Chief Executive of the NHS in Scotland shall appoint an Accountable Officer, accountable to the Scottish Parliament for the proper use of public funds by the Board. The Chief Executive of The State Hospital is the designated Board's Accountable Officer. The Chief Executive's duties as Accountable Officer are set out in Section 2.

1.3.5 The Chief Executive is ultimately accountable to the Board, and as Accountable Officer for the Board, to the Scottish Parliament, for ensuring that the Board meets its obligation to perform its functions within the available resources. The Chief Executive has overall Executive responsibility for the Board's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Board's system of internal control.

1.3.6 The Chief Executive shall be responsible for the implementation of the Board's financial policies and for co-ordinating any corrective action necessary to further these policies, after taking account of advice given by the Finance Director on all such matters. The Finance Director shall be accountable to the Board for this advice.

1.3.7 The Chief Executive may delegate such of his/her functions as Accountable Officer as are appropriate and in accordance with these Standing Financial Instructions and Accountable Officer Memorandum.

1.3.8 The Chief Executive will be responsible for signing the 'Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Health Board' as part of the Board's Annual Accounts.

1.3.9 The Chief Executive must ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.

1.3.10 The Finance Director is responsible for:

a) Implementing the Board's financial policies and for co-ordinating any corrective action necessary to further these policies
b) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions

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c) Ensuring that sufficient records are maintained to show and explain the Board's transactions, in order to disclose, with reasonable accuracy, the financial position of the Board at any time

and, without prejudice to any other functions of directors and employees to the Board, the duties of the Finance Director include:

d) Providing financial information to the Board and the Scottish Government Health and Social Care Directorate (SGHSCD)
e) Setting the Board's accounting policies consistent with SGHSCD and Treasury guidance and generally accepted accounting practice
f) Preparing and maintaining such accounts, certificates, estimates, records and reports as the Board may require for the purpose of carrying out its statutory duties.

1.3.11 All directors and employees, severally and collectively, are responsible for:

a) The security of the property of the Board
b) Avoiding loss
c) Exercising economy and efficiency in the use of resources
d) Conforming with the requirements of:

- Standing Orders
- Standing Financial Instructions
- Scheme of Delegation
- Finance Procedure Manual

1.3.12 No action should be taken in a manner devised to avoid any of the requirements of, or the financial limits specified in, these governance documents.

1.3.13 Any contractor or employee of a contractor, who is empowered by the Board to commit the Board to expenditure or who is authorised to obtain income, shall comply with these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.14 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Finance Director.

1.3.15 For any period of secondment of the HR Director, responsibilities assigned to HR Director within these Standing Financial Instructions and the Scheme of Delegation will be delegated to Chief Executive.

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2 RESPONSIBILITIES OF CHIEF EXECUTIVE AS ACCOUNTABLE OFFICER

2.1 Introduction

2.1.1 Under the terms of Sections 14 and 15 of the Public Finance and Accountability (Scotland) Act 2000, the Principal Accounting Officer for the Scottish Government has designated the Chief Executive of The State Hospitals Board for Scotland as Accountable Officer.

2.1.2 Accountable Officers must comply with the terms of the Memorandum to National Health Service Accountable Officers, and any updates issued to them by the Principal Accountable Officer for the Scottish Government.

2.2 General Responsibilities

2.2.1 The Accountable Officer is personally answerable to the Scottish Parliament for the propriety and regularity of the public finances for The Board. The Accountable Officer must ensure that The State Hospitals Board for Scotland takes account of all relevant financial considerations, including any issues of propriety, regularity or value for money, in considering policy proposals relating to expenditure, or income.

2.2.2 It is incumbent upon the Accountable Officer to combine his/her duties as Accountable Officer with their duty to The Board, to whom he/she is responsible, and from whom he/she derives his/her authority. The Board is in turn responsible to the Scottish Parliament in respect of its policies, actions and conduct.

2.2.3 The Accountable Officer has a personal duty of signing the Annual Accounts of the Board for which he/she has responsibility. Consequently, he/she may also have the further duty of being a witness before the Audit Committee of the Scottish Parliament, and be expected to deal with questions arising from the Accounts, or, more commonly, from reports made to Parliament by the Auditor General for Scotland.

2.2.4 The Accountable Officer must ensure that any arrangements for delegation promote good management and that he/she is supported by the necessary staff with an appropriate balance of skills. This requires careful selection and development of staff and the sufficient provision of special skills and services. He/she must ensure that staff are as conscientious in their approach to costs not borne directly by their component organisation (such as costs incurred by other public bodies, or financing costs, e.g. relating to banking and cash flow) as they would be were such costs directly borne.

2.3 Specific Responsibilities

2.3.1 The Accountable Officer must:

- Ensure that from the outset, proper financial systems are in place and applied, and that procedures and controls are reviewed from time to time to ensure their continuing relevance and reliability, especially at times of major changes
- Sign the Accounts and the associated Governance Statement assigned to him/her, and in doing so accept personal responsibility for ensuring that they are prepared under the principles and in the format directed by Scottish Ministers
- Ensure that proper financial procedures are followed, incorporating the principles of separation of duties and internal check, and that accounting records are maintained in a form suited to the requirements of the relevant Health Board Manual for Accounts
- Ensure that the public funds for which he/she is responsible are properly managed and safeguarded, with independent and effective checks of cash balances in the hands of any official
- Ensure that the assets for which he/she is responsible, such as land, buildings or

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other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate

- Ensure that, in the consideration of policy proposals relating to the resources for which he/she has responsibilities as Accountable Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and where necessary brought to the attention of the Board
- Ensure that any delegation of responsibility is accompanied by clear lines of control and accountability, together with reporting arrangements
- Ensure that effective management systems appropriate for the achievement of the organisation's objectives, including financial monitoring and control systems have been put in place
- Ensure that risks, whether to achievement of business objectives, regularity, propriety, or value for money, are identified, that their significance is assessed and that systems appropriate to the risks are in place in all areas to manage them
- Ensure that arrangements have been made to secure Best Value as set out in the Scottish Public Finance Manual
- Ensure that managers at all levels have a clear view of their objectives, and the means to assess and measure outputs, outcomes or performance in relation to these objectives
- Ensure managers at all levels are assigned well defined responsibilities for making the best use of resources (both those assumed by their own commands and any made available to organisations or individuals outside The State Hospitals Board for Scotland) including a critical scrutiny of output and value for money
- Ensure that managers at all levels have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively regarding regularity and propriety of expenditure

2.3.2 The Accountable Officer has a responsibility to ensure that the Board achieves high standards of regularity and propriety in the consumption of resources. Regularity involves compliance with relevant legislation (including the annual Budget Act), relevant guidance issued by the Scottish Ministers - in particular the Scottish Public Finance Manual - and any framework document (e.g. Management Statement / Financial Memorandum) setting out the accountability arrangements and other relevant matters. Propriety involves respecting the Parliament's intentions and conventions and adhering to values and behaviours appropriate to the public sector.

2.3.3 The Accountable Officer has a responsibility for ensuring compliance with parliamentary requirements in the control of expenditure. A fundamental requirement is that funds should be applied only to the extent and for the purposes authorised by Parliament in Budget Acts (or otherwise authorised by section 65 of the Scotland Act 1998). Parliament's attention must be drawn to losses or special payments by appropriate notation of the organisation's Accounts. In the case of expenditure approved under the Budget Act, any payments must be within the scope and amount specified in that Act.

2.3.4 In his/her stewardship of public funds all actions must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct. The Accountable Officer must not misuse his / her official position to further his / her private interests and care should be taken to avoid actual, potential, or perceived conflicts of interest.

2.4 Advice to the Body

2.4.1 In accordance with section 15(8) of the PFA Act the Accountable Officer has particular responsibility to ensure that, where he / she considers that any action that he / she is required to take is inconsistent with the proper performance of his / her duties as Accountable Officer, he / she obtain written authority from the body for which he / she is designated and to send a copy of this as soon as possible to the Auditor General. A copy of such written authority should also be sent to the Clerk to the Public Audit Committee.

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The Accountable Officer should ensure that appropriate advice is tendered to the body on all matters of financial propriety and regularity and on the economic, efficient and effective use of resources. The Accountable Officer will need to determine how and in what terms such advice should be tendered, and whether in a particular case to make specific reference to his / her own duty as Accountable Officer to seek written authority and notify the Auditor General.

2.4.2 The Accountable Officer has particular responsibility to see that appropriate advice is tendered to the body on all matters of financial propriety and regularity and on the economic, efficient and effective use of resources. If he / she considers that the body is contemplating a course of action which is considered would infringe the requirements of financial regularity or propriety or that could not be defended as representing value for money within a framework of Best Value he / she should set out in writing the objection to the proposal and the reasons for this objection. If the body decides to proceed, he / she should seek written authority to take the action in question. In the case of a body sponsored by the Scottish Government the sponsor Directorate should be made aware of any such request in order that, where considered appropriate, it can inform the relevant Scottish Government Accountable Officer and Cabinet Secretary / Minister. Having received written authority he / she must comply with it, but should then, without undue delay, pass copies of the request for the written authority and the written authority itself to the Auditor General and the Clerk to the Public Audit Committee.

2.4.3 If because of the extreme urgency of the situation there is no time to submit advice in writing to the body in either of the eventualities referred to in paragraph 2.5.2 before the body takes a decision, the Accountable Officer must ensure that, if the body overrules the advice, both his / her advice and the body's instructions are recorded in writing immediately afterwards.

2.4.4 If the Accountable Officer is also a member of the Management Board of the body, he / she should ensure that his / her responsibilities as Accountable Officer do not conflict with those as a Board member. For example, if the body proposes action which as Accountable Officer he / she could not endorse and would therefore advise against he / she should, as a Board member, vote against such action, or ensure that opposition as a Board member as well as Accountable Officer is clearly recorded if no formal vote is taken. It will not be sufficient to protect his / her position as a Board member merely by abstaining from a decision which cannot be supported.

2.5 Appearance before the Public Audit Committee

2.5.1 Under section 23 of the PFA Act the Auditor General may initiate examinations into the economy, efficiency and effectiveness with which any part of the Scottish Administration, or certain other bodies, have used their resources in discharging their functions. The Accountable Officer may expect to be called upon to appear before the Public Audit Committee to give evidence on reports arising from any such examinations involving his / her body. The Accountable Officer will also be expected to answer the questions of the Committee concerning resources and accounts for which he / she is Accountable Officer and on related activities. He / she may be supported by other officials who may, if necessary, join in giving evidence or the Committee may agree to hear evidence from other officials in his / her absence.

2.5.2 He / she will be expected to furnish the Committee with explanations of any indications of weakness in the matters covered by paragraphs 2.3 above, to which their attention has been drawn by the Auditor General or about which they may wish to question him / her.

2.5.3 In practice, the Accountable Officer will have delegated authority widely, but cannot on that account disclaim responsibility. Nor, by convention, should he / she decline to answer questions where the events took place before his / her designation.

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2.5.4 The Accountable Officer must make sure that any written evidence or evidence given when called as a witness before the Public Audit Committee is accurate. He / she should also ensure that he / she is adequately and accurately briefed on matters that are likely to arise at the hearing. He / she may ask the Committee for leave to supply information not within his / her immediate knowledge by means of a later note. Should it be discovered subsequently that the evidence provided to the Committee has contained errors, he / she should let this be made known to the Committee at the earliest possible moment.

2.5.5 In general, the rules and conventions governing appearances of officials before Committees of the Scottish Parliament apply, including the general convention that officials do not disclose the advice given to the body. Nevertheless, in a case where he / she was overruled by the body on a matter of propriety or regularity, his / her advice would be disclosed to the Committee. In a case where he / she were overruled by the body on the economic, efficient and effective use of resources the Auditor General will have made clear in the report to the Committee that he / she was overruled. He / she should, however, avoid disclosure of the precise terms of the advice given to the body or disassociation from the decision. Subject, where appropriate, to the body's agreement he / she should be ready to discuss the costs, benefits and risks of options considered and explain the reasoning for the decision taken. He / she may also be called on to satisfy the Committee that all relevant financial considerations were brought to the body's attention before the decision was taken.

2.6 Absence of Accountable Officer

2.6.1 The Accountable Officer should ensure that he / she is generally available for consultation, and that in any temporary period of unavailability due to illness or other cause, or during the normal period of annual leave, there will be a senior officer in the body who can act on his / her behalf if required.

2.6.2 In the event of the Accountable Officer not being available the Nursing & AHP Director shall deputise in any required capacity, as authorised to do so.

2.6.3 If it becomes clear to the body that he / she is so incapacitated that he / she will not be able to discharge these responsibilities over a period of four weeks or more, it should notify the Principal Accountable Officer of the NHS in Scotland so that he / she can appoint an Accountable Officer, pending return. The same applies if, exceptionally, he / she plans an absence of more than four weeks during which he / she cannot be contacted.

2.6.4 Where the Accountable Officer is unable by reason of incapacity or absence to sign the accounts in time for them to be submitted to the Auditor General the body may submit unsigned copies pending his / her return.

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3 ALL LOCATIONS, ESTIMATES, PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

3.1 Preparation and Approval of the Financial Plan and Budgets

3.1.1 The Chief Executive will compile and submit to the Board for approval annually a strategic plan covering a three/ five year period (as specified by SGHSCD). This shall include financial targets and spending proposals and forecast limits of available resources. The annual strategic plan will contain:

a) A statement of the strategies and significant assumptions on which the plan is based
b) Details of major changes in workforce, delivery of services or resources required to achieve the plan
c) Details of the performance management arrangements in place, including national and local targets.

3.1.2 The Finance Director will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board before the start of the financial year. Where it is not possible to agree a full budget, a roll forward budget will be approved prior to the start of the financial year, with a full budget approved by end June. Such budgets will:

- Be in accordance with the aims and objectives set out in the strategic plan
- Accord with workload and workforce plans
- Be produced following discussion with appropriate budget holders
- Be prepared within the limits of available funds
- Identify the assumptions used in their preparation and potential risks
- Reflect SGHSCD indicative budgets

3.1.3 The Finance Director will monitor financial performance against budget and strategic plan, periodically review them, and report to the Board.

3.1.4 All budget holders must provide information as required by the Finance Director to enable budgets, plans, estimates and forecasts to be compiled.

3.2 Budgetary Delegation

3.2.1 The Chief Executive may, within limits approved by the Board, delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

a) Amount of the budget
b) Purpose(s) of each budget heading
c) Individual and group responsibilities
d) Authority to exercise virement
e) Achievement of planned levels of service
f) The provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board in the Scheme of Delegation.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.2.5 Expenditure for which no provision has been made in approved plans and budgets and outwith delegated virement limits may only be incurred after authorisation by the Chief Executive or the Finance Director acting on their behalf, or the Board, dependant on the nature and level of expenditure.

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3.3 Budgetary Control and Reporting

3.3.1 The Finance Director shall monitor financial performance against budget and plan, periodically review them, and report to the Board. There should be a locally agreed mechanism for the early identification and reporting of exceptional financial pressures that cannot be managed.

3.3.2 The Finance Director will devise and maintain systems of budgetary control. These will include:

a) Financial reports to the Board at each meeting in a form approved by the Board containing:

- Revenue resource and expenditure to date showing trends and forecast year-end position against budget
- Performance against statutory targets
- Capital project spend and projected outturn against plan
- Explanations of any material variances from plan
- Where necessary, details of any corrective action and the Chief Executive's and/or Finance Director's view of whether such actions are sufficient to correct the situation
- Changes in the resources available to the Board
- Report on budgetary transfers.

b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible
c) Investigation and reporting of variances from financial, workload and workforce budgets
d) Monitoring of management action to correct variances
e) Arrangements for the authorisation of budget transfers.

3.3.3 Each Budget Holder is responsible for ensuring that:

a) Any likely overspending or reduction of income which cannot be met by virement is not incurred without prior consent
b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement
c) No permanent employees other than those provided for in the budgeted establishment as approved by the Board are appointed without the approval of the Senior Management Team and signed off by the Finance Director.

3.3.4 The Finance Director has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.4 Cost Improvements and Income Generation

3.4.1 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the strategic plan and a balanced budget.

3.5 Capital Expenditure

3.5.1 The general rules applying to delegation SFI 3.2 and reporting SFI 3.3 also apply to capital expenditure. (The particular applications relating to capital expenditure are in SFI 7).

3.6 Financial Performance Returns

3.6.1 The Chief Executive is responsible for ensuring that the required financial performance returns are submitted to the SGHSCD.

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4 ANNUAL ACCOUNTS AND REPORTS

4.1.1 The Board is responsible for ensuring proper accounting records are maintained which disclose with reasonable accuracy, at any time, the financial position of the Board and enable the Board to ensure that the accounts comply with the National Health Service (Scotland) Act 1978 and the requirements of the SGHSCD.

4.1.2 The Board, in regard to the preparation of accounts, is required to:

a) Select suitable accounting policies and then apply them consistently
b) Make judgements and estimates that are reasonable and prudent
c) State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts
d) Prepare the accounts on the going concern basis unless it is inappropriate to assume that the Board will continue to operate.

4.1.3 The Finance Director, on behalf of the Board, will:

a) Prepare, for the Board, periodic and annual financial reports in accordance with the accounting policies and guidance given by the SGHSCD and the Treasury, the Board's accounting policies, and generally accepted accounting practice
b) Prepare and submit annual financial reports to the Scottish Ministers certified in accordance with current guidelines
c) Submit financial returns to the Scottish Ministers for each financial year in accordance with the timetable prescribed by the SGHSCD.

4.1.4 The following statements will be completed and attached to the annual accounts:

a) Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Health Board
b) Statement of NHS Board Members' Responsibilities in Respect of the Accounts
c) A management commentary comprising of an Annual Report which includes a Performance Report and Accountability Report
d) Remuneration and Staff Report
e) Governance Statement

4.1.5 The Board's audited annual accounts must be presented to a public meeting, not later than 6 months after the Board's accounting date. The audited annual accounts shall not be presented until the Audit Committee has approved them in the first instance and then the Board and thereafter laid before the Scottish Parliament.

4.1.6 The Board will publish an annual report after the Annual Accounts have been laid before the Scottish Parliament in accordance with guidelines on local accountability, and present it at a public meeting, (MEL(1994) 80, Guidance to NHS Scotland, Preparation of Local NHS Annual Reports 2001-2002). The document will comply with the Boards Manual for Accounts.

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5 BANK AND GOVERNMENT BANKING SERVICE (GBS)

5.1 General

5.1.1 The Finance Director is responsible for managing the Board's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will take into account guidance/directions issued from time to time by the SGHSCD.

5.1.2 The Board will implement Project Bank Accounts (in construction contracts) where the project value is greater than the monetary limits detailed within Scottish Government guidance "Implementing Project Bank Accounts in Construction Contracts" dated 20 December 2016. This guidance applies to relevant bodies in scope of the Scottish Public Finance Manual (SPFM).

5.1.3 No employee shall hold Board monies in any Bank accounts outwith those approved by the Board. The Finance Director shall be notified of all funds held on behalf of the Board. This should be taken to include Exchequer Funds, Patients Private Funds and Project Bank Accounts.

5.1.4 Banking arrangements shall comply with current guidance as in MEL (2000)39, HDL (2001) 49 and subsequent guidance.

5.2 Bank and GBS

5.2.1 The Finance Director is responsible for:

a) Establishing bank account(s) for the Board's exchequer funds
b) Establishing separate bank accounts for the Board's non-exchequer funds (including Project Bank Accounts)
c) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made
d) Reporting to the Board all arrangements made with the Board's bankers for accounts to be overdrawn.

5.3 Banking Procedures

5.3.1 The Finance Director will prepare detailed instructions on the operation of bank accounts, which must include:

a) The conditions under which each account is to be operated
b) The limit to be applied to any overdraft
c) Those authorised to sign cheques or other orders drawn on the Board's bank accounts, and the limits of their authority.

5.3.2 The Finance Director must advise the Board's bankers in writing of the conditions under which each account will be operated, including the Board's resolution. No other officer than the Finance Director shall authorise the opening of an account in the name of The State Hospital, for which signed authority will be required by the Finance Director and one other executive director.

5.3.3 The Scottish Minister will be able to direct where Boards may invest temporary cash surpluses. This in practice will be restricted to GBS accounts with the effect of reducing overall exchequer borrowing. Temporary cash surpluses shall only be held in GBS account. Required amounts will be transferred to the commercial bank account as required to cover any salary or creditor payments. The amount of working cash held in commercial accounts should be limited to no more than £50,000. Any excess funds should be invested with the GBS accounts.

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6 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The Finance Director is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Finance Director is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges

6.2.1 The Board shall follow the SGHSCD's guidance in setting prices for services.

6.2.2 The Finance Director is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the SGHSCD or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

6.2.3 All employees must inform the Head of Financial Accounts promptly of money due arising from transactions which they initiate/deal with, including all contracts, service agreements, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 Debt Recovery

6.3.1 The Finance Director is responsible for the appropriate recovery action on all outstanding debts and overpayments.

6.3.2 Income not received should be dealt with in accordance with losses procedures.

6.3.3 Overpayment when detected should be recovered.

6.3.4 The Finance Director shall establish procedures for the write-off of debts after all reasonable steps have been taken to secure payment.

6.4 Security of Cash, Cheques and Other Negotiable Instruments

6.4.1 The Finance Director is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable
b) Ordering and securely controlling any such stationery
c) Provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines and for absence cover
d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Board.

6.4.2 All officers whose duty it is to collect or hold cash shall be provided with a safe or with a lockable cash box, which will normally be deposited in a safe. The officer concerned shall hold only one key and all duplicates shall be lodged with the Finance department or other officer authorised by the Finance Director, and suitable receipts obtained. The loss of any key shall be reported immediately to the Finance Director. The Finance Director, on receipt of a satisfactory explanation, shall authorise the release of the duplicate key. The Finance Director shall arrange for all new safe keys to be dispatched directly to him/her from the manufacturers. The Finance Director shall be responsible for maintaining a register of authorised holders of safe keys.

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6.4.3 The Finance Director shall prescribe the system for the transporting of cash and un-crossed pre-signed cheques and shall approve, where appropriate, the use of the services of a specialist security firm.

6.4.4 During the absence (e.g. on holiday) of the holder of a safe key or cash box key, the officer who acts his/her place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

6.4.5 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses. (See Section 15 – Disposals and Condemnations, Losses and Special Payments).

6.4.6 Official money shall not under any circumstances be used for the encashment of private cheques.

6.4.7 All cheques, postal orders, cash etc, shall be banked intact and promptly. Disbursements shall not be made from cash received, except under arrangements approved by the Finance Director.

6.4.8 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Board is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Board from responsibility for any loss.

6.4.9 Large sums of cash collected for unofficial purposes (e.g. for retirements, leavers) should not be retained at ward / department level. Such funds should be passed to the finance department for lodgement in the safe. Once the collection is complete the cash will be returned to the collector.

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7 CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

7.1 Capital Investment

7.1.1 The Chief Executive:

a) Shall ensure that there is an adequate appraisal and approval process, detailed in the Finance Procedure Manual, in place for determining capital expenditure priorities and the effect of each proposal upon service plans. These should form part of the Boards' Property and Asset management strategy.
b) Is responsible for ensuring that a Capital programme, showing the full, lifetime cost of each project, is brought to the Board for approval at the start of each financial year, in a format agreed by the Board
c) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost
d) Shall ensure that the capital investment is not undertaken without confirmation of Board support and the availability of resources to finance all revenue consequences, including capital charges.

7.1.2 For every capital expenditure proposal over £2,000,000 (£1,000,000 if IM&T project) the Chief Executive shall ensure:

a) That a business case (in line with the guidance contained within the Scottish Capital Investment Manual) is produced, for the approval of the Board, setting out:

- An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs
- Appropriate project management and control arrangements

b) That the Finance Director has certified professionally to the costs and revenue consequences detailed in the business case.

7.1.3 For capital schemes where the contracts stipulate staged payments, the Chief Executive will issue procedures for their management.

7.1.4 The Finance Director shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure, including reporting to the Board.

7.1.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

7.1.6 The approval of the Chief Executive shall be required for any variations which exceed the lower of £25,000 or 10% of approved expenditure of any scheme.

7.1.7 The Chief Executive shall issue to the manager responsible for any scheme:

a) Authority to proceed to tender
b) Approval to accept a successful tender within established limits
c) Guidance on relevant legislation, SGHSCD requirements, Board procedures etc.

7.1.8 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with Scottish Capital Investment Manual guidance and the Board's Standing Orders.

7.1.9 The Finance Director shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

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7.2 Asset Registers

7.2.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Finance Director concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year – generally within the annual audit review. The minimum data set to be held within the registers shall be as specified in CEL (2010)35 as issued by the SGHSCD.

7.2.2 Additions to the fixed asset register must be clearly identified and be validated by reference to:

a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties
b) Stores, requisitions and wages records for own materials and labour including appropriate overheads
c) Lease agreements in respect of assets held under a finance lease and capitalised.

7.2.3 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

7.2.4 The Finance Director shall approve procedures for reconciling balances on fixed asset accounts in ledgers against balances on fixed asset registers.

7.2.5 The value of each asset shall be revalued or indexed and depreciated in accordance with guidance issued by the SGHSCD.

7.3 Security of Assets

7.3.1 The overall control of fixed assets is the responsibility of the Chief Executive.

7.3.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including any donated assets) must be approved by the Finance Director. This procedure shall make provision for:

a) Recording managerial responsibility for each asset
b) Identification of additions and disposals
c) Identification of all repairs and maintenance expenses
d) Physical security of assets
e) The express prohibition of any unauthorised use or disposition of Board assets
f) Periodic verification of the existence of, condition of, and title to, assets recorded
g) Identification and reporting of all costs associated with the retention of an asset
h) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

7.3.3 The Finance Director shall prepare procedural instructions on the security and checking and disposal of assets (including cash, cheques and negotiable instrument, and also including donated assets).

7.3.4 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the Finance Director.

7.3.5 Each employee has a responsibility for the security of property of the Board and it is the responsibility of directors and senior employees in all disciplines to ensure appropriate routine security practices in relation to NHS property as may be determined by the Board are applied. Any breach of agreed security practices must be reported in accordance with instructions.

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7.3.6 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Finance Director concerning the form of any register and the method of updating.

7.3.7 Any damage to the Board's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

7.3.8 Registers shall be maintained by the responsible officer for:

- Equipment on loan;
- Leased equipment.

7.3.9 Where practical, assets should be marked as Board property.

7.4 Sale of Property, Plant and Equipment,

7.4.1 There is a requirement to achieve best value for money when disposing of property, plant and equipment assets belonging to the Board. Competitive tendering should normally be undertaken in line with the requirements of SFI 10.3.

7.4.2 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

a) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer
b) Obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Board
c) Items to be disposed of with an estimated sale value of less than £5,000 this figure to be reviewed annually
d) Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract
e) Land or buildings concerning which SGHSCD guidance has been issued but subject to compliance with such guidance.
f) Assets that can be transferred to another NHS body at their Net Book value.

7.4.3 Managers must ensure that:

a) All assets are be disposed of in accordance with MEL(1996)7 'Sale of surplus and obsolete goods and equipment'
b) The Finance Director is notified of the disposal of any such assets
c) All proceeds from the disposal of such assets are notified to the Finance Director.

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8 SERVICE LEVEL AGREEMENTS (SLAs)

8.1.1 Service Level Agreements between two NHS organisations, for example by Health Boards with Boards for the supply of healthcare services, are subject to the provisions of the NHS and Community Care Act 1990. Such contracts do not give rise to legal rights or liabilities but a dispute may be referred to SGHSCD.

8.1.2 Service level agreements provided by the independent healthcare sector on behalf of the NHS are subject to the provisions of HDL (2005) 41. This letter sets out the arrangements that should apply for ensuring the quality of services and identifies that the Chief Executive should ensure the necessary contracting and clinical governance arrangements are put in place.

8.1.3 The Chief Executive is responsible for ensuring Service Level Agreements are agreed and in place before 1 April each year, following discussion between the relevant Boards. The following areas should be covered:

a) Costing and pricing of services
b) Tendering of services
c) Terms and conditions for funding
d) Monitoring of service provision, quality and performance.

8.1.4 Service Level Agreements for The State Hospital providing services to other Boards should be so devised as to minimise risk whilst maximising the Board's opportunity to generate income. Any pricing at marginal cost must be undertaken by the Finance Director and reported to the Board where material. Non-recurrent income should not be used for recurrent purposes without the authority in writing of the Chief Executive.

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9 TERMS OF SERVICE AND PAYMENT OF EXECUTIVE DIRECTORS AND EMPLOYEES

9.1 Remuneration and Terms of Service

9.1.1 The Board has established a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting (MEL(94) 80).

9.1.2 The Board will remunerate the Chairperson and Non-Executive Directors in accordance with instructions issued by Scottish Ministers.

9.1.3 The Remuneration Committee will:

a) Advise the Board about appropriate Remuneration and Terms of Service for the Chief Executive and other Executive Directors (and other senior employees), including:

- All aspects of salary (including any performance related elements/bonuses)
- Provisions for other benefits, including pensions and cars
- Arrangements for termination of employment and other contractual terms.

b) Make such recommendations to the Board on the Remuneration and Terms of Service of Executive Directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Board – having proper regard to the Board's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate.

c) Monitor and evaluate the performance of individual Executive Directors (and other senior employees)

d) Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking into account such national guidance as is appropriate.

9.1.4 The Remuneration Committee shall report in writing to the Board the basis for its recommendations – generally in the form of an Annual Report. The Board shall use the report as the basis for its decisions, but remain accountable for taking decisions on the Remuneration and Terms of Service of Executive Directors. Minutes of the Board's meetings should record such decisions.

9.1.5 The Board will approve proposals presented by the Chief Executive for setting of Remuneration and Terms and Conditions of service for those employees not covered by the Committee.

9.2 Funded Establishment

9.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.

9.2.2 The funded establishment of any department may not be varied, after approval of the annual budget, without the approval of the Chief Executive through the Senior Management Team subject to section 3 of the Scheme of Delegation.

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9.3 Staff Appointments

9.3.1 No director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary basis, or hire agency staff, or agree to changes in any aspect of remuneration:

a) Unless given delegated authority to do so by the Chief Executive
b) Within the limit of his/her approved budget and funded establishment
c) In accordance with procedures approved by the Human Resources Director.
d) In accordance with the relevant pay scales / Terms and Conditions of service.

9.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

9.3.3 The budget impact of all staff appointments must have the authorisation of the Finance Director or his/her delegated officer, before appointment.

9.4 Contracts of Employment

9.4.1 The Human Resources Director will be responsible for:

a) Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation
b) Dealing with variations to, or termination of, contracts of employment.

9.5 Pay and Payroll Documentation

9.5.1 The Human Resources Director is responsible for ensuring that proper arrangements are in place for:

a) The final determination of pay and expenses
b) Verification authorisation and documentation of payroll data
c) Verification and authorisation of expenses payments
d) Prescribing the form of appointment, notification of change and termination forms
e) Prescribing the form of completion of time records and other payroll notifications
f) Prescribing the form for claiming expenses
g) Ensuring the arrangements for the determination, verification and notification of pay and payroll data are supported by appropriate (contract) terms and conditions of service, adequate internal controls and audit review procedures.

9.5.2 Each Director and employee is responsible for complying with the systems in place in the Board for the prompt and accurate provision of information related to the verification of their personal entitlement to pay and expenses and for complying with appropriate Terms and Conditions of Service.

9.5.3 All payroll change forms must be authorised by the Finance Director.

9.6 Processing of Payroll

9.6.1 The Finance Director is responsible for:

a) Specifying timetables for submission of properly authorised time records, other payroll notifications and authorised expense claims
b) Making payment on agreed dates
c) Agreeing method of payment to be by bank credit (BACS).

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9.6.2 The Finance Director will issue instructions regarding:

a) The timetable for receipt and preparation of payroll data and the payment of employees
b) Maintenance of subsidiary records for superannuation, income tax, social security benefits, arrestments and other authorised deductions from pay
c) Security and confidentiality of payroll information
d) Checks to be applied to completed payroll after processing
e) Authority to release payroll data under the provisions of the Data Protection Act
f) Method of payment to employees will be bank credit (BACS)
g) Procedures for payment by bank credit to employees
h) Procedures for the recall before payment of bank credits
i) The collection of payroll deductions and payment of these to appropriate bodies
j) Pay advances and their recovery
k) Maintenance of regular and independent reconciliation of pay control accounts
l) Separation of duties of compiling payroll and checking of payroll after processing
m) A system to ensure the recovery from employees or leavers of sums of money and/or property due by them to the Board
n) Ensuring payroll processing is supported by adequate internal controls and audit review procedures.

9.6.3 Appropriately nominated managers have delegated responsibility for:

a) Completing accurate roster records consistent with approved conditions of service, and other notifications in accordance with agreed timetables
b) Completing roster records and other notifications in accordance with the Human Resources Director's instructions and in the form prescribed by the him/her
c) Submitting commencement, change or termination forms in the prescribed form immediately upon knowing the effective date of the relevant date. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Human Resources Director must be informed immediately.

9.7 Settlement Agreements, Early Retirement and Redundancy

9.7.1 The Human Resources Director, jointly with the Finance Director is responsible for:

a) Ensuring compliance with the guidance issued by the Health Workforce and Performance Directorate in the situations described above.
b) Ensuring that detailed, accurate costings are produced showing the impact of any instances of early retirement/redundancy on the financial performance of the Board.

9.8 Relocation Expenses

9.8.1 The Human Resources Director is responsible for:

a) Preparing a policy relating to the payment of removal expenses and presenting it to the Board for approval
b) Maintaining detailed procedures for the implementation of this policy
c) Ensuring that monitoring and tracking arrangements are in place for the payment of such expenses.

9.9 Non Salary Rewards

9.9.1 The Scottish Public Finance Manual sets out arrangements for establishment of non salary reward schemes, and provides the following examples:

- Cash bonuses
- Amenities and recreational facilities

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- Gifts, vouchers, and entertainment offered as rewards under recognition schemes
- Payment by the employer of its staffs' personal subscriptions to sports or leisure clubs
- Rewards leading to donations to a charity or other external body
- Provision of cars where they are needed for official purposes and are covered by an existing and agreed scheme which includes charging for any private use.

9.9.2 The Scottish Government Finance Pay Policy Team should be consulted prior to the implementation of any non-salary reward scheme to determine whether it will require approval under the Public Sector Pay Policy for Staff Pay Remits or Senior Appointments.

9.9.3 The tax implications for both employers and employees of the provision of all non-salary rewards – cash and non-cash – should be carefully considered. In considering such schemes, it may be appropriate for the Finance Director to seek expert PAYE advice.

9.9.4 When consulting about a proposed scheme, or advising employees of a scheme to be implemented, the Human Resource Director should ensure that mechanisms are in place to advise employees of the tax implications for recipients and how these are to be handled.

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10 NON-PAY EXPENDITURE

10.1 Delegation of Authority

10.1.1 The Board will approve the total level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget holders.

10.1.2 The Finance Director will identify:

a) Managers who are authorised to place requisitions for the supply of goods and services
b) The maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Finance Director shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always seek to obtain the best value for money for the Board through the application of these SFIs, and of all relevant Financial Operating Procedures. In so doing, the advice of the Board's Procurement Manager shall be sought.

10.2.2 National contracts agreed by National Procurement, should be used wherever possible, HDL (2006)39, updated by CEL 05(2012). The Accelerated Procurement initiative was established by the NHS Chief Executive Officers' Group in August 2010. The group recognised the essential nature of the engagement between procurement professionals and the wider Health Board teams to maximise the delivery of benefits for NHSScotland, and to ensure that appropriate professional input from across the service is provided to assist in Best Value outcomes for procurement activity. This work was developed further and is now controlled within the NHSScotland Procurement Steering Group. The key principles of this engagement are set out below:

a) National, regional & local contracts: Where national, regional or local contracts exist (including framework arrangements) the overriding principle is that use of these contracts is mandatory. Only in exceptional circumstances and only with the authority of the Board's Procurement Manager or the Finance Director, based on existing schemes of delegation, shall goods or services be ordered out-with such contracts. Procurement leads will work with National Procurement and other national contracting organisations to ensure best value decisions are made, and that a record of exceptions is maintained for review.
b) Engagement: Technical User Groups (TUGs) should be established by each Health Board for key projects with decision making powers from their Executive Board through a scheme of delegation. Each TUG will be responsible for supplier award and product selection decision making within their Board for local contracts and will provide representation to national CAP (Clinical/Commodity Advisory Group) panels for national contract activity. The decision of the TUG will be mandatory across the Board and will be made prior to development of national contract tendering activities.
c) CAP Panel Membership: CAP panels will have a membership consistent with the principle of decision making based on the consensus of the majority of informed users. Boards should ensure that appropriate representation, based upon the clinical or commodity area concerned is released to and provided with the appropriate authority to input on behalf of a Board and/or clinical specialism.
d) Commitment Contracts: The CAP and TUG groups will work to the principle of seeking to award Commitment based contracts. This means where possible a supplier(s) will be selected for an agreed volume of business by each Board and such volumes aggregated to provide a national commitment level.

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Where commitment cannot be provided, CAP and TUG groups will support the principles of reduced variation and increased consistency, commensurate with clinical and operational requirements.

e) eCommerce Systems: In support of governance and transparency each Board should adopt the Scottish Government national eCommerce solutions and associated business processes for all procurement activity. These solutions will include Public Contracts Scotland, Public Tenders Scotland, Collaborative Content Management and Pecos. Use of alternative or local systems for procurement activity must be approved by the Board's Procurement Manager or the Finance Director, based on existing schemes of delegation. Procurement leads will work with National Procurement and any other relevant bodies to ensure appropriate decisions are made.

f) Transparency: All awards whether from existing framework contracts or local tender processes will be established following the principles of openness and transparency. This requires clear specifications of need and award criteria against which competing offers can be assessed. All members of evaluation panels must confirm that they have no conflict of interest in relation to the specific procurement activity. Any individual wishing to challenge an award decision must also confirm likewise. Any member of staff who confirms a conflict of interest will not be able to be involved in such panels or challenges.

g) No Purchase Order / No Payment: Each Board must implement a policy where no payment shall be made to any supplier where there is no pre-let purchase order. Only if a separately agreed payment mechanism has been pre-arranged should direct payments be made. Each supplier should be formally notified of this and the limit of the Board's liability if they proceed with supply without such order cover.

10.2.3 The Finance Director shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.2.4 The Finance Director will:

a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SFI 10.3 and reviewed regularly

b) Prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds

c) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

- A list of directors/employees (including specimens of their signatures) authorised to order goods/certify invoices and the limits of that authority.
- Certification that:

  - ✓ Goods have been duly received, examined and are in accordance with specification and the prices are correct
  - ✓ Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct
  - ✓ In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined
  - ✓ Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained

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- ✓ The setting of thresholds for matching invoices to orders and good received notes – above which additional budget holder authorisation is required
- ✓ The account is arithmetically correct
- ✓ The account is in order for payment

- A timetable and system for submission to the Finance Director of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.
- Instructions to employees regarding the handling and payment of accounts within the Finance Department

d) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

10.2.5 Prepayments are only permitted where exceptional circumstances apply. In such instances:

- Prepayments are only permitted where the financial advantages outweigh the disadvantages and the intention is not to circumvent cash limits.
- The appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Board, if the supplier is at some time during the course of the prepayment agreement, unable to meet his commitments. The report must include a statement of support from the Procurement Manager for the proposed prepayment agreement.
- The Finance Director will need to be satisfied with the proposed arrangements before contractual arrangements proceed.
- The budget manager/holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or the Chief Executive if problems are encountered.
- Regardless of the arrangements for paying suppliers, the Finance Director shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for payment.

10.2.6 Official Orders must:

a) Be consecutively numbered
b) Be in a format approved by the Finance Director
c) State the Board's terms and conditions of trade
d) Only be issued to, and used by, those duly authorised by the Chief Executive.

10.2.7 Managers must ensure that they comply fully with the guidance and limits specified by the Finance Director and that:

a) All contracts, leases, tenancy agreements and other commitments which may result in a liability are notified to the Finance Director in advance of any commitment being made
b) Contracts above specified thresholds are advertised and awarded in accordance with ~~EU and GATT~~ WTO GPA rules on public procurement and comply with the Public Contracts (Scotland) Regulations 2015 and the Procurement Reform Act Scotland 2014~~White Paper on Standards, Quality and International Competitiveness (CMND 8621)~~
c) Officers are also expected to use their discretion in obtaining more than the minimum number of quotations if they have doubts about the competitiveness of those obtained
d) Where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the SGHD – MEL (1994)4
e) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

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- Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars; conventional hospitality, such as lunches in the course of working visits
- Any officer who receives an offer shall notify his/her manager as soon as practicable. The manager will consult with the Finance Director (and/or Chief Executive) on what action is to be taken

- Visits at suppliers' expense to inspect equipment etc. must not be undertaken without the prior approval of the Chief Executive

f) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Finance Director on behalf of the Chief Executive
g) All goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash
h) Verbal orders must only be issued very exceptionally – by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order"
i) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds
j) Goods are not taken on trial or loan in circumstances that could commit the Board to a future uncompetitive purchase
k) Advice is sought from the appropriate supplies advisor, and the Finance Director (and/or the Chief Executive) is consulted if this advice is not acceptable
l) Changes to the list of directors/employees authorised to certify invoices are notified to, and agreed with, the Finance Director
m) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Finance Director
n) Purchases via Purchasing Cards are in accordance with instructions issued by the Finance Director
o) Petty cash records are maintained in a form as determined by the Finance Director.

10.3 Tendering Procedures

10.3.1 The procedure for making all contracts by or on behalf of the Board shall comply with these Standing Financial Instructions.

10.3.2 ~~Directives by the Council of the European Union prescribing~~Public Contracts (Scotland) Regulations 2015 and the Procurement Reform Act Scotland 2014 ~~procedures~~ for awarding all forms of contracts shall have effect as if incorporated in Standing Orders and Standing Financial Instructions.

10.3.3 The Board shall comply as far as is practicable with the requirements of the "Scottish Capital Investment Manual". In the case of management consultancy contracts the Board shall comply as far as is practicable with SGHSCD guidance "The Use of Management Consultants by Scottish Health Authorities" (MEL (1994) 4).

10.3.4 Where the estimated value of the contract is £5~~1~~0,000 or greater (exclusive of VAT), ~~competitive~~ a regulated tender process will be carried out. Where the estimated value of the contract is between £5,000 and £50,000 a quotation process~~s~~ will be carried out and both processes will cover: ~~will be invited for:~~

- The supply of all goods, materials and manufactured articles not available to the Board through national contracts
- For the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the SGHSCD)
- For the design, construction and maintenance of building and engineering works

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(including construction and maintenance of grounds and gardens)
- For disposals of assets.

10.3.5 The Chief Executive and Finance Director may dispense with the requirements for competitive tendering or quotations if they jointly agree that it is not possible or desirable to undertake or obtain having regard for all the circumstances. Such decisions and their reasons must be recorded. Formal tendering procedures may be waived with the approval of the Chief Executive and Finance Director where:

a) The time scale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or
b) Specialist expertise is required and is available from only one source; or
c) The task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or
d) There is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
e) The Product has been used within the hospital or other secure units and meets a security need. You must provide evidence of other similar products and the reason why these will not suit. (statement from Security Director is required)or
f) As provided for in the Scottish Capital Investment Manual.
g) The overall value of the contract exceeds £10,000 + VAT.

10.3.6 The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

10.3.7 Where it is decided that competitive tendering is not applicable and should be waived by virtue of the above, the fact of the waiver and the reasons must be documented and reported by the Chief Executive to the Board in a formal meeting and recorded in a register kept for that purpose.

10.3.8 Except where 10.3.5 or a requirement under 10.3.2, applies, the Board shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate. This would normally comprise no less than three, firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

10.3.9 The Board shall ensure that normally the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. Where in the opinion of the Finance Director it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive. Suppliers shall normally be chosen in rotation from the list unless the approval of the Chief Executive or nominated officer is given.

10.3.10 Tendering procedures are set out in a separate Procurement Policy for Tendering and Contracting.~~Financial Operating Procedure.~~

10.3.11 Quotations are required where formal tendering procedures are waived under 10.3.5 a) or c) and where the intended expenditure or income exceeds, or is reasonably expected to exceed £5,000.

10.3.12 Where quotations are required under 10.3.4 they should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Board.

10.3.13 Quotations should be in writing unless the Chief Executive or nominated officer

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determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

10.3.14 All quotations should be treated as confidential and should be retained for inspection.

10.3.15 The Chief Executive or nominated officer should evaluate the quotations and select the one which gives the best value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.

10.3.16 Non-competitive quotations in writing may be obtained for the following purposes:

a) The supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or their nominated officer, possible or desirable to obtain competitive quotations
b) The goods/services are required urgently; and

c) Where tenders or quotations are not required, because expenditure is below £5,000, the Board shall procure goods and services in accordance with procurement procedures prepared by the Finance Director.

10.4 Contracts

10.4.1 The Board may only enter into contracts within its statutory powers and shall comply with:

a) Standing Orders
b) Standing Financial Instructions
c) ~~EU~~WTO GPA Directives and other statutory provisions
d) Any relevant directions including the Scottish Capital Investment Manual and guidance on the Use of Management Consultants (MEL(1994)4)
e) Such of the NHS Standard Contract Conditions as are applicable
f) ~~The key procurement principles set out in CEL 05(2012).~~Public Contracts (Scotland) Regulations 2015
g) Procurement Reform Act Scotland 2014

10.4.2 Where appropriate, contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

10.4.3 In all contracts made the Board shall endeavour to obtain best value for money. The Chief Executive shall formally nominate an officer who shall oversee and manage each contract on behalf of the Board.

10.4.4 All contracts entered into by the Board shall contain clauses, standard examples of which are detailed in the Procurement Policy, empowering the Board to:

a) Cancel the contract and recover all losses in full where a company or their representative has offered, given or agreed to give, any inducement to Board staff
b) Recover all losses in full or enforce specific performance where goods or services are not delivered in line with contract terms.

10.4.5 Contracts involving “Funds Held on behalf of the Board” shall be made individually to a specific named fund and shall comply with the requirements of the Charities Acts and regulations.

10.4.6 The Finance Director shall ensure that the arrangements for financial control and the financial and technical audit of building and engineering contracts and property transactions comply with guidance contained within The Property Transaction Handbook CEL (2011)08 and SCIM CEL (2009)19.

10.5 Grants and Similar Payments

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10.5.1 Any grants or similar payments to local authorities and voluntary organisations or other bodies shall comply with procedures laid down by the Finance Director which shall be in accordance with the relevant Acts.

10.5.2 The financial limits for officers' approval of grants or similar payments are set out in the Scheme of Delegation.

10.6 In-house Services

10.6.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Board may also determine from time to time that in-house services should be market tested by competitive tendering.

10.6.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

a) Service specification group, comprising the Chief Executive or nominated officer(s) and specialist(s)
b) In-house tender group, comprising representatives of the in-house team, a nominee of the Chief Executive and technical support
c) Evaluation group, comprising normally a specialist officer, a procurement officer and a Finance Director representative. For services having a likely annual expenditure exceeding £250,000, a Non-Executive Director should be a member of the evaluation group.

10.6.3 All groups should work independently of each other but individual officers may be a member of more than one group. No member of the in-house tender group may, however, participate in the evaluation of tenders.

10.6.4 The evaluation group shall make recommendations to the Board.

10.6.5 The Chief Executive shall nominate an officer to oversee and manage the contract.

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11 STORES AND RECEIPT OF GOODS

11.1.1 Subject to the responsibility of the Finance Director for the systems of control, overall responsibility for the control of stores shall be delegated to the Procurement Manager by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Finance Director. The control of Pharmaceutical stocks shall be the responsibility of a nominated pharmaceutical officer; the control of fuel oil and bio-fuel of a designated facilities manager.

11.1.2 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the nominated managers.

11.1.3 Wherever practicable, stocks should be marked as health service property.

11.1.4 The Finance Director shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

11.1.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Finance Director.

11.1.6 The nominated managers shall be responsible for a system approved by the Finance Director for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Finance Director any evidence of significant overstocking and of any negligence or malpractice (see also 15, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

11.1.7 Stock levels should be kept to a minimum consistent with operational efficiency.

11.1.8 Stocktaking arrangements shall be agreed with the Finance Director and there shall be a physical check covering all items in store at least once a year.

11.1.9 Those stores designated by the Finance Director as comprising more than seven days of normal use should be:

a) Subjected to annual or continuous stock-take
b) Valued at the lower of cost and net realisable value.

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12 RISK MANAGEMENT AND INSURANCE

12.1.1 The Chief Executive shall ensure that the Board has a programme of risk management which will be approved and monitored by the Board.

12.1.2 The programme of risk management shall include:

a) A process for identifying and quantifying risks and potential liabilities
b) Engendering among all levels of staff a positive attitude towards the identification and control of risk
c) Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk
d) Contingency plans to offset the impact of adverse events, including a business continuity plan
e) Audit arrangements including; incident reporting and review, internal audit, clinical audit, health and safety review
f) Arrangements to review and update the risk management programme
g) Development of a financial risk management strategy to cope with possible in-year variations to the initially set budgets.

12.1.3 The existence, integration and evaluation of the above elements will provide a basis for the Audit Committee to provide appropriate assurance to the Directors that the necessary controls are in place to allow the Directors to sign the Governance Statement in keeping with Corporate Governance in the NHS.

12.1.4 The Finance Director shall ensure that appropriate insurance arrangements exist in accordance with the risk management programme.

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13 INFORMATION TECHNOLOGY

13.1.1 The Finance Director is responsible for the accuracy and security of the computerised financial data of the Board and shall:

a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Board's data, programs and computer hardware for which she/ he is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 and General Data Protection Regulations (EU) 2016/679 (GDPR).
b) Ensure that adequate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system
c) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment
d) Ensure that the Board is compliant with information regulation and legislation
e) Ensure that electronic signatures are only used with the written approval of the Finance Director
f) Ensure that adequate controls exist for all acquisition/disposal of computer equipment
g) Ensure that an adequate audit trail exists through the computerised system and that such computer audit reviews as he may consider necessary are being carried out
h) Ensure that contingency planning, including business continuity, is undertaken and that adequate contingency arrangements are in place.

13.1.2 The Finance Director shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

13.1.3 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Health Boards /Boards in the area wish to sponsor jointly) all responsible directors and employees will send to the Finance Director:

a) Details of the outline design of the system
b) Contract details and/or standard contract conditions
c) In the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

These should form part of the national e-Health platform and be procured using framework agreements as set out in section 10.2.2, unless not suitable for the organisations due to cost or functionality.

13.1.4 The Finance Director shall ensure that for contracts for computer services for financial applications with another body, the Board periodically seek assurances that adequate controls are in operation, such as service audits.

13.1.5 Where computer systems have an impact on corporate financial systems the Finance Director shall satisfy him/herself that:

a) Systems acquisition, development and maintenance are in line with corporate policies such as the eHealth Strategy
b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that an audit trail exists
c) Systems are appropriate for future business need as well as the present
d) Finance Directorate staff have access to such data
e) Such computer audit reviews as are considered necessary are being carried out.

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13.1.6 The Associate Medical Director shall devise and implement any necessary procedures to protect the Board and individuals from inappropriate use or misuse of patient confidential information held on computer files after taking account of the Data Protection Act 1998 and General Data Protection Regulations (EU) 2016/679 (GDPR). The appointed Information Governance and Data Security Officer will provide the same assurances over all other non patient data.

13.1.7 The Finance Director shall devise and implement any necessary procedures to comply with the Freedom of Information (Scotland) Act 2002.

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14 AUDIT

14.1 Audit Committee

14.1.1 In accordance with Standing Orders the Board shall formally establish an Audit Committee, with clearly defined terms of reference, which will consider:

a) Internal control and corporate governance, including ensuring that relevant controls are in place and that appropriate assurances can be provided to allow the directors to sign the required statements
b) Internal audit
c) External audit
d) Standing orders and standing financial instructions
e) Accounting policies
f) Annual accounts (including the schedules of losses and compensations).

14.1.2 Where the Audit Committee is satisfied there is evidence of ultra vires transactions, evidence of improper acts, or any other issue, the Chair of the Audit Committee should raise the matter at a meeting of the Board or convene an emergency Board meeting if required. Exceptionally, the matter may need to be referred to the SGHSCD.

14.1.3 It is the responsibility of the Audit Committee with the guidance of the Finance Director to ensure that both an effective and cost effective internal audit service is provided. The Finance Director will retender Internal Audit services at least every five years. The Review panel will include the Chairman of the Audit Committee, the Chief Executive and the Finance Director and may also include other members of the Audit Committee. Tendering will be done on the basis of Technical ability, a Qualitative assessment and affordability.

14.2 Finance Director

14.2.1 The Finance Director is responsible for:

a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control, including the establishment of an effective internal audit function
b) Ensuring that Internal Audit is adequate and meets the NHS mandatory audit standards
c) With regard to the Governance Statement, arranging for the provision of the necessary compliance evidence which would:

- Identify and disclose where there is a significant control weakness
- Show where a control has been introduced during the financial year;

d) Developing and documenting an effective Fraud, Theft and Other Financial Irregularity Policy, and
e) Investigating cases of fraud, misappropriation or other irregularities, in consultation with the Chief Internal Auditor, Counter Fraud Service and the Police, where appropriate and shall notify the Chief Executive and Audit Committee
f) Ensuring that the Chief Internal Auditor prepares a detailed operational plan each financial year for approval by the Audit Committee
g) Ensuring that an annual internal audit report is prepared by the Chief Internal Auditor, in accordance with the timetable laid down by the Audit Committee, for the consideration of the Audit Committee and the Board. The report must cover:

- A clear statement on the effectiveness of internal control
- Major internal control weaknesses discovered
- Progress on the implementation of internal audit recommendations
- Progress against plan over the previous year.

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14.2.2 The Finance Director or designated auditors are entitled without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature
b) Access at all reasonable times to any land, premises or employees of the Board
c) The production of any cash, stores or other property of the Board under an employee's control
d) Explanations concerning any matter under investigation.

14.3 Internal Audit

14.3.1 The role, objectives and scope of Internal Audit are set out in the mandatory Public Sector Internal Audit Standards.

14.3.2 Internal Audit will review, appraise and report upon:

a) The extent of compliance with and the financial effect of relevant established policies, plans and procedures
b) The adequacy and application of financial and other related management controls, including internal financial controls
c) The suitability of financial and other related management data
d) The extent to which the Board's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

- Fraud and other offences
- Poor risk assessment
- Waste, extravagance, inefficient administration
- Poor value for money or other causes.

14.3.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Finance Director must be notified immediately.

14.3.4 The Chief Internal Auditor, or appointed representative, will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairperson and Chief Executive of the Board.

14.3.5 The Chief Internal Auditor shall be accountable to the Finance Director. The reporting and follow-up systems for internal audit shall be agreed between the Finance Director, the Audit Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standardsl. The reporting and follow-up systems shall be reviewed at least every 3 years.

14.3.6 The Chief Internal Auditor shall issue reports in accordance with the Internal Audit reporting mechanism agreed by the Audit Committee. Failure to take any necessary remedial action within a reasonable period shall be reported to the Chief Executive. Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation of the objectivity of the audit, the Chief Internal Auditor shall seek the advice of the Chairperson of the Board.

14.4 External Audit

14.4.1 The external auditor is concerned with providing an independent assurance of the Board's financial stewardship including value for money, probity, material accuracy, compliance with guidelines and accepted accounting practice for NHS accounts. Responsibility for securing the audit of the Board rests with Audit Scotland. The appointed External Auditor's statutory duties are contained in the Public Finance and Accountability (Scotland) Act 2000.

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14.4.2 The external auditor has a general duty to satisfy him/herself that:

a) The Board's accounts have been properly prepared in accordance with directions given under s86(1) of the National Health Service (Scotland) Act 1978
b) Proper accounting practices have been observed in preparation of the accounts
c) The Board has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources
d) The Internal Audit function is adequate.

14.4.3 In addition to these responsibilities, Audit Scotland's Code of Audit Practice requires the appointed auditor to consider:

a) Whether the statement of accounts presents a true and fair view of the financial position of the Board
b) The Board's main financial systems
c) The arrangements in place at the Board for prevention and detection of fraud and corruption
d) Aspects of the performance of particular services and activities
e) The Board's management arrangements to secure economy, efficiency and effectiveness in the use of resources.

14.4.4 The Board's Audit Committee provides a forum through which Non-Executive Directors can secure an independent view of any major activity within the appointed auditor's remit. The Audit Committee has a responsibility to ensure that the Board receives a cost-effective service and that co-operation with senior managers and Internal Audit is appropriate.

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15 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

15.1 Disposals and Condemnations

15.1.1 The Finance Director shall maintain detailed procedures for the disposal of assets (excluding land) including condemnations, and ensure that these are notified to managers.

15.1.2 When it is decided to dispose of an asset, the head of department or authorised deputy will determine and advise the Finance Director of the estimated market value of the item, taking account of professional advice where appropriate.

15.1.3 All unserviceable articles shall be:

a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Finance Director
b) Recorded by the relevant officer, in a form approved by the Finance Director, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Finance Director.
c) The relevant officer shall ensure that any article disposed of, is done so in accordance with appropriate guidance or regulations.
d) The relevant officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Finance Director who will take the appropriate action.

15.1.4 The Security Director will ensure that the Board complies with the Property Transactions Handbook and will ensure that detailed procedures are in place for the disposal of land.

15.2 Losses and Special Payments

15.2.1 The Finance Director must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

15.2.2 Special payments are defined in more detail in the Scottish Public Finance Manual. The main types which may be relevant to the State Hospital are:

- A compensation payment is one made in respect of unfair dismissal in respect of personal injuries, traffic accidents, damage to property etc, suffered by staff or by others.
- Special severance payments are paid to employees beyond and above normal statutory or contractual requirements when leaving employment in public service whether they resign, are dismissed or reach an agreed termination of contract. See the section of the SPFM on Severance, Early Retirement and Redundancy Terms.
- Ex gratia payments are payments made where there is no legal obligation to pay. There must always, however, be good public policy grounds for making such payments. Into this category will fall some out of court settlements, such as cases where the pursuer has no legal case but the Board wants to stop the litigation because it is costly in time and resources. It would not however include cases where the settlement is a negotiated price to settle a potentially higher legal liability. Other examples of ex gratia payments would be payments as compensation for distress or loss arising from a perceived failure of the Board but where there was no legal obligation to pay.

15.2.3 Within limits delegated to it by the SGHSCD (CEL 10 (2010), the Board, following the recommendation of the Audit Committee, shall review the Summary of Losses and Special Payments which shall be prepared by the Finance Director in the form laid down in the Health Board Manual for Accounts, SFR 18.

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	No of Cases	£	Delegated Limit
Theft / Arson / Wilful Damage			
Cash			10,000
Stores/procurement			20,000
Equipment			10,000
Contracts			10,000
Payroll			10,000
Buildings & Fixtures			20,000
Other			10,000
Fraud, Embezzlement & other irregularities (inc. attempted fraud)			
Cash			10,000
Stores/procurement			20,000
Equipment			10,000
Contracts			10,000
Payroll			10,000
Other			10,000
Nugatory & Fruitless Payments			10,000
Claims Abandoned:			
(a) Private Accommodation			10,000
(b) Road Traffic Acts			20,000
(c) Other			10,000
Stores Losses:			
Incidents of the Service			
- Fire			20,000
- Flood			20,000
- Accident			20,000
Deterioration in Store			20,000
Stocktaking Discrepancies			20,000
Other Causes			20,000
Losses of Furniture & Equipment and Bedding & Linen in circulation:			
Incidents of the Service – Fire			10,000
- Flood			10,000
- Accident			10,000
Disclosed at physical check			10,000
Other Causes			10,000
Compensation Payments - legal obligation			
Clinical			250,000
Non-clinical			100,000
Ex-gratia payments:			
Extra-contractual Payments			10,000
Compensation Payments - ex-gratia - Clinical			250,000
Compensation Payments - ex-gratia - Non Clinical			100,000
Compensation Payments - ex-gratia - Financial Loss			25,000
Other Payments			2,500
Damage to Buildings and Fixtures:			
Incidents of the Service – Fire			
- Fire			20,000
- Flood			20,000
- Accident			20,000
- Other Causes			20,000
Extra-Statutory & Extra-regulationary Payments			0
Gifts in cash or kind			10,000
Other Losses			10,000

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15.2.4 The Finance Director shall be authorised to take any necessary steps to safeguard the Board's interests in bankruptcies and company liquidations.

15.2.5 For any loss, the Finance Director should consider whether any insurance claim can be made.

15.2.6 The Board shall delegate to the Chief Executive and the Finance Director, acting jointly, its responsibility for the approval of losses and authorisation of special payments for such categories or values of losses as within limits to the Board by the SGHSCD.

15.2.7 The Finance Director shall maintain a Losses and Special Payments Register in which write-off action is recorded – which shall be reviewed on an annual basis.

15.2.8 No losses or special payments exceeding delegated limits (CEL 10 (2010)) shall be written off or made without the prior approval of the SGHSCD.

15.3 Theft, Fraud, Embezzlement, Corruption and Other Financial Irregularities

15.3.1 The Finance Director must prepare a 'fraud response plan', incorporating the requirements of HDL (2004) 23, updated by CEL(2009)18, that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

15.3.2 The Finance Director will be the nominated contact for the National Fraud Initiative (NFI) and will authorise the release of the required data for this purpose. The Finance Director may delegate the NFI investigation and reporting requirements, to suitable representatives. The Finance Director will ensure that all staff receive the required notifications that their information will be used for this purpose.

15.3.3 The following procedures should be followed, as a minimum, in cases of suspected theft, fraud, embezzlement, corruption or other financial irregularities to comply with Scottish Government Health Department Circular No HDL(2002)88 This procedure also applies to any non-public funds.

15.3.4 The Chief Executive has the responsibility to designate an officer within the Board with specific responsibility for co-ordinating action where there are reasonable grounds for believing that an item of property, including cash, has been stolen.

15.3.5 It is the designated officer's responsibility to inform as he/she deems appropriate the police, the Counter Fraud Services (CFS), the appropriate director, the Appointed Auditor and Internal Auditor where such an occurrence is suspected.

15.3.6 Where any officer of the Board has grounds to suspect that any of the above activities has occurred, his or her local manager should be notified without delay. Local managers should in turn immediately notify the Board's Finance Director, who should ensure consultation with the CFS, normally by the Fraud Liaison Officer. It is essential that preliminary enquiries are carried out in strict confidence and with as much speed as possible.

15.3.7 If, in exceptional circumstances, the Finance Director and the Fraud Liaison Officer are unavailable the local manager will report the circumstances to the Chief Executive who will be responsible for informing the CFS. As soon as possible thereafter the Director of Finance should be advised of the situation.

15.3.8 Where preliminary investigations suggest that prima facie grounds exist for believing that a criminal offence has been committed, the CFS will undertake the investigation, on behalf of, and in co-operation with, the Board. At all stages the Finance Director and the Fraud Liaison Officer will be kept informed of developments on such cases. All referrals to the CFS must also be copied to the Appointed Auditor.

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15.3.9 The Chief Executive has also the responsibility to designate an officer within the Board as Counter Fraud Champion. The role is a strategic one, and focuses on spearheading change in culture and attitudes towards NHS fraud. Full background to this role is included within CEL 3 (2008). As such the role of Champion will complement the role of the Fraud Liaison Officer and includes responsibility for:

- Raising the profile of counter fraud initiatives and publicity
- Ensuring recommendations from investigation reports by NHSScotland Counter Fraud Services (CFS) are implemented
- Monitor implementation of CFS recommendations and ensure compliance with them
- Set clear guidelines and measures for monitoring the effectiveness of implementation.

15.4 Remedial action

15.4.1 As with all categories of loss, once the circumstances of a case are known the Finance Director will require to take immediate steps to ensure that so far as possible these do not recur. However, no such action will be taken if it would prove prejudicial to the effective prosecution of the case. It will be necessary to identify any defects in the control systems, which may have enabled the initial loss to occur, and to decide on any measures to prevent recurrence.

15.5 Reporting to the SGHSCD

15.5.1 Under Enhanced Reporting of NHS Fraud & Attempted Fraud CEL (2010)10 an annual return SFR18 must be completed, as part of the annual account process, to report all cases of Fraud to the SGHSCD. There may be occasions where the nature of scale of the alleged offence or the position of the person or persons involved, could give rise to national or local controversy and publicity. Moreover, there may be cases where the alleged fraud appears to have been of a particularly ingenious nature or where it concerns an organisation with which other health sector bodies may also have dealings. In all such cases, the SGHSCD must be notified of the main circumstance of the case at the same time as an approach is made to the CFS. However all significant or unusual incidents involving patients' finds or endowments should be reported to the SGHSCD.

15.6 Responses to Press Enquiries

15.6.1 Where the publicity surrounding a particular case of alleged financial irregularity attracts enquiries from the press or other media, the Chief Executive should ensure that the relevant officials are fully aware of the importance of avoiding issuing any statements, which may be regarded as prejudicial to the outcome of criminal proceedings.

15.7 Counter Fraud Services (CFS) – Access to Data

15.7.1 CFS work closely with the Board and may at times require access to evidence relating to ongoing investigations. Scottish Government Health & Social Care Directorate endorse that Boards should support the important role played by CFS and that any CFS staff acting on the Finance Director's behalf should be allowed access to the following:

- All records, documents and correspondence relating to relevant transactions
- At all reasonable times, access to any premises or land of The State Hospital
- The production or identification by any employee of the Board, cash, stores or other property under the employee's control

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16 PATIENTS' PROPERTY

16.1.1 The Board has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients.

16.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission that the Board will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

16.1.3 The Security Director must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16.1.4 Where SGHSCD instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Finance Director.

16.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained. Any payment by the Hospital towards funeral expenses should be approved by the Finance Director.

16.1.6 Staff should be informed, on appointment, formally in writing by the Human Resources Director and by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

16.1.8 The Finance Director shall prepare an abstract of receipts and payments of patients' private funds in the form laid down in the Health Board Accounts Manual. This abstract shall be audited independently and presented to the Audit Committee annually.

16.1.9 In general staff are not allowed to receive benefit from any patient's Will. If staff become aware of an intention to include themselves in a Will, staff should discourage such action. This should be reported to the appropriate manager. Anyone receiving a bequest should report this to their line manager to determine further action. Except in cases of the direst emergency, staff should not be involved in witnessing or otherwise in the making of a patient's Will. Any reference of such matters by a patient to a member of staff should immediately be communicated to Advocacy or the Board management, who may arrange for a local solicitor's services to be made available to the patient, if that is wished.

16.1.10 In order to comply with the Gambling Act 2005, patients are not allowed to gamble or place bets. Clinical staff should therefore not approve any requests from patients to withdraw funds for this purpose.

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17 RETENTION OF DOCUMENTS

17.1.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in SHM 58/60, NHS MEL (1993)152 “Guidance for the Retention and Destruction of Health Records” and HDL (2006) 28 “The Management, Retention and Disposal of Administrative Records”, The Scottish Government records management: NHS code of practice (Scotland) version 2.1: 11 January 2012.

17.1.2 The documents held in archives shall be capable of retrieval by authorised persons.

17.1.3 Documents held under the above guidance shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

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18 STANDARDS OF BUSINESS CONDUCT

18.1 General Responsibility

18.1.1 It shall be the responsibility of the Chief Executive to:

- Ensure that the Scottish Government Health and Social Care Directorate guidelines on standards of business conduct for NHS staff (MEL (1994) 48) are brought to the attention of all staff, and effectively implemented
- Develop local policies and the processes to implement them, in consultation with staff and local staff representatives
- Ensure that such policies are kept up to date.

18.1.2 The Ethical Standards in Public Life etc. (Scotland) Act 2000 provides a code of conduct for members of The State Hospitals Board for Scotland. This code was incorporated into Board Standing Orders in May 2003. The principles that apply to gifts and hospitality set out in Standing Orders (Section 3) apply equally to all staff.

18.2 Acceptance of Gifts and Hospitality

18.2.1 The acceptance of gifts, hospitality or consideration of any kind from contractors and other suppliers of goods or services as an inducement or reward is not permitted under the Corruption Acts 1906 and 1916. In the event of a contractor or other supplier of goods or services making such an offer to any officer, either for their personal benefit or the "benefit" of the Board, the guidance given in HSG(93)5 and NHS Circular HDL (2003) 62 (or subsequent guidance issued by the Scottish Government Health and Social Care Department) must be followed. Initially, the matter must be reported to an individual's line manager, or the relevant Director. Acceptance, or refusal, of gifts or hospitality must be entered in a Register of Hospitality and Interests, which will be maintained by the Finance Director. The register will also record details of hospitality provided by the Board's employees:

a) Articles of a low intrinsic value, such as business diaries or calendars, need not be refused
b) Care should also be taken in accepting hospitality such as lunches and dinners, corporate hospitality events etc. All such offers should be reported to the officers line manager before accepting.
c) Visits at suppliers expense to inspect equipment etc should not be undertaken without the prior approval of the Chief Executive and in the case of the Chief Executive by the prior approval of the Chairman. Costs associated with such visits will be borne by The State Hospital.
d) If officers are involved in the acquisition of goods and services they should adhere to the ethical code of the Institute of Purchasing and Supply.
e) Officers should ensure that the acceptance of commercial sponsorship will not influence or jeopardise purchasing decisions.

18.3 Private Transactions

18.3.1 Where offers of goods or services do not involve inducement or reward, employees should still not accept gifts from commercial sources other than inexpensive articles such as calendars or diaries. If any such gifts should arrive unsolicited, the advice of the Finance Director should be sought.

18.4 Declaration of Interest

18.4.1 Employees having official dealings with contractors and other suppliers of goods or services should avoid transacting any kind of private business with them by means other than normal commercial channels. No favour or preference as regards price or otherwise which is not generally available should be sought or accepted.

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18.4.2 In accordance with Standing Order 5, the Chief Executive shall be advised of declared pecuniary interests of Directors or senior staff for recording in the Register of Hospitality and Interests.

18.4.3 The Finance Director is responsible for putting in place arrangements for staff to declare interests. In accordance with Data Protection principles, access is strictly controlled on a need to know basis. The only department likely to be passed this information would be the Procurement Department where there may be concern about the possibility of entering into contracts with organisations which could conflict with registered interests.

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Annex 1 Minimum Financial Controls
(extract from guidance on preparation of Statement of Internal Control March 2010)

Corporate Governance	
The Control Environment	
Public Finance & Accountability (Scotland) Act 2000 HDL(2003)11	Code of Corporate Governance
SSI(2001)301/2 MEL(1994)80	Standing Orders
MEL(1994)80, Annex 4 MEL(1992)35	Scheme of Reservation and Delegation
Appointed Officer Memorandum SSI(2001) 301/2	Accountable Officer Responsibilities
MEL(1994)80, MEL(1996)42 HDL(2002)25, SGHD Audit Committee Handbook	Audit Committee
HDL(2002)11, MEL(1996)42	Internal Audit function
Section 2 of the National Health Service Reform (Scotland) Act 2004 HDL(2002)11	Structures of assurance including CHPS
The Community Care (Joint Working etc.) (Scotland) Regulations 2002 CCD5/2005 CCD11/2002 Governance for Joint Services (Paper by Audit Scotland, Scottish Government & COSLA)	Partnerships including Joint Futures
Identification and Evaluation of Risks and Objectives	
HDL(2006)12 HDL(2004)46	Local Development Plan and regional planning
MEL(1994)15, MEL(1999)14, MEL(1994)80	Risk Management
Control Processes	
	Compliance with laws and regulations

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Monitoring and Corrective Action	
MEL(1994)80, Annex 5	Performance reporting
MEL(1994)80, Annex 9	Policies, procedures and control frameworks
Best Value in Public Services – Secondary Guidance to Accountable Officers	Best Value
Clinical Governance	
MEL(1998)75, MEL(1998)29, MEL(2000)29, HDL(2005)41	Clinical Governance Committee
HIS Standards	Health Improvement Scotland Reports
Staff Governance	
HDL(2004)39, HDL(2005)52 Staff Governance Standard	Staff Governance Committee
HDL(2006)54, HDL(2006)23 HDL(2002)64, MEL(1994)80, Annex 1	Remuneration Committee
KSF/Agenda for Change guidance	Performance management and development
Financial Governance	
SI(1994)No. 468	Financial reporting
MEL(1994)80 NHS 1974(GEN)88	Standing Financial Instructions
MEL(1994)48 Standards Commission	Standards of Business Conduct Model Code of Conduct
HDL(2005)5 MEL(1994)48 RIPSA CEL11(2013)	Fraud Theft & Corruption Policy and Response Plan
NHS 1974(GEN)88	Budgetary control system
SI(94) No 468, MEL(1994)80, Annex 9 HDL(2001)49	Financial Procedures

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MEL(1992)35 &59 ,MEL(1998)9	Acquisition, use, disposal and safeguarding of assets
MEL(1992)18 HDL(2002)87, MEL(1996)48, SCIM	Capital investment control and project management
MEL(1992)8 MEL(1992)9	Property transactions procedures Delegation of authority: land transactions
Annual Accounts Manual Capital Accounting Manual SPFM	Financial accounting and annual accounts presentation Capital accounting policy and guidance Financial policies and guidance for Scottish central government bodies
Schedule 6, part 11,section 6(1) 1990 Health Act Accountable Officer Memorandum	Arrangements to ensure resources are used effectively, efficiently and economically
Scottish Government IFRS Technical Application Notes	Application of International Financial Reporting Standards from 2009/10 and the International Financial Reporting Manual issued by HM Treasury
Health Workforce & Performance Directorate Guidance 13 March 2015	Settlement Agreements
Information Governance	
MEL(1994)64 HDL(2005)46 NHSScotland eHealth Strategy Board guidance	IM&T strategy
HDL(2006)41 MEL(1992)14 MEL(1992)45 NHS Information System Security Manual issued under MEL(1994)75	Information Security Policy
NHS Scotland Information Governance Standards	Information Governance Toolkit and annual improvement plan

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Paper No 22/30

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 April 2022
Agenda Reference:	Item No: 17
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Annual Review 2020/21
Purpose of Report:	For Noting

1 SITUATION

The Scottish Government conducts an annual review of each NHS Board, the core purpose of which is for NHS Boards to be held to account for their performance.

The Annual Review of The State Hospitals Board for Scotland for the year 2020/21 took place on 5 April 2022 by way of MS Teams; and was led by Mr Kevin Stewart, Minister for Mental Wellbeing and Social Care.

2 BACKGROUND

Due to the extreme pressures experienced in the winter period, the review necessarily had to be re-scheduled from its original date in January 2022.

The Minister chaired the review, and Mr John Burns Chief Operating Officer for NHS Scotland was also present alongside a Senior Policy Officer from the Mental Health Directorate.

The Board was represented by the Chair and Chief Executive as well as the Director for Finance and e-Health, supported by the Board Secretary.

The review encompassed the Board's performance for 2020/21, as well as taking the opportunity to consider performance and any key challenges during 2021/22. In preparation for the review, the Board submitted a fully detailed briefing document providing a summary overview of each of these periods.

3 ASSESSMENT

The Minister opened the review by offering thanks for the preparation work completed by the Board, and asking the Chair to make some introductory remarks. Mr Moore noted that the Board's key aims during each year had continued to be the safe delivery of patient care and staff wellbeing as well as a focus on organisational resilience and capacity. He highlighted that throughout the pandemic The State Hospital (TSH) had been able to continue to deliver its core purpose and function, although some adjustment to policy and operationality had been required in order to do so. He also emphasised that staff commitment and flexibility had enabled TSH to do this. Further,

that this period had also included change within the make-up of the Board itself, including new Non-Executive members as well as his own appointment as Chair. He also underlined that the Board was alert to the work being progressed at a national level around the delivery of forensic mental health services in Scotland.

Following this introduction, Mr Jenkins led a summary of TSH performance for the period 1 April 2020 to 31 March 2021, including financial governance, operational delivery and workforce with key focus on responsibility and accountability. This included detailed focus on the experience of the Board during the Covid-19 pandemic during this this time. This was followed by discussion led by the Minister to scrutinise the Board's performance for this period, particularly seeking assurance on the governance arrangements for the Board and the response to the pandemic as well as staff wellbeing, and the actions taken to focus on staff recruitment and retention. The Minister also highlighted the importance of the Supporting Healthy Choices workstream and the physical health of patients.

The second part of the review reflected on performance during the period 1 April 2021 to 31 March 2022, and Mr Jenkins again provided a summary overview of the key aspects. Following this, the Minister undertook a forward look with discussion on the key issues in planning and delivery of performance for The State Hospital, and a focus on recovery from the pandemic.

The Minister provided positive feedback on the Board's overall performance, as well as the response to the Covid-19 pandemic, and noted that the Board had been able to navigate its way through the difficult challenges this had presented.

He paid particular tribute to the contribution made by staff and recognised the pressures experienced by staff at all levels over the course of the past two years. He conveyed the thanks to all staff from the Scottish Government.

Following this, the Minister wrote to the Chair to outline the outcome of the review, and this letter is attached (Appendix A) and which will be published on the Board's website. A further update will be brought to the Board on progress against the key points highlighted.

4 RECOMMENDATION

The Board is invited to **note** this year's Ministerial Review took place on 5 April 2022, and that the Minister has written to the Chair to confirm the outcome.

Author:
Margaret Smith
Board Secretary
01555 842012

Paper No 22/30

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To inform the NHS Board on Scottish Government leadership of its Annual Review for 2020/21.
Workforce Implications	No particular impact - noted that the Partnership Forum been asked to contribute to the briefing provided.
Financial Implications	None directly considered.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested as part of its workplan
Risk Assessment (Outline any significant risks and associated mitigation)	No direct consequences and the report is for information
Assessment of Impact on Stakeholder Experience	Clinical Forum and Partnership Forum involvement in briefing to government.
Equality Impact Assessment	Not required.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not applicable.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Minister for Mental Wellbeing and Social Care
Kevin Stewart MSP

Scottish Government
Riaghaltas na h-Alba
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Brian Moore,
Board Chair,
The State Hospital

Via email:
brian.moore3@nhs.scot

21 April 2022

Dear Brian,

THE STATE HOSPITAL ANNUAL REVIEW: 05 APRIL 2022

1. Thank you for attending The State Hospital's Annual Review with your Chief Executive on 05 April 2022. I am writing to summarise the key discussion points.

2. As you will be aware, the intention was for Ministers to conduct a full round of Annual Reviews during Winter. Whilst that has not proved possible due to the Covid-19 pandemic, Annual Reviews remain an important part of the accountability process for the NHS and, therefore this review was taken forward via video conference later than was originally planned.

3. The meeting marked the first Annual Review for you as Board Chair of the State Hospital and I want to thank you for the contribution you have made since your appointment in July 2021. I would also like to recognise and thank Gary Jenkins, Chief Executive for his leadership and management of The State Hospital throughout the pandemic. Finally, I want to thank the staff at The State Hospital and thank them for the work they have done under tremendous pressure over the past two years.

4. The agenda for this year's round of Reviews was split into two sections to cover: the pandemic experience in 2020/21 and the forward look for key planning issues for the remainder of 2021 into 2022.

Pandemic Experience

5. You helpfully provided an overview of the functions and the layout of The State Hospital which was very informative, which aided the rest of the discussion.

6. I was encouraged to learn that the governance processes at The State Hospital are robust and that during the initial phases of the pandemic the board managed to stay

on track, meeting regularly and keeping to their standing orders. I was also interested to hear of the structure of command at The State Hospital and the way that challenges faced due to Covid-19 were assessed and overcome through the infrastructure that had been put in place and that there was collaboration with external services in order to achieve this. It was positive to hear of the successes in testing and protecting both staff and patients at The State Hospital as well as the rollout of the vaccination across the service.

7. In terms of finance, it is reassuring that in 2020/21 The State Hospital delivered a balanced position and that savings targets were met. I see that there were several impacts from Covid-19 on finance over the course of the year and I am glad to hear that these have been communicated effectively with my officials in Health Finance and I hope this collaboration and transparency continues.

8. The State Hospital has faced challenges with workforce throughout 2020/21, with staff absences and overtime being the main issues which continued throughout the year. It is promising that such a focus has been put on the wellbeing of staff with the creation of the wellbeing centre. I would invite The State Hospital to continue this focus going forward. I can see from the review that there is an emphasis on driving down absences and alleviating some pressure from overtime costs and I will be interested to hear what is put in place in order to mitigate these pressures as well as the results of the increased collaboration with partnerships.

9. I see that there has been drift on key performance indicators, especially on patient health. It was good to hear that this is now a number one priority for The State Hospital and I look forward to hearing of the progress in regards to this throughout the year.

Look Forward

10. It was pleasing to see that The State Hospital is approaching recovery and renewal with diligent scrutiny. I understand that The State Hospital must learn to live with the pressures of Covid-19 and it was encouraging to see that there is some key progress to be made in order to stabilise the governance structure and ensure that is fit for purpose and for The State Hospital to return to business as usual as soon as possible.

11. I look forward to The State Hospital relaying the results of the implementation of the new clinical model and the security update. These projects are integral to the working of The State Hospital as well as its financial fidelity and it is hoped that the delivery of these projects progresses as per the timelines discussed in the review.

12. As previously stated I would be interested to be kept abreast of developments pertaining to workforce. Both in terms of wellbeing and recruitment. It was noted that financial performance is facing a challenge from the pressure on The State Hospital's workforce and therefore this is a key factor in The State Hospital's recovery out of the pandemic. I would encourage The State Hospital to remain transparent with both the Sponsor Team and Health Finance in regards to issues emerging at The State Hospital which may hinder its ability to deliver care to its patients and hit its financial targets.

13. I would like to be kept appraised of the details of the upcoming meeting with NSS regarding Northern Irish patients at The State Hospital and the funding of housing such patients.

14. Finally, I am interested to see what plans you have to change your website. As I stated in the review, it was not easy to navigate and therefore did not lend itself to de-mystify the work that The State Hospital takes forward. Changes that improve the user interface and increase the ease of access of information on the website would be welcomed.

Conclusion

15. I want to reiterate my thanks to the Board and local staff for their ongoing efforts, professionalism and commitment over the course of 2020/21 and in the face of the Covid-19 pandemic.

16. Scottish Ministers are aware that you are clear that there is no room for complacency now that the pandemic appears to be waning. The greatest challenge now lies with the recovery after the last two years and we are confident that under the Board's leadership, The State Hospital are well placed to continue their efforts and deliver their service with the care of their patients at heart.

Kind regards,

KEVIN STEWART

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 April 2022
Agenda Reference:	Item No: 18
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 31 March 2022
Purpose of Report:	For Noting

1 SITUATION

The Board is asked to consider the Revenue and Capital Resources spending plans, and monitor financial outturn. This report provides information on the financial performance, which is also issued quarterly to Scottish Government (SG) along with the statutory financial reporting template. It is also reported internally within the Hospital's management structure.

2 BACKGROUND

Scottish Government are ordinarily provided with an annual Operational Plan and 3-year financial forecast template. The Operational Plan has for 2021/22, as in 2020/21, been paused and replaced with the Board's Remobilisation Plan.

At SG's request, TSH formally sought six months' funding for Covid-related costs, based on half of last year's funding provision. Following an initial July payment, a second sum was received in October's allocation for the second six months of the year, on the same basis as the first allocation and for further review closer to year-end (refer to further note in 3.2).

There are delays (re Covid) in the Perimeter Project which are being monitored by the Project Board and for which any delay costs will be quantified for consideration (into 2022/23).

The established base budgets forecast a breakeven year end position, set on achieving £1.249m efficiency savings, as referred to in the table in section 4.

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £40.783m is primarily the forecast Scottish Government Revenue Resource Limit core and non-core allocations, and anticipated additional allocations.

The Board is reporting an under spend of £0.017m to 31 March 2022, being the draft year-end position subject to audit – the movement in month taking cognisance of year-end accruals and

other closing adjustments. Erostering implementation costs and Office 365 licence pressures currently known have been accrued at the year-end.

PAIAW funding is now being released monthly – being a significant element for the Board because of our high levels of overtime and high Nursing vacancies.

3.2 Key financial pressures / potential benefits.

Revenue (RRL): -

Office 365

An accrual was set aside March 2021 to help address the licence cost pressure, which is being monitored through the Head of eHealth, and for which the various licence options have been evaluated with regard to cost scoping in line with national guidance and local priorities. There was a large increase noted in February so the new accrual is based on this.

Covid-19

We have received two allocations, in June £338k. and in October £369k. A review of spend confirmed to the year-end will determine any adjustment to these allocations.
An accrual has been input for unspent allocation to consider recurring costs into 2022/23 and the plan for 22/23 will now be adjusted to remove the anticipated Covid RRL now that there is SG confirmation of cessation of funding.

Clinical Model review update

There is risk noted that the updated Clinical Model review is expected to differ in structure from that which was originally considered and evaluated pre-Covid. Any additional cost pressures arising will be established and reviewed as part of the overall process.

Patient Visiting

There is expected to be a Business Case put forward to CMT for additional staff cost pressure required to cover patients' visitor's services (due to changes re Covid).

eRostering

This is expected to be a pressure, unless met from RRL, which is yet to be confirmed from SG once the national approach and overall national financial position is agreed – for which the project is underway. At this early stage, potential pressure of circa £250k is possible for TSH in 2022/23, which we have now accrued.

PAIAW

Some pressure potentially remains re prior years still outstanding – with claimants being in the hand of CLO (some of whom have recently been paid.) This has also been re accrued.

Travel

As previously acknowledged, benefits have arisen due to most meetings and courses now being virtual through the Covid crisis, with future budgets being set accordingly.

3.3 Year-to-date position – 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 12	Budget WTE	Actual WTE
Nursing And Ahp's	22,658	22,658	22,822	(164)	401.63	422.26
Security And Facilities	6,600	6,600	6,546	54	120.64	114.26
Medical	2,969	2,969	2,840	128	21.70	21.86
Chief Exec	1,982	1,982	1,979	3	22.07	20.06
Human Resources Directorate	992	992	976	15	14.05	13.78
Finance	3,127	3,127	3,085	43	29.02	30.78
Cap Charges	2,642	2,642	2,642	0	0.00	
Misc Income	(600)	(600)	(974)	374	0.00	0.00
Central Reserves	414	414	850	(436)	(1.00)	0.00
	40,783	**40,783**	**40,766**	**17**	**608.11**	**623.00**

Nursing, and Security – see further detail below.

Medical – Underspends are noted in research (arising from delays in certain projects) and Medical Non Pay (mainly travel and course fees – due to the effect of the pandemic).

CE – nothing significant to note.

HR – An underspend is noted in the Learning Centre's corporate training.

Finance – Pay savings are noted in the Finance department and non-pay underspends throughout the Directorate. However, pressures are noted for some known compensation payments.

Capital Charges –The budget is currently carried forward from previous year, awaiting SG confirmation of the required change to the allocation for the forecasted 2021/22 position (core to non-core adjustment). This underspend has partly offset unidentified savings.

Miscellaneous Income (MI) – The budget now recognises income billed for exceptional circumstance patients.

Central reserves – Some of the unused RRL has been deferred to 2022/23 for delays in projects.

Nursing And Ahp's	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 12	Budget WTE	Actual WTE
Advocacy	148	148	150	(2)	0.00	
AHPs & Dietetics & SLAs	716	716	576	140	13.33	13.19
Hub & Cluster Admin & Clinical Operations	864	864	782	82	24.97	20.77
NPD & Infection Control & Clin Gov	479	479	439	40	5.80	5.50
Clinical Psychology	1,390	1,390	1,414	(24)	19.50	16.54
Directors Personal Assistants	51	51	188	(138)	0.00	3.65
PCI & Pastoral	230	230	242	(12)	3.40	3.66
Skye Centre	1,813	1,813	1,650	162	37.33	39.50
Ward Nursing	16,966	16,966	17,380	(414)	297.30	319.45
	22,658	**22,658**	**22,822**	**(164)**	**401.63**	**422.26**

Highlights from Nursing & AHPs: -

AHPs, Skye Centre, NPD – reflects vacancies in year.

Hub & Cluster Admin plus Directors PAs - There has been structural realignment to some budgets, for which adjustments are awaiting finalisation, for example PAs now being split over three cost centres.

Psychology – reflects savings not yet realised.

PCI – Visitors travel underspend is still accrued, which will support costs from the delay in the patients garden upgrade now underway.

Ward nursing – Overtime equates to actual WTEs worked. Covid funding now being released monthly, similarly for PAIAW, to match spend. There are also savings that were not realised.

Security And Facilities	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 12	Budget WTE	Actual WTE
Risk & Resilience	127	127	115	13	2.00	2.00
Facilities	4,658	4,658	4,549	110	78.87	71.76
Security	1,814	1,814	1,880	(66)	39.77	40.50
Perimeter Security	0	0	3	(3)	0.00	0.00
	6,600	**6,600**	**6,546**	**54**	**120.64**	**114.26**

Highlights from Security and Facilities: -

Risk & Resilience – Noted benefit of new start not in post from the start of the year.

Facilities – Housekeeping vacancies and kitchen vacancies noted, also holiday pay not fully utilised (necessitating a revision required to the future budget, however part will be vired for new Security post). Utilities currently overspent.

Security – An element of overtime and on-call pressures has been met from Covid funding. Other overtime has arisen from high sickness levels. Perimeter overtime relating to Security.

4 ASSESSMENT – SAVINGS

The following table summarises the savings set by Directorate.

Cumulative Savings	Savings - Annual Target	Achieved to date / post base adj'ts	(Still to be achieved) / over achieved
Directorate	**£'k**	**£'k**	**£'k**
Chief Executive	(143)	124	(19)
Finance	(26)	53	26
Nursing & AHP's	(392)	477	85
Human Resources	(15)	20	5
Medical	(20)	55	35
Security & Facilities	(215)	386	171
Unidentified (phased ytd) - so all 'achieved'	(438)	109	(329)
Total	**(1,249)**	**1,223**	**(27)**

While an improved level of recurring saving remains a national / audit focus, it should be noted that of the Hospital's budget only 15% of costs are non-pay/staff-related while by comparison, many territorial boards have a non-pay cost element of around 65% and other National boards have non-pay costs ranging from around 80% (NSS, NES) to 30/40%; while certain boards also treat vacancy savings, or a proportion thereof, as recurring savings.

Although unidentified savings are significant the budget is phased evenly over the year against monthly underspends but just not specifically matched to ledger codes.

National Boards Contribution – The eight National Boards (formerly Special Boards) continue to work towards joint efficiencies and collaborative working. The recurring level of contribution to the collective £15m savings challenge which the Board agreed and approved for 2021/22 remains at £0.220m, and this is also forecast for 2022/23.

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation anticipated from Scottish Government for the year is £0.269m. £0.500m now received December 2021 for the work to be undertaken on the Key Safes & MSRs. A new allocation was also received in March for fleet decarbonisation.

With regard to the Perimeter Security Project allocation, £2.879m was received in December 2021 being for year 2 of 2. While there are elements of unforeseen delays in the project – likely now to June 2022 – unspent monies are being carried forward from year-end to close in the new financial year. SG are aware of the new projected completion date.

£0.052 has been released to Capital from Revenue for an earlier VAT correction.

CAPITAL CRL 2021/2022 As at March 2022	ANNUAL PLAN	YTD PLAN	YTD SPEND	under/ (over)
PERIMETER SECURITY	£'k	£'k	£'k	£'k
STANLEY SECURITY SOLUTIONS LTD		1,994	1,994	0
DOIG & SMITH		13	13	0
THOMSON GRAY LTD		134	134	0
TSH STAFFING APR - FEB'22		208	208	0
DJ GOODE		17	17	0
SENSTAR CORP		20	20	0
VAT RECLAIM		-55	-55	0
PERIMETER SECURITY TOTAL (Yr 1 of 2)	**2,879**	**2,331**	**2,331**	**0**
CAPITAL				
IM&T		52	52	0
OTHER		205	205	0
CAPITAL	**269**	**257**	**257**	**0**
SECLUSION ROOMS & KEY SAFES		12	12	0
CAPITAL	**500**	**12**	**12**	**0**
FLEET DECARBONISATION		12	12	0
CAPITAL	**17**	**12**	**12**	**0**
Total CRL	**3,665**	**2,613**	**2,613**	**0**

6 RECOMMENDATION

Revenue
The draft year-end position subject to audit is £0.017m underspend, with breakeven therefore anticipated for the year-end, including consideration of hand back or carry forward of Covid monies finalised by accruing part of the second in-year allocation to go against some 2022/23 spend (since very recent notification of no further Covid funding).

Capital
Slight underspend is noted against recurring CRL due to timings of capital work. Also, as noted above, delays in the Perimeter Security project means unspent funds carried forward to 2022/23 – with an anticipated end date of mid-June.

Agreement is now being reached between TSH and SG to confirm the in-year underspend in Seclusion Rooms and Key Safes being c/f to 2022/23 due to delays in the timings of both projects.

The Board, and Scottish Government are asked to note the content of this report.

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
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:	28 April 2022
Agenda Reference:	Item No: 19
Sponsoring Director:	Director of Security, Estates and Facilities
Author(s):	Programme Director / Head of Estates and Facilities
Title of Report:	Perimeter Security and Enhanced Internal Security Systems Project
Purpose of Report:	For Noting and Approval

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.

2. BACKGROUND

The Governance for the project is provided by a Project Oversight Board (POB) co-chaired by the Chief Executive and the Director of Security, Estates and Facilities.

The Project Oversight Board meets monthly. The POB last met on 21st April 2022 and is scheduled to meet again on 19th May 2022.

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:

Quality targets are being met, project costs are projected to overspend by a small amount and project timescales have been reviewed and adjusted (See “Project Timescale” at point 3b below). A strategic overview of progress during the period from February 2020 to date is as follows:

- Construction Phase – 84% completed (7 workfaces in progress, 18 to be commenced)
- Testing and Commissioning – not yet commenced
- Detailed Design Packages – 100% completed
- Construction Health and Safety documentation – 93% completed (14 to be commenced)

b) Project Timescales & Quality Issues:

Programme Rev 38 has been accepted with caveats; this projects completion at the end of July 2022, exceeding the contract completion date by approximately 13 weeks. The caveats include issues that have the potential to create further slippage.

All quality targets are being met.

c) Finance – Project cost

The project is proceeding according to the current projected cost plan.

The key project outline is:

Project Start Date:	April 2020
Planned Completion Date:	July 2022
Contract Completion Date:	April 2022
Main Contractor:	Stanley Security Solutions Limited
Lead Advisor:	ThomsonGray
Programme Director:	Doug Irwin
Total Project Cost Projection (inc. VAT):	£10,529,255
Total costs to date (Inc. VAT) at 14th February 2022:	£ 9,432,791

The expenditure to date is in line with the revised plan agreed with the contractor, with the schedule planned for the months to come 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.

Actual spend to date at 14th April 2022 is broadly in line with the revised Stanley planned schedule of works, though regular underspends have increased the total sum to be paid through 2022 - 2023.

50% of the 5% retention is due to be paid at completion, with the remaining 50% to be paid at the end of the defects and liability period of 2 years.

Rounded breakdown of actual spend to date –

Stanley	£ 6.784m (5% retention applied)
Thomson Gray	£ 0.699m
Doig & Smith	£ 0.008m
HVM Design	£ 0.017m
VAT	£ 1.501m
Staff Costs	£ 0.424m
	£ 9.433m

4 TERMS OF REFERENCE

The Project Oversight Board Terms of Reference have been reviewed at the Project Oversight Board of 21st April 2022. No changes have taken place other than to post holders and job titles. They require approval by The State Hospitals Board and are attached at Appendix 1.

5 RECOMMENDATION

That the Board **note** the current status of the Project and approve the changes to Terms of Reference.

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	N/A
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).	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.

Appendix 1

The State Hospitals Board for Scotland

Perimeter Security and Enhanced Internal Security Systems Project

Project Oversight Board - Terms of Reference

1. Purpose

The NHS Board has established a Project Oversight Board to provide the required degree of assurance on the progression of the Perimeter Security and Enhanced Internal Security Systems Project in accordance with the Corporate Objectives of The State Hospitals Board for Scotland, and the appropriate statutory and mandatory standing orders and regulations.

The Project Oversight Board (POB) will provide oversight and assurance, and make recommendations to the NHS Board in line with its remit.

2. Membership

Members:

Gary Jenkins: Chief Executive Officer (Co-Chair)
David Walker: Director of Security, Estates and Resilience (Co-Chair)
Robin McNaught: Director of Finance and eHealth
Karen McCaffrey: Director of Nursing and Operations
Doug Irwin: Programme Director
Allan Connor: Employee Director
Bill Sinclair: Scottish Prison Service

In Attendance:

Kenny Andress: Head of Estates / Deputy Programme Director
Wesley Bathgate: Senior Project Manager, Thomson Gray (as required)
Derek McDonald: Security Advisor, Thomson Gray / D4 (as required)

The NHS Board Chair is not a member of the POB, but may attend any meetings of the POB.

3. Reporting Arrangements

The POB will report to the NHS Board following each meeting – this will be through the submission of the approved Minutes as well as a summary report of the key issues.

The POB will submit an Annual Report to the NHS Board, in June, and this will include: the name of the POB, membership and attendees and officer support, the frequency and dates of meetings, the activities of the POB during the year, any matters of concerns to the POB; confirmation that the POB has fulfilled its remit and of the adequacy and effectiveness of internal controls.

The POB will undertake an Annual Workplan aligned with the Project programme and this will be submitted with the Annual Report.

The POB will undertake an annual review of the Terms of Reference. If this review results in amendment, the revised Terms of reference should be submitted to the NHS Board for endorsement.

4. Key Responsibilities

1. To endorse the scope of the Project, and the benefits to be realised in development, including the clinical service delivery model of the NHS Board.
2. To ensure that the completed facilities are delivered on programme, within budget and are compliant with the NHS Board's corporate objectives and requirements.
3. To ensure that the resources required to deliver the project are available and committed.
4. To ensure appropriate governance through the procurement process and through the Capital Investment Group at Scottish Government.
5. To assure that the project remains within the framework of the overall project strategy, scope, budget and programme as set out in the business case.
6. To review and report changes to the scope of the project e.g. time, cost, quality, to the NHS Board.
7. To promote financial governance and monies and report the adherence within affordability parameter set out by Scottish Government and the NHS Board.
8. To review the risk management plan, ensuring all risks are identified; that appropriate mitigation strategies are actively applied, managed and escalated as necessary, providing assurance to the NHS Board that all risks are being effectively managed.
9. To ensure that staff, partners and service end users are fully engaged in designing operating policies that inform the detailed design and overall procedures that will apply, ensuring that the facilities are service led, not building led.
10. To ensure that communication planning enables the appropriate involvement of and communication with all stakeholders, internal and external, throughout the project.
11. To ensure that appropriate systems of assurance are in place for the functional commissioning of the facilities and operation of the project systems.

5. Conduct of Business

Meetings:

The POB will normally meet monthly. The Co-Chairs may convene additional meetings or change the frequency of meetings as deemed necessary.

The POB may ask any or all of those who attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

The NHS Board may ask the POB to convene further meetings to discuss particular issues on which they want the POB's advice.

Quorum:

A minimum of four members of the POB will be present for the meeting to be deemed quorate.

In the event of a meeting becoming inquorate once convened, the Co-Chairs may elect to continue receiving papers and to allow those present to ask questions and discuss particular matters. The minute should state the point at which the meeting became inquorate but notes of any discussion can be included. Every item discussed and noted in this way will be brought to the next meeting of the POB, under matters arising, for ratification.

Absence of Co-Chairs:
In the event of the Co-Chairs being absent, another member can be designated the chair for the meeting, and this should normally be arranged by the Co-Chairs in advance of the meeting.

Agenda, Papers, Workplan and Minutes:
The POB should have a workplan for the year mapped to the remit of the POB.

The Co-Chairs will set the agenda.

Papers should be submitted to the Project Administrator at least seven working days prior to the meeting. The finalised agenda and papers will be issued to members at least three working days before the date of each meeting.

The meeting will be minuted and will record decisions, actions and responsibilities, actions against identified risks and follow up. Minutes will be submitted to the NHS Board, and published on The State Hospital website as part of the NHS Board papers.

Annual Report:
The POB will prepare and submit an Annual report to the NHS Board in June each year, and this should include:

- The name of the POB, the Co-Chairs, Membership, Executive Leads and Officer supports.
- Frequency, Dates of meetings and attendance.
- The activities of the POB over the year, including confirmation of delivery of the workplan and review of the terms of reference. Should the terms of reference be revised, these should be submitted to the NHS Board for approval.
- Improvements that have been overseen by the POB
- Any areas of concern to the POIB, including Risk.
- Confirmation that the POB has fulfilled its remit, and of the adequacy and effectiveness of internal control.

6. Information Requirements

For each meeting the POB will be provided with a report which will include as a minimum:

Progress Update (business, design and construction)
Current status against key programme elements
Current status against cost planning
Project Risk Register with description of mitigating actions
Communications planning with internal and external stakeholders

7. Executive Leads
The Chief Executive Officer and the Director of Security, Estates and Facilities will co-chair the POB. Accountability for ensuring the longer term security needs of The State Hospital are aligned to the Director of Security, Estates and Facilities, within the project governance structure. Accountability for the financial aspects of the project are aligned to the Finance and Performance Management Director.
8. Access
POB Members will have free and confidential access to the Co-Chairs of the POB.
9. Rights
The POB may procure specialist advice at the expense of the organisation, subject to budgets agreed by the NHS Board or the Chief Executive Officer as Accountable Officer.

Author(s):	Margaret Smith, Board Secretary
To be ratified by The State Hospitals Board for Scotland:	
Review Date:	April 2022

Paper No. 22/33

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 April 2022
Agenda Reference:	Item No: 20
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Head of eHealth
Title of Report:	Digital Strategy
Purpose of Report:	For Noting

1 SITUATION

The eHealth department support the requirements of the Board and the ongoing digital transformation agenda. This update provides an overview of activities since the last annual report to Board.

2 BACKGROUND

Digital transformation continues to be monitored through the eHealth Group and the Digital Inclusion Group, through which existing and new initiatives are raised, prioritised and monitored to bring benefits to both patients and staff. This update details key recent activity for the Board's information.

3 ASSESSMENT

3.1 RiO EPR Upgrade

The principal focus for eHealth in recent months has been the upgrade to our Electronic Patient Record system – RiO – which has been successfully implemented with the system going live on 8 March 2022. This was slightly later than planned due to pre-installation works requiring completion by the supplier.

Every department in eHealth was involved with this upgrade and the new system has been very well received by staff who use Rio. Training was provided by way of online videos and LearnPro modules with two-thirds of staff fully trained at the point the system went live. While this initial rollout has delivered a ''like for like'' EPR at the time of implementation, the new Rio EPR has a significant increase in available future functionality over the previous version. Additional benefits and capabilities such as the integration with the new HEPMA system, planned for delivery over the next few months, will build on the systems capabilities for supporting patient care and treatment. The project is now fully signed-off with a project closure meeting held on 20 April, and the lessons learned have been highlighted for sharing with other project groups within the hospital.

3.2 HEPMA electronic prescribing

As noted above, the new HEPMA electronic prescribing system is approaching “go live” in late April, in partnership with NHS Lothian. Training plans are also underway, and a fuller update will be noted once the pilot wards are in place and full rollout is timetabled for the remaining wards / hubs.

3.3 Office 365

The full national-led Office 365 Project (fronted by NSS) has unfortunately not gone to plan. We still have a significant uptake on Teams use, but SharePoint and OneDrive capabilities have yet to be fully achieved. These options were originally scheduled for phase 3 of the delivery plan that ended in March 2022, however problems at the pilot Board (NSS) with SharePoint have caused them to scale back the pilot and its originally expected outcomes. Further discussions are being held nationally to look at the lessons learn from this pilot and these could highlight the need to refocus the direction of this element of the program.

There are some concerns that have been noted in NHSScotland regarding Information Governance and O365, with some Boards suspending further adoption until this is resolved. There is also a concern that the benefit realisations originally expected may not be delivered in the short term, as costs for O365 increase over the life of the agreement with Microsoft. Further discussion regarding the benefit realisations of the program and the suitability of licensing are being arranged through the national eHealth Digital Leads Group.

3.4 Virtual visiting

The offer has been accepted from Purple Visits of two free-of-charge 2 tablet devices for patients to use, together with one all-in-one pc for a communal device (for the Digital Inclusion group to trial) and all of the software required for security to manage the system. The Purple Visits team have been in Singapore completed large deployment of the system in Australia, and we are therefore expecting these units to be received in early-mid May for this to trial then to be taken forward.

3.5 eHealth staffing

At present we have five posts within the eHealth department which are fixed-term, all of which are critical to the function of the department and are delivering the value expected. To ensure the continued success of the department, permanent funding options are being reviewed within the department workplan. While this could be difficult in the current financial climate with all NHS funding under pressure, we will continue to deliver the best service possible with available resources, ensuring appropriate project prioritisation, and also address staff retention as a priority.

3.6 IT Hardware

There are still some supply issues worldwide with IT equipment – with some lead times for delivery in excess of six months. At present TSH has enough equipment for our needs and for our plans for 2022/23, with no risk currently identified from any shortfall – however this situation is expected to see restrictions until at least 2024 and so forward planning is being undertaken to ensure medium-longer term equipment demands are addressed well in advance.

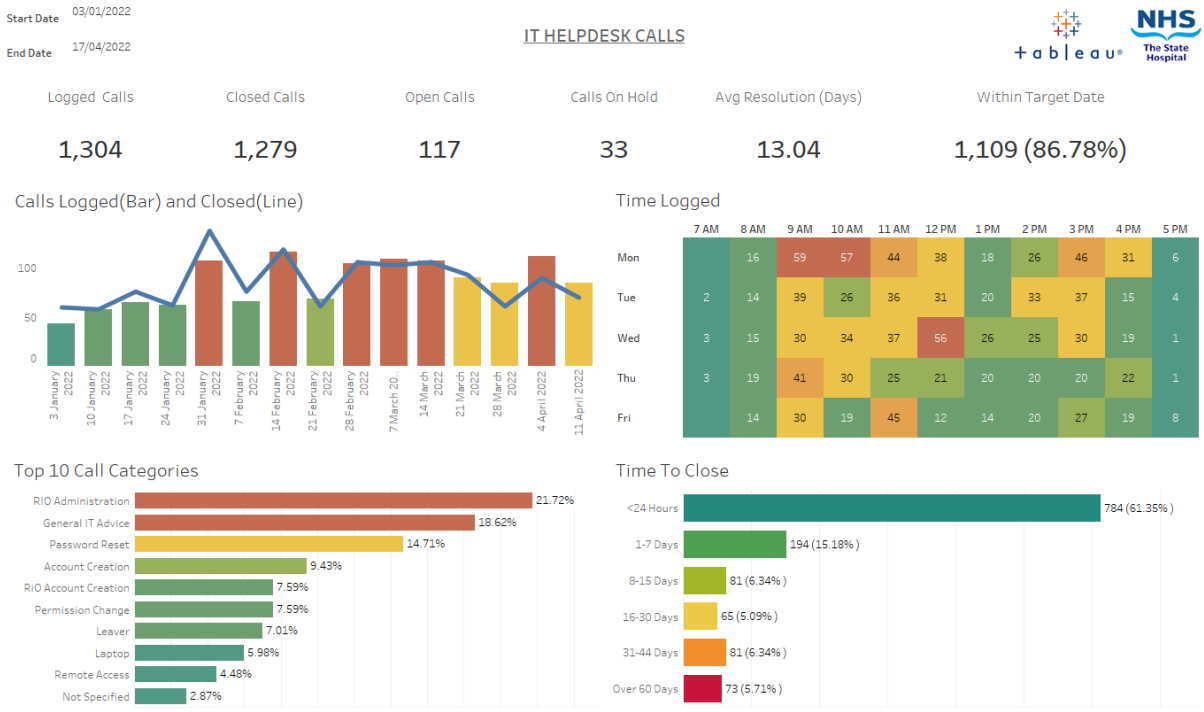
3.7 Cyber Security

There has been additional network traffic monitoring enabled both locally and national due to the war in Ukraine. We also have additional support and monitoring in place from the IT Security team at NSS and with Capita SWAN – and our IT Security Officer is attending daily updates on the national situation provided by the IT security team at NSS. At present there has been nothing of concern identified but we are continually monitoring the network traffic to ensure the State Hospital's digital systems are kept at the necessary levels of safety and security.

Locally we have had two notifications of virus/malware detection from our internal systems. Both saw action taken on individual computers to block this by our anti malware solution InterceptX. This system automatically removes and quarantines suspicious files to prevent infection and notifies the eHealth infrastructure team of the incident. There have also been email and staff bulletin notifications sent out to all staff reminding them to be vigilant when online and to report any suspicious emails or attachments to the eHealth Infrastructure department as soon as possible.

3.8 Helpdesk Calls

Below is an overview of all calls to the IT Helpdesk in 2022. The top three categories are RiO administration, general IT advice and password resets. There is no significant change to the percentage of calls closed within target date, which is in part related to staff leaving the department and the time taken to fill vacant post. The new helpdesk service agreement has been approved by the Organisational Management Team (OMT) and will now be implemented.



4 RECOMMENDATION

The Board is asked to note the update.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supporting Board Digital Transformation Strategy
Workforce Implications	Resource demands noted within specific eHealth projects.
Financial Implications	Revenue and capital costs noted within specific eHealth projects
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested through workplan and developed through eHealth Group
Risk Assessment (Outline any significant risks and associated mitigation)	Noted within specific eHealth projects
Assessment of Impact on Stakeholder Experience	Noted within specific eHealth projects
Equality Impact Assessment	Noted within specific eHealth projects
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 (within individual eHealth projects) □ There are privacy implications , full DPIA included.

Paper No. 22/34

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 April 2022
Agenda Reference:	Item No: 21
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Corporate Governance Improvement Action Plan
Purpose of Report:	For Noting

1 SITUATION

This report provides an update on The State Hospital (TSH) Corporate Governance Improvement Actions Plan to support the key corporate governance priorities as part of the NHS Scotland Blueprint for Good Governance.

This workstream has necessarily been paused at times as part of The State Hospital's resilience response, during the pandemic experience of the past two years. However, work is progressing across a range of workstreams encapsulated in the plan, and a summary is set out herein.

This improvement plan is based on the findings of a Board self-assessment conducted in 2018, and there is an expectation that national guidance will be provided on taking forward further assessment to help the Board evaluate its key priorities.

2 BACKGROUND

The five key areas of the improvement plan are outlined as follows:

- Setting the Direction
- Holding to Account
- Assessing Risk
- Engaging Stakeholders
- Influencing Culture

The Improvement Plan (attached as Appendix A) sets out the relevant workstreams under each of these five key areas.

Further consideration can be given to the following:

Item 2	Effective rostering within the nursing directorate
Item 7	Review of the performance metrics framework
Item 10	Communications Strategy
Item 12	Encourage public/carers/ staff to attend board meetings
Item 13	External locations for (in person) Board meetings
Item 14	Annual Review – off site location for public meeting
Item 18	Senior management visibility through staff engagement structure
Item 19	Senior management/ clinical attendance at (in person) hospital events
Item 21	Non- Executive Director visibility and connection

3 ASSESSMENT

Item 2 – Effective rostering within the nursing directorate:

The Director of Nursing, AHPs and Operations provided a detailed update to the Board at its seminar session which took place on 23 September 2021. Work with National Workforce Team is continuing, aligned to the legislative positon for safe staffing, and a pause on reporting requirements nationally.

Whilst the safe staffing legislation, and roll-out of the self-assessment toll remain paused to date, work has been progressing locally on both the test of change to the rota (through introduction of a 5/7-day shift patterns alongside the existing rota pattern. This is continuing with work currently focused on potential impacts to shift handovers, as well as to delivery of care and the patients experience. This is under active review by the CMT. Further, following work in partnership, recruitment is underway to a nursing bank, open to existing staff with interviews expected to take place in the week beginning 9 May, for the initial cohort. The dedicated short life working group will continue to monitor the development and impact of this change and the potential to grow this resource in the future.

Item 7 – Review of the performance metrics framework:

The Board has received newly formatted reporting in 2021, to give greater clarity on performance in reporting of Key Performance Indicators (KPIs) as well as to highlight the key areas for improvement. PuMP methodology has been established within the hospital to support alignment of performance reporting and improvement priorities. The Planning and Performance Team have progressed a performance workbook which brings together the performance framework for the organisation encompassing its KPIs, corporate objectives and operational planning milestones.

A development session for the Board will take place on 3 May 2022 led by the Board Development team at NHS Education for Scotland. This will enable wider consideration of how to best use data reporting to inform effective governance.

Item 10 Communications Strategy

The Board has been focused on promoting the excellence of care provided within TSH, and helping to support greater public understanding of forensic mental health care.

During March 2022, TSH continued its strategy to promote this strategy through release of a range of short films featuring key staff from clinical disciplines, describing the care delivered to our patients, and these were promoted through the use of social media.

The Board received progress reporting in December 2021, and considered development of its strategy in this area with an update being presented to the Board during April 2022.

Items 12 and 13: Public Board Meetings

Prior to the pandemic, the Board had been considering how to encourage wider attendance at its meeting, including the public, and this was linked to holding meetings outwith the hospital site. There has followed a period of meetings being held on a digital platform, due to restrictions and community infection. This brought an unexpected potential benefit as this format may help to support greater public accessibility, especially as a National Board serving patients in both Scotland and Northern Ireland.

The Board has planned to re-consider this position in 2022, taking into account the lessons learned through the pandemic rather than moving back to the previous position of holding Board (and Committee) meetings in person as was the case prior to the pandemic. It is proposed that the Board does so cautiously, and taking into account how Covid-19 may continue to be impactive, and any potential risk or changes in the position. With this in mind, planning should encompass hybrid options, and aim for implementation in the second half of 2022.

Item 14: Annual Review

The Board has received an update on the Ministerial Annual review for 2020/21, which took place virtually on 5 April 2022, and should note that national guidance is now awaited on how the next review for 2021/22 will be taken forward. If it is possible for this to return to an in person setting, as was the case prior to the pandemic, then consideration can be given as to how best to encourage public participation. Similar to Board meetings, an on-site hospital visit by Scottish Government could be combined with a digital access meeting to allow wider question and answer session.

Items 18 and 19: Visibility of Senior Leadership

This item originally served to flag a need to develop more structured engagement, particularly with staff and to embed more firmly in key areas of strategic development. During the pandemic period, this was developed through the Recovery and Innovation workstream, and since then considerable progress through planning leadership on key workstreams – for Remobilisation Planning and Clinical Model Implementation. These include development of structured routes through which staff have the opportunity to engage and be included in the feedback loop, and offer constructive input to the development of planning change.

Structured engagement is now embedded within TSH, and aligned to the new portfolio structure, being led by the Chief Executive, and is aligned to the Corporate Management Team.

The Board workplan includes reporting, to include staff and wider engagement, on key workstreams, and therefore offer a means through which the Board will receive regular updates for assurance. Therefore, the Board is asked to consider if this action can be closed, in relation to this plan.

Item 21 - Non-Executive Director visibility and connection

This action was necessarily paused during the pandemic to ensure alignment to the national position in terms of public health and infection control.

However, the programme of Leadership Walkrounds, as part of the Scottish Patient Safety Programme is now underway, and Non-Executive Directors are included within the schedule for this. Staff feedback to date is very positive, welcoming the opportunity to meet with Board members in person and to demonstrate the work of the hospital. The Project Manager for this workstream is linking with Non-Executives to take this forward, ensuring planning and support is in place for each visit.

Similarly, a schedule has also been set up to enable Non-Executive Directors to attend the Patient Partnership Group (PPG) in person. This commenced in February and will continue to ensure a presence at one meeting a month, as well as the opportunity to link with the Person Centred Improvement Team to learn about the key issues the PPG is focused on. The PPG includes representation of patients from each ward, and gives Non-Executives a good opportunity to hear and engage with feedback directly in an informal setting.

These programmes are embedded in practice, and offer regular opportunity and means for Non-Executives to engage with both staff and patients, and will support an increase in visibility of the Board across the organisation. The Board is asked to consider whether this action can be closed as part of this plan.

4 RECOMMENDATION

The Board is asked to:

- Note the key areas of development, as well as the context in which some actions continue to be paused due to Covid-19.

Author:
Margaret Smith
Board Secretary
01555 842012

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	In support of the Corporate Governance Blueprint, and development of a Once for Scotland approach for cohesive governance across NHS Scotland
Workforce Implications	None identified to date
Financial Implications	None identified to date
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested as part of workplan – to enable reporting to Scottish Government
Risk Assessment (Outline any significant risks and associated mitigation)	None identified to date – this report supports good governance and considers overview whilst each workstream provides reporting and risk are outlined therein.
Assessment of Impact on Stakeholder Experience	Implementation will benefit stakeholder engagement through the workstreams indicated in the improvement plan
Equality Impact Assessment	Not required to be formally 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).	No impact identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One □ There are no privacy implications. X There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND - IMPROVEMENT PLAN **Appendix A**

BLUEPRINT FUNCTION		ACTION	LEAD	ASSURANCE SYSTEM	TIMESCALE	PROGRESS
SETTING THE DIRECTION	1	Reconfirm the Board's strategic direction, and communicate this through the Strategy Map and development of strapline statement for corporate documents.	CEO	CMT	June 2019	**Completed:** Strapline finalised following hospital wide competition. Strategy Map reviewed as part of review of Corporate Objectives.
	2	Review of effective rostering system within nursing as component of focus on effective workforce utilisation and safe staffing legislation.	Director of Nursing, AHPs and Operations	CMT	New: **December 2021 Board Update**	**December 2019:** Work to ensure effective rostering is in place with the support of electronic systems. Testing of SSTS eRostering module in one ward with wider rollout planned. Restrictions on effective rostering remain due to fixed shift pattern; alternative, flexible shift pattern introduced for all new appointments to ward nursing posts which increased capacity Internal Audit planned for Jan 2020. **Update: February 2020** RSM undertook audit 6th to 10th January 2020, range of actions linked to this point accepted for progression. **Update: December 2020** Work restarted - further planning and review underway in conjunction with interim management structure. **Update April 2021:** Work with the National Workforce Team has generated several pieces of work to streamline processes including potential adaptations to rostering and shift patterns to improve rostering, create capacity

						and reduce overtime. This workstream will continue to be progressed in Partnership during 2021. Full update to Board Seminar in May 2021 (deferred). **Update August 2021:** Dedicated reporting to Staff Governance Committee on implementation of legislation, dedicated reporting to Clinical Governance Committee in respect of staffing inked to impact on care. Meeting with the National Workforce Team in September 2021, and presentation to Board as part of seminar in September. **Update December 2021:** Safe Staffing legislation/reporting paused. Reporting on staffing impacts in nursing embedded into fora (Clinical Governance Committee/ OMT/ Partnership Forum. Rostering masterclass delivered to SCNs with support from national safe staffing team. Agreed to test a nationally agreed safe staffing readiness self-assessment template, which will be available to us in December 2021 Implementation of a 'safe to start' real time staffing assessment and are reporting our nurse staffing levels daily on a risk rated basis Working in partnership to agree a rostering protocol and test of change on 5/7 shift pattern. CMT agreed bank and supplementary staffing options for future implementation, following work progressed in partnership.

						Update April 2022: Safe staffing legislation remains paused, with progress expected during 2022. Self-Assessment further rollout planned also paused to date. 5/7 shift pattern – work progressed on staff feedback particularly around impacts on shaft handovers and to service delivery / impacts on patient experience currently underway. Bank - Recruiting underway to Nursing Bank amoung existing staff group with interviews for first cohort planned, and SLWG to take forward to monitor development and impacts and potential to grow thereafter.
	3	Development of more robust processes to compare planned and actual spend and to account for any variance.	Director of Finance and eHealth	CMT /Board	September 2019	**Completed:** Process in place- Planned and actual £ spend per budget line reviewed with each individual budget holder on a line-by-line basis from the 2019/20 mid-year 6-month reviews (30/9/19) – a summary of any significant or material variances is collated to be reported as appropriate.
HOLDING TO ACCOUNT	4	Ensure compliance with new national guidelines in management of Executive pay and performance through remuneration Committee approval for annual ESM pay and performance cycle.	Chair /Interim HR Director	Remuneration Committee	Ongoing	**Completed**

	5	Ensure implementation of attendance management policy through support from HR to line managers help identify and act upon patterns of absence. Continued implementation of the action plan developed through the Attendance Management Improvement Task Group (AMITG).	Interim HR Director	CMT	Ongoing 2019/20 – revised and completed	**Completed:** Once for Scotland Workforce Policy Implemented. Training for Line Managers and HR Managers delivered. Update presented on attendance management to each Board Meeting. Improvement activity now directed by the HR and Wellbeing Group.
	6	Implementation and compliance with Once for Scotland HR policies within TSH. Focus on policy awareness through completion of metacompliance / staff bulletins/ staff training in Single Investigatory process.	Interim HR Director	Partnership Forum/CMT	New: April 2022 national target	**Completed:** TSH readiness for planned implementation of phase 2 for April 2022. HR and Wellbeing Group is now well established and will support links with Partnership Forum/ Staff Governance Committee to ensure appropriate governance, with updates to the Board if required.
	7	Review performance framework and assurance information systems to support review of performance.	Head of Corporate Planning	CMT	New: **January 2022**	**On Track -** Strategic Review of Performance underway with draft performance framework in development based on balanced scorecard approach of better health better care, better value and better workforce. Operational definitions for suggested KPI's being developed with associated data sources identified.

						Update: December 2020 Presentation to Board in November 2020, work progressing with oversight through CMT **Update April 2021**: Format of KPI report changed to provide clarity on KPI's performance and describe the areas for improvement. Data map developed to illustrate where data is reported across governance and management groups. PuMP pilot being taken forward with HR to support alignment of performance improvement and reporting of KPI's in line with Organisational priorities and linked to departmental priorities. **Update August 2021. P**uMP rolled out to EHealth following the HR programme, and underway. Performance Workbook created across directorates and linked to governance. Strategic Planning and Performance Group set up and met for first time in August 2021, reporting line to the CMT. Link also made to Active Governance workstream for board development session planned for November 2021. Further update to Board in due course. **Update December 2021:** Board Development Session on Active Governance scheduled for 13 January 2022, and Board will consider this action further following that. **Update April 2022:** Session delayed due to extreme pressures during January – now scheduled for 3 May 2022.

	8	Blueprint Improvement Plan to be placed on Board Workplan for review at each Board Meeting.	Chair	Board	June 2019	**Completed**
ASSESSING RISK	9	Further development of risk management with focus on risk register to ensure this is clearly defined with set of mitigating measures against each risk which also have a focus on improvement actions.	Director Security, Resilience and Estates	Audit Committee / Board	New: June 2021	**Completed:** Work progressed to review the Corporate Risk register and link to development of local registers throughout TSH. Regular reporting of Corporate Risk Register to Board and tracked through monthly reporting at CMT and quarterly at OMT. Local Risk tracked and link made to CRR.
ENGAGING STAKEHOLDERS	10	Review and develop the Communications Strategy to include proactive engagement with aim of addressing dissonance between strategic aims of the hospital and public perception of these aims.	CEO	Board	New: **Roll out over June to December 2021**	**December 2019 -** Review of media strategy in progress with regular updates to the Board. **Update: December 2020** Presentation to Board seminar November 2020, and re-engagement of workstream at start of 2021. **Update April 2021-** Work being progressed January to June 2021 in preparation for roll out. **Update December 2021:** Presentation by Head of Communications to Board. **Update April 2022:** Roll out of Presentations highlighting work of TSH during March 2022, released on YouTube and promoted through

						social media platforms. Re-start of progress on communications options appraisal exercise following paused due to incident command, and Board reporting in April 22.
	11	Promotion of The State Hospital as an employer in the local area. Increase number of modern apprenticeships. Participate in local school careers events, local and university recruitment fairs.	Interim HR Director	CMT	New: August 2021	**Completed** Full range of recruitment activity in place.
	12	Encourage carers / volunteers /staff / local population to attend public Board Meetings through additional promotion and links with local community.	Board Secretary	Board	**New: Review April 2022**	**On Track** – through promotion of external Board Meetings /Annual Review session in 2020. **Update: December 2020** Reviewed in Board Seminar November 2020, and awaiting national guidance. Local review to be taken forward to engage virtually. **Update: February 2021**: Board agreed value of digital means of engagement and further work to be take forward to enable this to be taken forward linking to attendance by patients as well. **Update August 2021:** Board to consider further in September Development Session **Update December 2021:** Board received presentation in development session to review the options and consider within context of

						continuing impacts of Covid-19. Decision to necessarily pause until Spring 2022. In meantime encouragement given through CMT to staff to attend as observers in digital meetings when possible. **Update: April 2022:** Board to reconsider the position, and to consider move towards change to how to manage meetings based on previous presentation to board on exploring options including hybrid meetings, and to compare to other NHS Boards. To consider the timescale for any change.
	13	Hold two Board Meeting each year at external locations to promote role as national Board.	Board Secretary	Board	Paused due to Covid-19 restrictions	**Update: February 2020:** Board Meeting 27 February in Lanark Memorial Hall, digital participation under review. **Update August 2021:** Board to consider further in September Development Session **Update December 2021:** detailed consideration by Board in context of Covid-19 in development session, on hold to spring 2022. **Update April 2022:** Depending on discussion of Item 12 above, Board may wish to consider whether planning for this should also commence.
	14	Annual Review - Public Meeting to be held outside of the hospital to help engage public engagement and attendance.	Board Secretary	Board	Paused due to Covid-19	**Update: December 2019:** Plan to be progressed as part of Annual Review. The review in 2020 was redesigned due to Covid-19. Awaiting national guidance for the current year. **Update December 2021:** Confirmation of virtual Annual Review for 2020/21, took place 5 April.

						This will depend on national guidance for 2021/22 review arrangements.
INFLUENCING CULTURE	15	Define culture in The State Hospital in terms of key strengths and weaknesses - take forward through development sessions	CEO	Board	New: August 2021	**Completed:** **Update: February 2020** Progressed in conjunction with response to Sturrock and Clinical Model Review – Culture, Values & Behaviours, Leadership workstream led by CEO. **Update: December 2020** Workstream re-formulated and developed more widely under Recovery and Innovation Group during Covid. Planning in place for development of this framework in spring 2021, and reporting to come to Board as part of workplan. **Update: April 2021** A programme of work, from the themes identified through the staff engagement activity has been taken forward. Oversight of the Recovery and innovation group is through CMT, and updates to all staff through bulletin. Future developments will connect through the staff HR and Wellbeing group **Update: August2021:** Workstream led through HR and Wellbeing. Staff wellbeing reporting comes to Board as part of covid reporting, with dedicated reporting to replace this at end of pandemic as part of overall workforce reporting/ workplan.

	16	Implement a Staff Recognition Scheme for long service as well as individual contribution to the organisation.	Interim HR Director	CMT	September 2019	**Completed**- first ceremony 24 October 2019.
	17	Embed a culture of quality across the organisation through initiatives such as TSH3030, Quality Forum and sharing our work more widely.	CEO	CMT	February 2020	**Completed and Board now gets full updates at each meeting.**
	18	Senior Management visibility through regular front line staff engagement meetings with CEO / Directors' Group - plan a calendar of events to ensure regular engagement.	CEO	CMT	New: **Review April 2022**	**Update: December 2019** wider engagement across TSH – progressed in conjunction with response to Sturrock and Clinical Model Review. **Update: December 2020** This agenda has been developed throughout the incident command structure period, with strengthening of layers of leadership. Key learning has been taken and progressed through to interim management structure. **Update: April 2021** Review of digital means of connection under development with software procured. Training and development to be progressed for rollout **Update December 2021:** Directors schedule on site is produced weekly ensuring on site presence rather than digital links. Directors lead on engagement with teams to ensure visibility.

						Hospital events not being taken forward face to face so remainder of action ON HOLD. **Update April 2022:** Structured engagement more firmly embedded through development of planning leadership and key workstreams – for Remobilisation Planning, Clinical Model Implementation. Board to consider if new management structure aligned to CMT, is now supporting means and route for engagement, and that reporting will come to the Board in these areas through its workplan for 2022. To consider closing this item on the action plan.
	19	Senior Team / RMO presence at key events in hospital calendar e.g. patient learning awards/ sportsman dinner. Promote this through management structures.	CEO / Medical Director	CMT	New: **Review April 2022**	**Update: December 2019** Coordination of central diary of events to help facilitate attendance. **Paused due to Covid-19** **Update August 2021:** Covid restrictions depending event planning through hybrid of in person and digital means with coordination of diary to be led through Corporate Services Team and in place for October 2021. **Update December 2021:** Hospital events not being taken forward face to face. Digital platform for Staff Awards. Remainder of action ON HOLD. **Update April 2022:** Ability to take forward on site events is under remit of CMT given the need to coordinate across site in line with national recovery. Suggest add to CMT agenda

						to ensure review for second half of 2022. Consider closing as item on this action plan.
	20	Link in with Scottish Government once appointment of the Independent National Whistleblowing Officer and Board Champion has been appointed.	Change to Interim HR Director	Board	March 2021	**Completed**
	21	Plan a schedule of Non-Executive Director informal visits across TSH to help promote the values and behaviours of the organisation.	Chair	Board	New: **Update to Board December 2021**	**February 2020** - Schedule in place for patient and staff engagement with NXD attendance at PPG meetings. **Paused due to Covid-19** **Update: December 2020** Restart may be possible in 2021. PPG meetings have, in part re-commenced virtually, explore possibility of NXD attendance at these meeting virtually. Digital agenda being progressed including online staff engagement for Exec Team. This should be progressed to include NXDs. **Update April 2021:** PPG meetings taking place in person for ID population, and new video conferencing equipment under procurement for wider patient group. Non- Executive attendance to be kept under review for 2021 when possible. **Update August 2021:** Covid restrictions depending, non –executive presence on site now being taken forward as per hybrid model of engagement. Workplan Including PPG/

						Leadership Walkrounds planned for October 2021 onwards. Link to hospital events such as staff awards through digital means. **Update December 2021:** PPG link and meeting schedule /Patent Safety Walkrounds schedule established (depending on any future restrictions). Link to Staff awards available to Non Execs. **Update April 2022**: Schedule now in place and commenced in February 2022. Consider closing item on this action plan.

Updated 19.04.22

M Smith

APPROVED Minutes of the meeting of the Audit Committee held on Thursday 7 October 2021 at 9.45am via Microsoft Teams **AC(M) 21/05**

PRESENT:

Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	David McConnell **(Chair)**

IN ATTENDANCE:

Internal

Chair Person	Brian Moore
PA to Finance and Performance Management Director	Fiona Higgins **(Minutes)**
Chief Executive	Gary Jenkins
Finance and Performance Management Director	Robin McNaught
Head of Corporate Planning and Business Support	Monica Merson
Head of Procurement	Stuart Paterson
Director of Nursing, AHP and Clinical Operations	Mark Richards
Director of Security, Estates and Facilities	David Walker

External

Director, Azets	Chris Brown
Internal Audit, RSMUK	Victoria Gould
Head of Internal Audit, RSMUK	Asam Hussain

1 APOLOGIES

David McConnell chaired the meeting and welcomed those present, including Allan Connor to his first Audit Committee as Employee Director and Stuart Paterson as Head of Procurement, attending to present the Procurement Annual Report.

Apologies for absence were noted from Pam Radage and Margaret Smith.

2 CONFLICTS OF INTEREST

There were no conflicts of interest to note.

3 MINUTES OF THE PREVIOUS MEETING OF 17 JUNE 2021 AND 22 JULY 2021

The Minutes of the previous meetings held on 17 June 2021 and 22 July 2021 were **approved** as accurate records.

Members noted that the Patient Funds Audit for 2020/21 is currently being undertaken with auditors working both on site and remotely. This should be available for presenting to the January 2022 meeting.

ACTION: FIONA HIGGINS

4 MATTERS ARISING - ACTION NOTES UPDATE

Members **noted** the recorded actions and that that all were either complete, on the current agenda for further discussion, not yet due or were delayed as a result of Covid 19 priorities.

INTERNAL AUDIT

5 INTERNAL AUDIT PLAN 2021/22 – PROGRESS REPORT

Members received and noted a Progress Report on 2021/22 Internal Audit work for the period to date, which was presented by Asam Hussain, Head of Internal Audit, RSMUK. The report provided an update on progress against the internal audit plan, approved at the Audit Committee in March 2021. Members noted that 2 reports have now been finalised and are on today's agenda for discussion. Scope and timings for the Resilience of Security Systems audit is currently being discussed with David Walker, Director of Security, Estates and Resilience and it has been agreed that in light of the ongoing work on the Security Perimeter Project this audit be delayed to the 2022/23 audit year. Further to additional discussion and due to the continuing Covid crisis, it has also now been agreed that the Incident Management Audit also be similarly deferred. Replacement audits will be identified and communicated to the Audit Committee.

Members noted that the delayed audit of the new Clinical Model may require to be further postponed due to the ongoing pandemic and the challenges to the implementation of the new Clinical Model whilst operating under covid restrictions. This will require future agreement from Members as matters clarify.

Members noted the Progress Report and acknowledged and approved the re-scheduling of the audits as detailed in the report.

6 INTERNAL AUDIT TRACKING REPORT

Members received and noted an updated Internal Audit Plan and Strategy for the period 2021/22 which was presented by Asam Hussain, Head of Internal Audit, RSMUK. The report detailed that from the 11 actions reviewed

- 2 are complete
- 2 are not yet due for implementation
- The remaining are currently being implemented

Members noted the content of the report

7 EFFECTIVE ROSTERING AND OVERTIME MANAGEMENT

Members received and noted the finalised report following the internal audit of Effective Rostering and Overtime Management which was presented by Asam Hussain, Head of Internal Audit, RSMUK. The report provided the Audit Committee with a conclusion of Partial Assurance due to the weaknesses in recording and approving overtime / additional hours to be worked, a lack of guidance documentation relating to rostering policies and procedures and the level of monitoring of additional hours worked and the resulting impact on overtime costs. There were 3 high and 3 medium recommendations made.

Mark Richards advised that progress has been made on a number of points highlighted in the audit and a Short Life Working Group, with partnership involvement, was now taking forward the recommendations made.

Brian Moore commented that this was a helpful report with a lot of operational detail and thanked Mark Richards and Allan Connor for their detailed comments on the matters within the report and the progress made against each recommendation to date, noting the challenges encountered.

Stuart Currie asked if the target date set for the conclusion of the actions was realistically set as March 2022 for both high and medium actions, taking into consideration the significant pieces of work and the challenges around implementation of the actions. He also asked if there was any correlation between staff absence and the level of staff working additional hours. Mark Richards advised that this had not been specifically inquired into but that it was a reasonable point to raise and agreed that this could be undertaken, though would be a much more detailed piece of work.

Gary Jenkins welcomed the detailed discussions around the 6 and 12 week rotas and David McConnell acknowledged the detailed report and that the actions and Short Life Working Group were being monitored through the Partnership Forum.

Members noted the report and the recommendations and actions resulting from the audit.

8 GOVERNANCE

Members received and noted the finalised report following the internal audit of Governance which was presented by Victoria Gould, Internal Audit, RSMUK. The report provided the Audit Committee with a conclusion of Substantial Assurance and recommended one management action, on the use of the Skills Matrix for Members, which was assessed as low.

Gary Jenkins advised that the recommendation would be addressed and noted that it would be helpful to see how the work CMT and that of the new executive groups feed into the Committee's work and development.

Brian Moore noted the positive report as a good starting point / position statement for moving forward.

Members noted the report and the recommendation within the audit.

INTERNAL CONTROL AND CORPORATE GOVERNANCE

9 CORPORATE RISK REGISTER UPDATE

Members received and noted a report on the Corporate Risk Register, which was presented by David Walker, Director of Security, Estates and Resilience. The report provided an update on the current risk registers, including any changes made and provided assurance to members that all corporate risks are fully reviewed. There are no proposals for any additions to the Corporate Risk Register.

Section 3.4 of the report provided detail of the changes made to three of the corporate risks since the previous meeting:

CE14 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
Was downgraded to Major x Possible (High) after the risk assessment was reviewed by Senior Nurse for Infection Control and Risk Management Facilitator and then agreed by CMT. This decision was made based on vaccination rates, control measures in place within the hospital and levels of transmission within the community.

ND70 Failure to utilise our resources to optimise excellent patient care and experience
Has been increased by the Director of Nursing and AHP to Major x Possible (High) from Medium due to current staffing pressures within the hospital that is affecting the care being delivered to patients.

FD93 Failure to complete actions from Cat 1/2 reviews within appropriate timescale
CMT have accepted the decision to move this risk to the Director of Security due to the movement of the Risk and Resilience Department to the Security Directorate. This will be updated when the risk is next due for review.

These require to be updated in Appendix A, which members also agreed should have the addition of a column indicating high/medium/low.

ACTION: DAVID WALKER

Members noted the content of the report.

10 RISK AND RESILIENCE ANNUAL REPORT 2020/21

Members received and noted the Risk and Resilience Annual Report for the period 2020/21 which was presented by David Walker, Director of Security, Estates and Resilience. The report provided a summary of the work undertaken by the Risk and Resilience Department (formerly the Risk Management team) over the reporting period and provides information relating to proposed pieces of work for the 2021/22 period.

David Walker highlighted the various changes within the team across the reporting period following the implement of the new management structure at the Hospital.

Members noted the content of the report and the significant amount of work undertaken by the department during the reporting period. Thanks were noted to Stewart Dick, Risk Management Facilitator for his work with the risk register and Datix during the reporting period and in particular with the vacancy within the department.

11 PROCUREMENT ANNUAL REPORT

Members received and noted the Procurement Annual Report for the period 2020/21 which was presented by Stuart Paterson, Head of Procurement, who advised that the report is required by the Scottish Government in order to ensure there is a continuous drive across all Boards to achieve excellence in procurement activities. The report highlights the main activity of the Hospital's Procurement function, including addressing areas of known future activity that may impact on the resources and skills of the procurement function.

The Annual Report provided a summary of the regulated procurement planned for the period April 2021 to March 2022.

The three year Procurement Strategy will be presented to the committee in 2022 for review, this will address any key procurement issues.

The report also detailed the collaborative work undertaken by the department with the National Health Boards Procurement Group which focusses on collective targeted savings through joint working across the National Procurement community. Being part of this has allowed the Hospital to benefit from the ability to purchase unique products at competitive prices.

Members agreed it was a comprehensive and useful report, and had noted in particular the detailed section on waivers and thanked Stuart Paterson for his presentation to the Committee.

Members noted Annual Report for the period 2020/21

12 FRAUD UPDATE

Members received and noted an update on fraud allegations and notifications received from Counter Fraud Services, which was presented by Robin McNaught, Director of Finance and eHealth. Members noted that since the previous Audit Committee a significant number of alerts had been received, particularly in relation to procurement and finance, these continue to be circulated for awareness.

Members noted the content of the alerts circulated by Counter Fraud Services in the last quarter and the update on fraud allegations.

13 FRAUD ACTION PLAN

Members received and noted an update on the Board's approach to countering fraud and the level of engagement with Counter Fraud Services based on the discussions from the annual customer engagement visit. The update was presented by Robin McNaught, Director of Finance and eHealth.

Members noted the progress on engagement activities; noted the update on Communication; reviewed the Fraud Action Plan (appendix 1) and noted that there was no further revision to the top ten risks identified from the FRAM (appendix 2).

14 POLICY UPDATE REPORT

Members received and noted a report on policy implementation across the Hospital, which was presented by Robin McNaught, Director of Finance and eHealth. The report detailed that as at 28 September 2021 the State Hospital has 131 policies with 20 being past their review date. Unfortunately the Policy Approval Group which had been due to take place on 28 September 2021 was postponed until 6 October 2021, so four policies will be put forward at this rescheduled meeting for approval. A detailed breakdown of the current policies which were past their review dates and those due for review by March 2022 were included in the report.

Members noted the content of the report including a verbal update noting the overall improvement made on the status of policies

EXTERNAL AUDIT

15 EXTERNAL AUDIT ANNUAL REPORT 2020/21

Members received and noted the final version of the external auditors' Annual Audit Report to the Board and the Auditor General for Scotland. This report is normally scheduled to be presented to the June Meeting of the Committee, however, as has been widely the case across the NHS, these reports have been delayed by the impact of the pandemic. The Committee did however receive an earlier draft of the report at its July meeting which focussed on matters which allowed finalisation of the Annual Report and Accounts. The full version of the report, presented here, provides a conclusion to the audit work undertaken in respect of the year 2020/21 and, in particular, wider scope audit conclusions and findings are included.. The report provides conclusions across the key areas of:

- Annual Accounts
- Financial Sustainability
- Financial Management
- Governance and Transparency
- Value for Money

Members thanked the External Auditors and noted the content of the report. The Committee also noted that the tender with Azets had been extended by one year and that this would result in Chris Brown being the Engagement Lead for the audit for over 10 years (Audit Scotland's specified limit). Therefore this position will now be taken on by Karen Jones. Members offered their thanks and appreciation to Chris for his contribution and support over the period of his appointment.

OTHER ISSUES

16 EFFECTIVENESS OF AUDIT COMMITTEE

Members received a report from Robin McNaught, Director of Finance and eHealth, which provided advice on the requirement for self-assessment by the Committee, as outlined by the Scottish Government Audit Committee Handbook. The Committee had completed the Self Assessment Checklist, in line with the Scottish Government Handbook in September 2020, with additional guidance in the context of the challenges posed by coronavirus.

The report provided an overview of the feedback received and members noted that no areas of concerns were raised, with an overall positive response received, with feedback evidencing that the Terms of Reference over the core functions are reviewed and approved annually. Further the Committee has sufficient membership, authority and resources to discharge its role effectively and independently.

Members highlighted the following :

Induction

- The Blueprint for Good Governance should provide further guidance, and a revision is expected in the coming months
- Consideration to be given to facilitated development sessions for Members

Independence of Committee from other Board Governance Committees

- Members acknowledged the challenges associated with this in light of the small size of the Hospital Board
- Members and Directors to ensure there is no duplication of reports to committees
- There are advantages to having a smaller Board in relation to the wider breadth of understanding of the landscape that this allows.

Feedback from Board to Accountable Officer

- A mechanism for progressing this is to be agreed

Members agreed this was a useful process and that this it should continue to be undertaken annually.

ACTION: ROBIN McNAUGHT / MARGARET SMITH

17 DRAFT AUDIT COMMITTEE WORKPLAN 2022

Members **approved** the Audit Committee Workplan for the period 2022 subject to removal of Sickness Absence Update which is now monitored through the Staff Governance Committee.

ACTION: FIONA HIGGINS

18 FINANCE, EHEALTH AND AUDIT GROUP UPDATE

Members received and noted an update from Robin McNaught, Director of Finance and eHealth on the Finance, eHealth and Audit Group. The report highlighted the key issues addressed and considered by the group, assuring the Committee that there are robust arrangements in place for monitoring and review of the effectiveness of management arrangements within the Board.

Members acknowledged and agreed the proposal from the Corporate Management Team that an SBAR update be provided to the Audit Committee rather than the full minutes, which contain a significant amount of operational detail. The terms of reference of this group will be amended to reflect this change.

ACTION: FIONA HIGGINS

19 SECURITY, RISK AND RESILIENCE, HEALTH AND SAFETY GROUP UPDATE

Members received and noted an update from David Walker, Director of Security, Estates and Resilience on the Security, Risk and Resilience, Health and Safety Group. The report highlighted the key issues addressed and considered by the group, with a new inclusion of Sustainability and the requirement to provide a Climate Change Risk Assessment, a significant piece of work being taken forward by the Heads of Security and Risk and Resilience. The report provides assurance to the Committee that there are robust arrangements in place for monitoring and review of the effectiveness of management arrangements within the Board.

Members acknowledged and agreed the proposal from the Corporate Management Team that an SBAR update be provided to the Audit Committee rather than the full minutes, which contain a significant amount of operational detail. The terms of reference of this group will be amended to reflect this change.

ACTION: FIONA HIGGINS

20 ANY OTHER BUSINESS

There was no other business.

21 DATE AND TIME OF NEXT MEETING

The next meeting will take place in January 2022, date and time to be confirmed.